CORRELATES OF REPRODUCTIVE COERCION AND STRATEGIES TO MINIMIZE HARM AMONG LATINA WOMEN

by

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Abstract

Statement of problem: Reproductive coercion (RC) is abusive or controlling behavior that interferes with autonomous reproductive health decision-making by women. It is understudied, especially in Latina women, and is a critical factor in health outcomes disproportionately experienced by Latina women, such as unintended pregnancy.

Methods: This study used an exploratory sequential mixed-methods design. In Phase 1, 13 adult Latina women who reported lifetime experience of RC participated in in-depth interviews to define RC, risk factors and safety strategies, and pregnancy intention. Findings from Phase 1 informed the quantitative phase (Phase 2), the administration of a linguistically appropriate survey on lifetime and past-year prevalence of IPV and RC, risk factors, safety and harm reduction strategies, and unintended pregnancy with 500 Latina women seeking services at an urban health center.

Results: The current definition of RC is clearly applicable to Latina women. Cultural norms impacted vulnerability and resistance to RC. Factors that significantly increased risk of RC among the sample, included younger age, concurrent IPV and partner binge-drinking. There was a significant association ($p=0.001$) between RC and unintended pregnancy, and this relationship was not moderated by the use of safety and harm reduction strategies.

Conclusions: This study adds to the growing body of literature on RC by identifying risk factors and outcomes of RC specific to a population of Latina women. Findings support the risk factors that have been identified in other studies as also relevant in this population and highlight areas for providers to have heightened suspicion for RC, such as women presenting with unintended pregnancy or seeking abortion and any woman who is suspected or confirmed to be experiencing IPV. This study also supports increased provider vigilance for RC among young Latina women reporting more than one recent partner. The use of existing provider guidelines for RC is supported in Latina women, with perhaps the greatest benefit to be gained from offering support

services to plan for safety and harm reduction when make decisions about leaving unhealthy and unsafe relationships.

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Dedication

For Dad (1941-2018)

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Dissertation Organization

This dissertation is organized into five chapters. Chapter 1 provides introductory and background foundation for the study, the purpose and specific aims, and the conceptual framework for this research. Chapter 2 (Manuscript 1) was published in 2016 (Grace, K. T., & Anderson, J. C. (2016). Reproductive Coercion: A Systematic Review. *Trauma, Violence, & Abuse*, *19*(4), 371–390. http://doi.org/10.1177/1524838016663935) and systematically reviews the recent literature on reproductive coercion (RC) to develop the conceptual framework for the study. An addendum to Chapter 2 summarizes updates to the RC literature since publication of Manuscript 1. Chapter 3 (Manuscript 2) has been submitted for publication and is currently under review (Grace, K. T., Alexander, K. A., Jeffers, N. K., Miller, E., Decker, M. R., Campbell, J., & Glass, N. (under review). "The path makes us strong": Experiences of reproductive coercion among Latina women and strategies for minimizing harm. *Journal of Midwifery and Women's Health*.), and presents findings from Phase 1 of the study, qualitative interviews with Latina women who have experienced RC. An addendum to Chapter 3 provides additional findings relevant to Aim 1 of the study, which were not included in the manuscript due to space limitations. Chapter 4 (Manuscript 3) is a publication-ready paper on findings from Phase 2 of the study, a survey of 500 Latina women on RC prevalence, risk factors, harm reduction strategies and outcomes. Finally, Chapter 5 provides a summary of findings from all three manuscripts. This chapter discusses limitations of this study as well as implications for research and practice. Three appendices are also provided: Appendix A is the study protocols document, Appendix B is the qualitative interview guide, and Appendix C is the list of measures for the survey.

Chapter 1 : INTRODUCTION

Background and Rationale

Reproductive coercion (RC) is abusive or controlling behavior that interferes with autonomous reproductive health decision-making by women.[1,2] It is a type of intimate partner violence (IPV) that is a unique and understudied phenomenon,[1,3–13] and a proximate cause of unintended pregnancy.[1,5,7] RC behaviors can include sabotaging birth control methods, refusing to wear condoms, blocking access to contraception, or pressuring a woman to continue or to terminate a pregnancy. It is one of many forms of power and control exercised by an abusive partner, but it can also occur in the absence of physical or sexual violence.[1,5–7,10,12] Questions exist about the relationship between these distinct but related phenomena. Some of what is known about RC is suggested in qualitative literature but has not been thoroughly explored quantitatively, such as specific RC tactics[14–18] and strategies used by women to resist RC.[2,14,16–18]

Coercive behaviors in the area of reproductive health are not a new phenomenon. RC behaviors have been described in IPV literature for several decades.[19–25] In 2010, researchers began to label these behaviors as RC and to study them as a distinct entity from IPV.[1,2] Measures of RC have continued to evolve since this time. An RC Scale has been developed which is used in various iterations in a variety of studies, ranging from a recently validated 5-item scale[26] to the full 11-item scale,[27] and measures evaluate RC experiences ranging from the past 3 months to lifetime. Some studies use investigator-developed measures of a variety of RC behaviors, ranging from 1 question[28] to as many as 24.[29] Currently there is debate about re-wording measures to remove partner's intent (e.g., "so that you would become pregnant") since the behavior itself is what is associated with negative health outcomes, and partner intent may be unknown.[30,31]

The diverse methodology and measures used in this emerging area of research, make comparison between studies challenging. However, as this field of research expands, knowledge

about RC is increasing. Prevalence in community samples ranges from 5 percent (past 3-months)[7] to 25.9 percent (lifetime).[27] Population-based data reveals prevalence of RC ranging from 1.1 percent (past year RC measured with 1 question)[28] to 8.6 percent (lifetime RC measured with 2 questions).[32] The highest prevalence in a study of a special population was 51 percent (past year) in a sample of 474 mostly African-American teen parents.[20] Studies on RC that examine the impact of race and ethnicity, while limited, suggest that women who identify as African American, Latina or multiracial may be disproportionately affected.[1,5,7,10]

Latina women experience disproportionate negative health outcomes in some areas of sexual and reproductive health[33] (when compared to non-Hispanic White women) such as unintended birth,[34] sexually transmitted infection and associated fertility complications[35] and use of less effective contraception.[36] In some areas, however, Latina women experience better outcomes than other races and ethnicities, such as higher rates of breastfeeding.[37] There is some evidence that Latina health outcomes are influenced by the so-called "healthy immigrant effect", which describes positive health outcomes among newly immigrated people, and deteriorating outcomes along with time lived in the United States.[38–40]

Latinas* are a diverse ethnic group originating from many diverse countries and influenced by diverse cultural norms, but the gender role norms of *Machismo* (often simplistically explained as strongly masculine, emphasizing bravery and virility) and *Marianismo* (often described as strongly feminine, emphasizing submission and modesty) are suggested as strong cultural influences that may impact vulnerability to IPV.[41] These same norms are also sources of strength and resilience for Latino communities, as *Machismo* also connotes courage, respect, and protection of family, and *Marianismo* also connotes a strong mother who is central to the

* Prior research interchangeably refers to participants as Latina (of Latin American descent) or Hispanic (of Spanish-speaking origin); for purposes of clarity we will use the term Latina unless referencing a particular study which uses a different term.

family.[42] Cultural norms of *Familismo* (importance of family), *Respeto* (respect for others) and *Simpatía* (preference for positive interactions)[43,44] may also offer sources of vulnerability and/or resilience. These norms were hypothesized to influence RC vulnerability or ability to resist RC and were explored in the study.

Pregnancy intention is a complex and multidimensional construct, which encompasses intended pregnancy (occurring at the time or later than the woman wanted it to), and unintended pregnancy (including pregnancy occurring earlier than the woman wanted (mistimed) and unwanted pregnancy (never wanted by the woman)).[45] Enthusiasm for a pregnancy is not necessarily reflected in pregnancy intention, as an unintended pregnancy may be received with great joy, and an intended pregnancy may be met with a variety of emotions. Intended pregnancy is a public health outcome measure reflecting autonomy and agency among women and couples.[46] This study examined unintended pregnancy, which is associated with negative health outcomes for women and children, including preterm birth,[47] inadequate prenatal care,[48,49] perinatal depression,[50] exposure to teratogens and harmful behaviors in pregnancy,[49,51] and reduced breastfeeding.[49] Latina women experience increased rates of unintended pregnancy when compared with other races/ethnicities.[52,53]

In summary, Latina women suffer disproportionately poor reproductive health outcomes; there are aspects of IPV and RC that are unique to sociocultural contexts that help explain this.

Purpose and Study Aims

The purpose of this study was to explore the experience of, risk factors for, and strategies used to resist RC, and the relationship with unintended pregnancy, among Latina women, in order to inform healthcare practice guidelines and interventions.

This study used an exploratory sequential mixed-methods design. To achieve the study aims, two phases were conducted. In Phase 1, adult Latina women who reported lifetime

experience of RC participated in in-depth interviews to define RC, risk factors and safety strategies, and pregnancy intention. Findings from Phase 1 informed the quantitative phase (Phase 2), the administration of a linguisticallyappropriate survey on lifetime and past-year prevalence of IPV and RC, risk factors, safety and harm reduction strategies, and unintended pregnancy with 500 adult and adolescent Latina women seeking services at an urban health center. The study was approved by the Johns Hopkins Medicine Institutional Review Board (IRB00129418). The specific aims were:

Phase 1:

Aim 1: Describe the experience of RC, the use of safety and harm reduction strategies for RC, and pregnancy intention among low-income Latina women seeking IPV services at an urban clinic.

Phase 2:

Aim 2: Examine multi-level risk factors (e.g. male partner factors, acculturation, poverty, trauma/violence history, time in United States, country of origin, employment) for RC among low-income Latina women, ages 15-45, seeking services at an urban clinic.

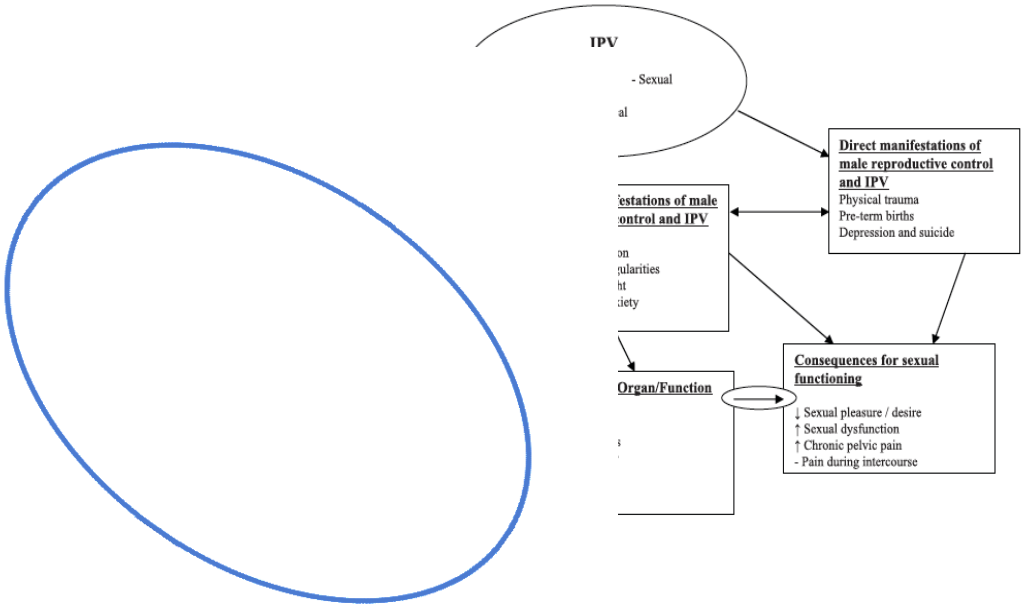
Aim 3: Determine the relationship between RC and unintended pregnancy in low-income Latina women, ages 15-45, seeking health or social services at an urban clinic.

Aim 4: Explore whether the use of specific safety strategies moderates the relationship between RC and unintended pregnancy, in order to inform the adaptation of existing guidelines[54] and interventions[6] for RC for Latina women.

Conceptual/Theoretical Framework

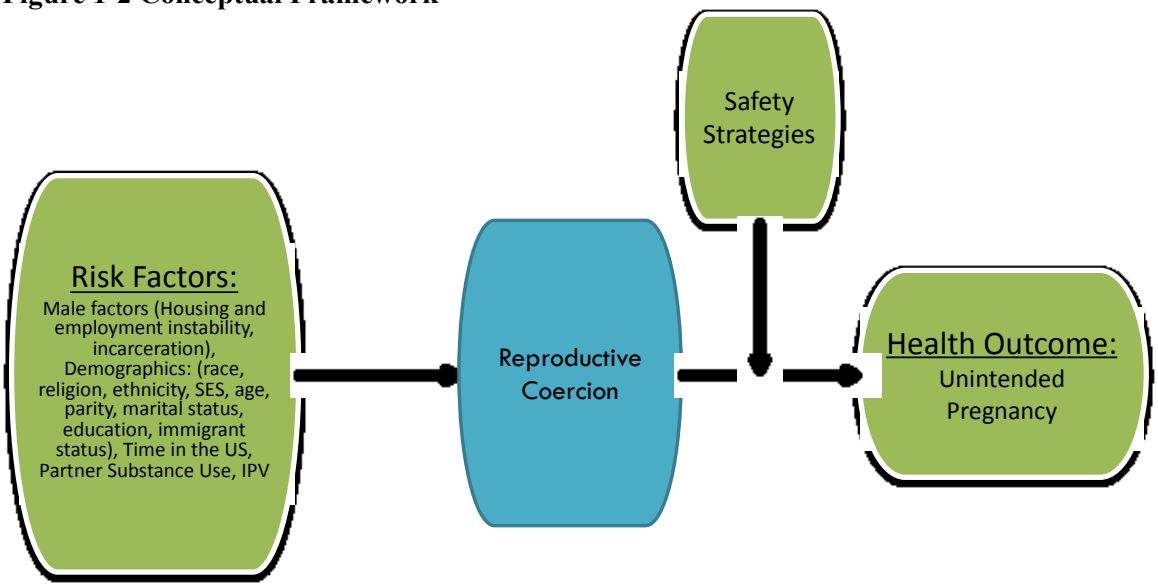
The conceptual framework for this study builds on Moore et al.'s model of IPV and Health Outcomes,[2] (Figure 1-1) which describes how RC and IPV may contribute to unintended pregnancy. Relevant components of this model are highlighted.

Figure 1-1. Moore's Model of IPV and Health Outcomes



An adapted conceptual model that depicts this relationship in the context of Latina women was developed to guide this study's design and variable selection, based on existing Latina health, IPV and RC literature (Figure 1-2).

Figure 1-2 Conceptual Framework



Risk factors for RC are suggested by existing literature on RC and IPV. These factors were explored in Phase 1 of the study and measured in Phase 2. These include male partner factors: male partner substance use is associated with IPV in studies of Latina women,[55] but has not been studied in RC literature. Demographics: research demonstrates that race and ethnicity,[1,5,7,10] low socioeconomic status,[10] lower parity,[56,57] and less educated[1,7] women have higher risk of RC. Younger women have a higher risk of RC in existing literature,[17,58] and higher odds of IPV in studies of Latina women.[55] Single women have higher risk of RC in existing literature,[7,10] and divorced or separated women have higher risk of IPV in studies of Latina women.[55] Time in the United States: Some literature on IPV and Latina women demonstrates higher risk for more recent immigrants;[59] in contrast, other studies demonstrate higher risk with greater levels of acculturation;[60,61] Studies on unintended pregnancy[34] show risk levels increasing along with time in the United States. IPV is very clearly and strongly correlated with RC,[1,3,5–13,56,57,62,63] although this correlation has not been specifically examined in Latina women.

The use of **safety and harm reduction strategies**: Findings from existing RC literature are limited but suggest that women resist RC by choosing injectable methods of contraception,[5] hiding contraceptive use,[14,17,18,64] obtaining contraception in another country so that a partner could not read the label,[17] lying about being pregnant,[18] having abortions against partners' wishes,[2] lying to a partner about non-existent fines for an IUD insertion appointment,[17] checking condom placement during sex,[16] and secretly leaving the abortion clinic after being dropped off by a pressuring partner.[17] These strategies to resist attempts at control or coercion in a coercive relationship are consistent with literature on IPV in Latina women.[65] What is not known is what specific strategies are used by Latina women in regards to RC, and how they may inform clinical recommendations.

The primary **health outcome** measured in this study is unintended pregnancy, defined as either pregnancy occurring earlier than the woman wanted (mistimed) or pregnancy that was

never wanted by the woman (unwanted).[45] RC is strongly correlated with unintended pregnancy,[1,5,7] and Latina women experience increased rates of unintended pregnancy when compared with other races/ethnicities.[52,53] RC may be a cause of this health disparity. Phase 1 of the study explored pregnancy intention among Latina women, and the influence of cultural norms, and informed measurement of unintended pregnancy in Phase 2 of the study.

Significance

RC disproportionately affects women who are lower socioeconomic status,[10] single,[7,10] and African American, Latina or multiracial.[1,5,7,10] Existing RC literature includes substantial numbers of Latina participants,[4,7,10] but no studies examine correlates of RC stratified by race/ethnicity (only prevalence is reported by race and ethnicity)[1,5,7,10,66] or focus exclusively on Latina participants. When reported, prevalence of RC in Latina women ranges from 14[10]–17[1,5] percent.

Forty-five percent of pregnancies in the United States are unintended, and there is significant racial and ethnic disparity in this outcome.[46] Hispanic women have a 71% higher odds of unintended pregnancy compared to White women,[52] and have the second highest rate of unintended births.[46] This disparity is partially explained by young age, being US-born, higher education and single relationship status.[34,52] Latina and Hispanic women have unique patterns of contraceptive use, preferences and knowledge, which may also help explain this disparity.[36,67–74] RC, clearly identified as strongly correlated with unintended pregnancy[1,5,7] and differentially affecting different races and ethnicities,[1,5,7,10] may be another cause of this disparity; further studies such as this one will help establish this connection.

Latina women experience high rates of IPV relative to White women,[32,75,76] Country of birth and time in the United States are important in impacting risk.[55,59,77] In studies of Latino men, unique factors associated with IPV perpetration include higher acculturation and acculturation

stress, and patriarchal gender role attitudes.[41] Latina women with immigration concerns may be less likely to seek help or report IPV to police.[78,79] These factors may also impact RC among Latina women, but have not previously been studied; this study provides much needed evidence in this area.

Guidelines for providers who encounter women experiencing RC are limited to harm reduction strategies (less-detectable methods of birth control and abortion) and social services referral.[54,80] Harm reduction is a proven strategy with roots in the field of substance abuse[81–85] and application in IPV management,[86–90] and is based on best clinical practices. But research supporting these specific recommendations is limited, and does not specifically evaluate their use with Latina women.[6] Contraceptive use patterns vary by racial and ethnic group, which may impact the effectiveness of RC interventions. Findings about acceptability of intrauterine devices and implants among Latina women are conflicting, with some suggesting higher acceptability among Latina women[36,69,74] and some suggesting low acceptability of these methods, or a preference for male-controlled methods such as condoms and withdrawal.[68–70] These factors may impact effectiveness of existing RC guidelines. Refinement for Latina women may be necessary.

Innovation

Disparities in unintended pregnancy and in RC and IPV are significant health threats for ethnic minority women. There are aspects of IPV and RC that are unique to the sociocultural context of Latina women. Without understanding this context, interventions may not prove effective or relevant to Latina women. This study is innovative and timely in that it addresses a significant health problem for an ethnic minority group that has not been studied, to effect significant improvement in reproductive health outcomes. It also uses a mixed methods design to examine RC from multiple perspectives, and a large sample of exclusively Latina women which has not previously been done. Key variables such as RC and IPV are partner-specific, allowing

greater confidence in associations between these factors. And this study separates intention from behavior in measures of RC and safety and harm reduction strategies in order to increase sensitivity of measures and also to enable future analyses and further development of RC measures.

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Chapter 2 : MANUSCRIPT ONE

Reproductive Coercion: A Systematic Review

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Abstract

Reproductive coercion is behavior that interferes with the autonomous decision-making of a woman, with regards to reproductive health. It may take the form of birth control sabotage, pregnancy coercion, or controlling the outcome of a pregnancy. The objectives of this article are to address the questions: 1. What is known about reproductive coercion, its prevalence and correlates? 2. What strategies do women use to preserve their reproductive autonomy when experiencing reproductive coercion? 3. What interventions are effective to decrease reproductive coercion? In this review of 27 research studies, 12 contained findings regarding the general phenomenon of reproductive coercion, and 19 contained findings about at least one component of reproductive coercion. Additionally, 11 studies contained findings related to the intersection of IPV and reproductive coercion, 6 presented data on strategies women use to resist reproductive coercion, and 3 included intervention data. Variation in measurement makes synthesis of prevalence and correlate data challenging. The reviewed literature presents reproductive coercion as a phenomenon that disproportionately affects women experiencing concurrent IPV, women of lower socioeconomic status, single women, and African American and multiracial women. Women who experience reproductive coercion were found to present frequently for certain health services. Most data on reproductive coercion are descriptive; there is need for further research to examine the co-occurrence with related phenomena such as IPV and unintended pregnancy. More research is also needed on the strategies women use to resist reproductive coercion as well as interventions aimed at survivors and perpetrators of reproductive coercion and healthcare providers who encounter them.

Keywords: Reproductive coercion; Pregnancy; Contraception; Sexual violence; Pregnancy, unwanted; Domestic violence; Intimate partner violence

Introduction

In a violent intimate partner relationship, the underlying dynamic is often of an abuser utilizing a variety of tactics in an effort to create vulnerabilities, and to achieve power over and coercive control of his partner (Dutton & Goodman, 2005). Abusive partners may exert power and control in non-violent ways, such as isolation, financial control, and emotional abuse (Gentry & Bailey, 2014; Katerndahl, Burge, Ferrer, Becho, & Wood, 2013; Sanders, 2015). Non-violent power and control tactics may be exerted specifically on the reproductive health of women, in a phenomenon that has recently been labeled as reproductive coercion, or reproductive control. Within the context of intimate partner violence (IPV), the definition of coercion includes the threat of consequences for non-compliance with a demand, while control is defined as the influence one person has over another, and encompasses coercion (Dutton, Goodman, & Schmidt, 2005); the term reproductive coercion will be used in this review, as it is the term most commonly used in current literature. Reproductive health care providers and researchers have long recognized that women who experience IPV are vulnerable to negative reproductive health outcomes including unintended and unwanted pregnancy and sexually transmitted infections (Coker, 2007). The specific focus on the study of reproductive coercion enables researchers to examine the complex etiology of this phenomenon, as well as the intersection with IPV and unintended pregnancy.

Reproductive coercion is defined as behavior that interferes with the autonomous decision-making of a woman, with regards to reproductive health (Miller, Decker, et al., 2010; Miller, Jordan, Levenson, & Silverman, 2010; Moore, Frohwirth, & Miller, 2010). Specifically, this may take the form of birth control sabotage (such as removing a condom, damaging a condom, removing a contraceptive patch, or throwing away oral contraceptives), coercion or pressure to get pregnant, or controlling the outcome of a pregnancy (such as pressure to continue a pregnancy or pressure to terminate a pregnancy).

Perpetrators of reproductive coercion may be an intimate partner, a family member, or a family member of the partner (Gupta, Falb, Kpebo, & Annan, 2012). While it is recognized that women may place pregnancy pressure of varying degrees on their male partners, and may "entrap" partners into pregnancy and/or parenting by surreptitious means, research comparing the effects on female and male victims is lacking. Additionally, the underlying mechanisms and the impact on the victims may be inherently different. Important questions are raised by studying reproductive coercion of victims of any sex, and by any perpetrator, and the results can help inform our understanding of reproductive autonomy and freedom in reproductive choices. This review will focus on the phenomenon of reproductive coercion perpetrated by male intimate partners.

Since reproductive coercion was first labeled and purposefully studied in 2010 (Miller, Decker, et al., 2010; Moore et al., 2010) prevalence estimates have ranged from 8 (Black et al., 2011) to 16 percent (Clark, Allen, Goyal, Raker, & Gottlieb, 2014) of the populations being studied. However, prior to 2010, and even after, behaviors of reproductive coercion emerge in research findings without necessarily being labeled as such. By examining these findings as a whole, a greater understanding of reproductive coercion, its prevalence and correlates, and its knowledge gaps, emerges.

Several concepts are closely related or intersected with reproductive coercion. There is a strong relationship between reproductive coercion and IPV. Reproductive coercion is one of many forms of power and control exercised by an abusive partner, but it also can occur in the absence of any physical violence. Questions exist about the nature of the relationship and the chronology of occurrence of these distinct but related phenomena. In some cases reproductive coercion could be a harbinger of abusive behavior, while in others it could be a secondary form of control in addition to physical abuse.

Unintended pregnancy is a related phenomenon with significant intersection with the study of reproductive coercion. Reproductive coercion is one potential cause of unintended pregnancy; a deeper understanding of racial and ethnic disparities in reproductive coercion may help to explain some of the disparities in unintended pregnancy. Pregnancy intention, self-efficacy, and contraceptive compliance, are examples of important factors in the study of unintended pregnancy, but they omit important aspects of gender and power imbalance that also may be impacting this phenomenon (Connell, 1987).

Reproductive autonomy is also distinct but closely related to reproductive coercion. Reproductive autonomy describes a broader concept consisting of multiple domains of autonomous decision-making and empowerment with regards to reproductive health, including freedom from reproductive coercion, communication, and autonomy during decision-making (Upadhyay, Dworkin, Weitz, & Foster, 2014). This concept focuses on the ability to make decisions regarding reproductive health that may be impacted by multiple other forms of individual and systematic policies and pressures that are outside the scope of this review, including government coercion (forced sterilization, laws restricting fertility or abortion, etc.) and cultural or societal pressure regarding reproductive norms and expectations. While there is significant overlap between the concepts of reproductive autonomy and reproductive coercion, this review is limited to literature specific to the behaviors of reproductive coercion.

The objectives of this article are to review the current state of knowledge about reproductive coercion and about the specific behaviors of reproductive coercion, when examined separately, in an American context, to address the questions:

1. What is known about reproductive coercion, in terms of prevalence, correlates, and specific manifestations and behaviors?
2. What strategies do women use to preserve their reproductive autonomy when experiencing reproductive coercion?

3. What interventions are effective to decrease reproductive coercion?

Methods

Searches were conducted with the assistance of a research librarian in July 2015. Databases searched were PubMed, CINAHL, PsycINFO and Embase, and search terms included "reproductive", "coercion", "sexual partners", "pregnancy", "contraception", "birth control", "reproductive behavior" and "sexual behavior". These broad keywords were designed to encompass the specific behaviors of reproductive coercion. Inclusion criteria were research studies of humans, English language, and the five years before and after reproductive coercion was first named in the literature (Miller, Decker, et al., 2010; Miller, Jordan, et al., 2010; Moore et al., 2010) (2005 to 2015), that covered male partner reproductive coercion or any of the specific behaviors of reproductive coercion. Abstracts and titles were reviewed for this inclusion criteria, as well as exclusion criteria: only examining sexual coercion, IPV, or coercion by the government (e.g., forced sterilization). Articles that were potentially relevant were reviewed in full-text for inclusion and exclusion criteria. Research on reproductive coercion that is set outside the United States tends to address coercion by family members or in-laws, or to uncover cultural etiologies such as preference for male children, so to maintain focus on the gendered phenomenon of male partner reproductive coercion, this review excluded articles that were set outside the United States. Following database searches, a hand search was conducted, on the reference lists of all relevant articles.

The Meta-analysis of Observational Studies in Epidemiology (MOOSE) (Stroup et al., 2000) and Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (Liberati et al., 2009) protocols were used to guide the review. Data was extracted from each included article on the topics of reproductive coercion, birth control sabotage, pregnancy coercion, abortion coercion, intersection with IPV, intersection with unintended pregnancy, resistance strategies and interventions, and compiled chronologically to facilitate analysis of the

knowledge development that has occurred in this emerging area of research. Most studies reviewed for this paper contained findings in more than one subtopic on which data was gathered.

Quality assessments of each research study were conducted. Quantitative descriptive studies were evaluated with the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) checklist (Vandenbroucke et al., 2007). Qualitative studies were evaluated with the Journal of Obstetric, Gynecologic & Neonatal Nurses (JOGNN) Qualitative Research assessment tool for qualitative studies (Cesario, Morin, & Santa-Donato, 2002). Experimental studies were evaluated with the Effective Public Health Practice Project (EPHPP) quality assessment tool (Effective Public Health Practice Project (EPHPP), n.d.). And mixed methods studies were evaluated with the Journal of Mixed Methods Research review criteria (Journal of Mixed Methods Research, n.d.). The STROBE checklist and Journal of Mixed Methods tool do not include scoring systems, so these tools were adapted for purposes of this review, and a scoring system was created that was comparable to the JOGNN instrument, to enable comparison of studies. Quality was rated QI (75-100 percent of criteria were met), QII (50-74 percent of criteria were met), or QIII (less than 50 percent of criteria were met).

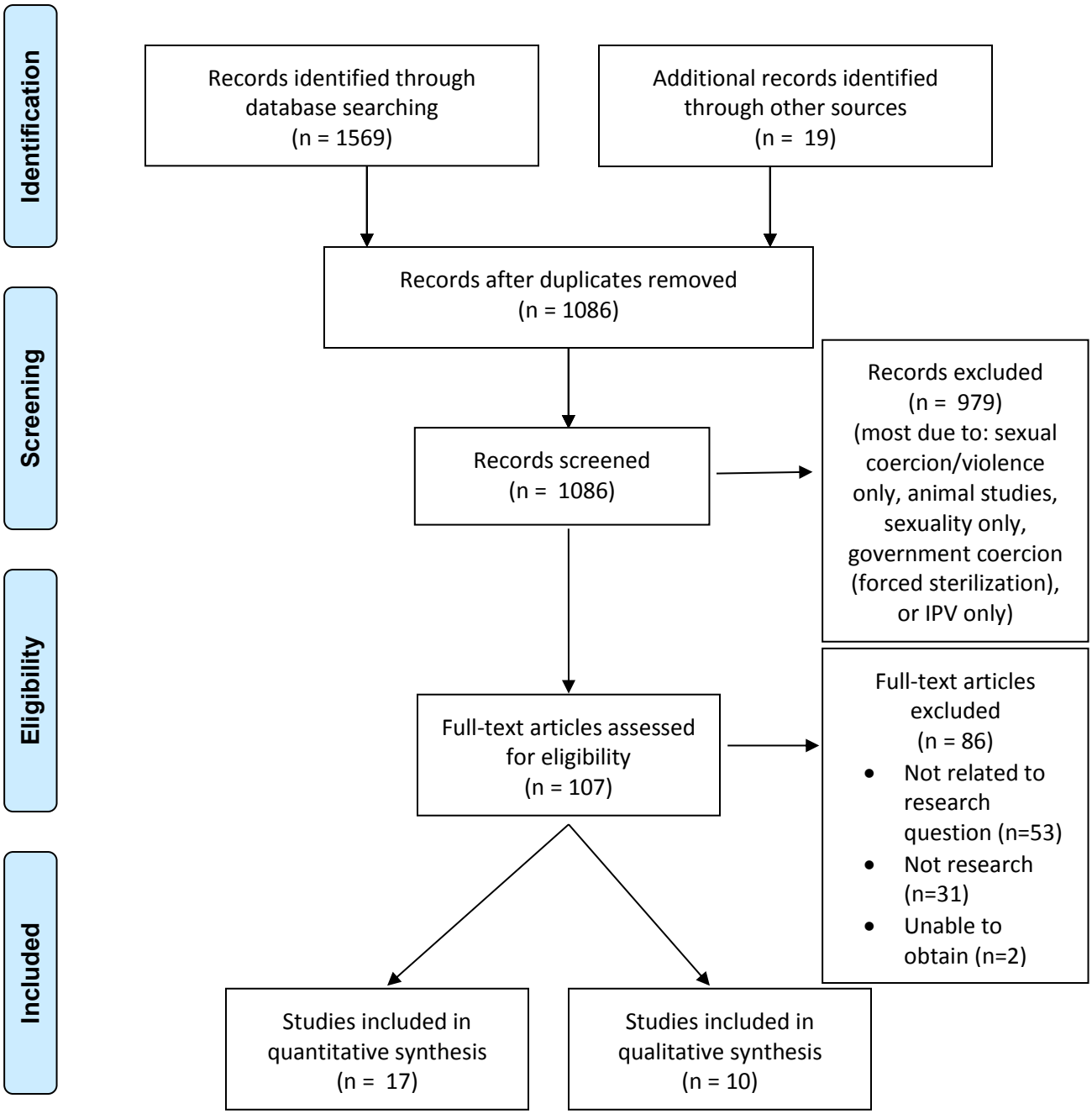
Results

Description of Studies

Search results are summarized and displayed in Figure 2-1. Initial searches of electronic databases yielded 1,546 citations, and the hand search of reference lists yielded an additional 19, for a total of 1,565 citations. After removing duplicates, screening titles and abstracts, and excluding articles based on exclusion criteria, 25 articles remained to be reviewed. Two articles reported on the same parent study (Borrero et al. (2015) focused on pregnancy intention but reported on findings about reproductive coercion; part way through their qualitative interviews, when reproductive coercion themes began to emerge, interview questions were added with that aim, and that became the focus of the second article by Nikolajski et al. (2015)).

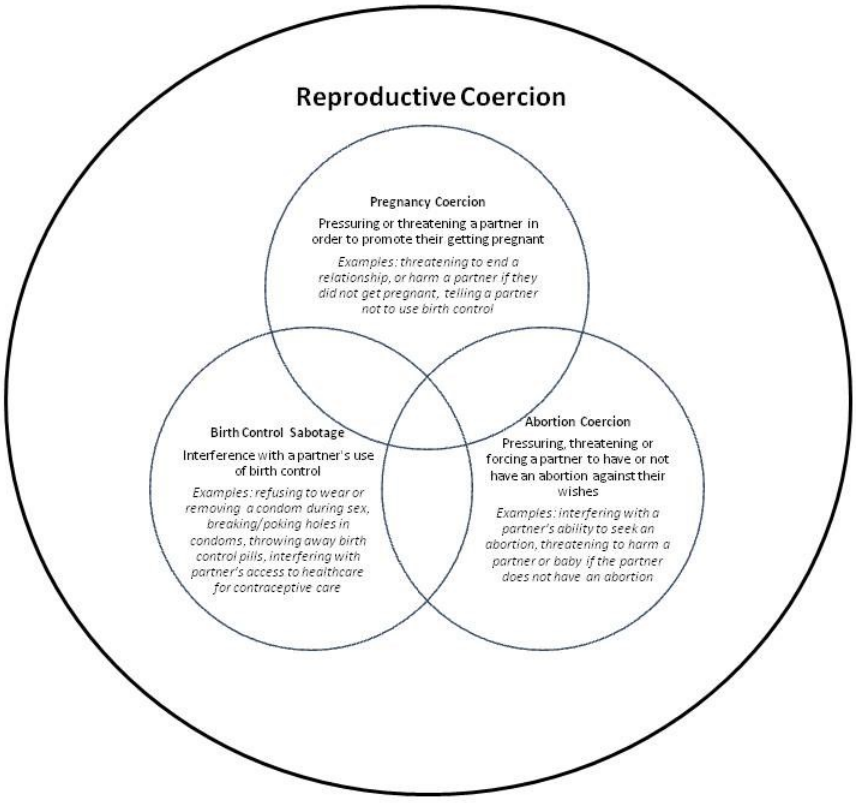
The research reviewed included 10 qualitative studies and 17 quantitative studies, of which 2 were mixed-methods, one was a randomized control trial and 14 were descriptive studies.

Figure 2-1 Results of Search Strategies on Reproductive Coercion



Of the 27 studies, 13 contained findings regarding the general phenomenon of reproductive coercion (Borrero et al., 2015; Clark et al., 2014; Hathaway, Willis, Zimmer, & Silverman, 2005; Kazmerski et al., 2015; McCauley et al., 2014, 2015; Miller et al., 2007; Miller, Decker, et al., 2010; Miller et al., 2014; Moore et al., 2010; Nikolajski et al., 2015; Sutherland, Fantasia, & Fontenot, 2015; Upadhyay et al., 2014), and 19 contained findings about a component of reproductive coercion – specifically birth control sabotage or pregnancy or abortion coercion (See Figure2-2 for conceptual map of reproductive coercion with examples of behaviors for each subdomain).

Figure 2-2. Reproductive Coercion and Subdomains Examples



(Borrero et al., 2015; Chibber, Biggs, Roberts, & Foster, 2014; Finer, Frohwirth, Dauphinee, Singh, & Moore, 2005; Foster, Gould, Taylor, & Weitz, 2012; Hathaway et al., 2005; Herrman,

2007; Miller, Decker, et al., 2010; Miller et al., 2007, 2011, 2012, 2014; Moore et al., 2010; Nikolajski et al., 2015; Patel, Laz, & Berenson, 2015; Silverman et al., 2010, 2011; Sutherland et al., 2015; Teitelman, Tennille, Bohinski, Jemmott, & Jemmott, 2011). Additionally, 11 studies contained findings related to the intersection of IPV and reproductive coercion (Clark et al., 2014; Dick et al., 2014; Gee, Mitra, Wan, Chavkin, & Long, 2009; Kazmerski et al., 2015; McCauley et al., 2014; Miller, Decker, et al., 2010; Miller et al., 2011, 2014, Silverman et al., 2010, 2011; Sutherland et al., 2015), 3 contained findings related to reproductive coercion and unintended pregnancy (Miller et al., 2014; Miller, Decker, et al., 2010; Sutherland et al., 2015), 6 contained findings related to strategies women use to resist reproductive coercion (Miller et al., 2007; Moore et al., 2010; Nikolajski et al., 2015; Sutherland et al., 2015; Teitelman et al., 2011; Thiel de Bocanegra, Rostovtseva, Khera, & Godhwani, 2010) and 3 contained findings on interventions for reproductive coercion (Burton & Carlyle, 2015; Clark et al., 2014; Miller et al., 2011). These results are summarized below, grouped according to the findings, with additional information reported in Tables 1-4.

Measurement Instruments

Several studies in this review used or adapted a set of 10 questions to measure reproductive coercion that were originally created by Miller et al., in 2010 (Miller, Decker, et al., 2010), based on earlier qualitative work (Miller et al., 2007). These questions, or adaptations of them, were used in a total of 9 studies (Clark et al., 2014; Dick et al., 2014; Kazmerski et al., 2015; McCauley et al., 2014, 2015; Miller, Decker, et al., 2010; Miller et al., 2011, 2014; Sutherland et al., 2015). Only four of these studies reported Cronbach alpha coefficients, and these ranged from 0.66-0.76, indicating moderate internal reliability (Dick et al., 2014; Kazmerski et al., 2015; Miller et al., 2014; Sutherland et al., 2015). The Miller et al. items have been used in racially and ethnically diverse populations, with only three studies testing it in a majority White population (McCauley et al., 2015; Miller et al., 2014; Sutherland et al., 2015). To

date, detailed psychometric analysis (validity testing and/or factor analysis) on the Miller et al. items has not been published.

In addition to the Miller and colleagues (2010) reproductive coercion measurement items, one other relevant instrument was discovered in the literature search for this review, which has recently been developed for measuring reproductive autonomy (Upadhyay et al., 2014). The article describing the validation of this instrument does not present prevalence data about reproductive coercion and so it is not included in tables, but results about strength of association of various characteristics with reproductive coercion are presented in the results section.

The Reproductive Autonomy Scale measures freedom from reproductive coercion as a subdomain of reproductive autonomy, in a 14-item instrument that includes 5 items specific to reproductive coercion, that are reverse-scored relative to the Miller and colleagues items. This instrument was validated in English and Spanish, in 19 suburban and urban sites across the United States, on a sample of 1,892 adolescent and adult women. The sample was ethnically and racially diverse, with 38 percent having a high school education or less, and 86 percent single women, but generalizability was limited by sampling exclusively from family planning and abortion facilities, which may also bias results in favor of those already motivated enough to reach healthcare providers. The final Cronbach alpha coefficient on the full instrument was 0.78, indicating moderate internal reliability, but the coefficient for the coercion-specific items was 0.82, indicating strong internal reliability. Construct validity was assessed through association with contraceptive use among women seeking to avoid pregnancy, which was associated in the expected direction on two of the three subscales (including the coercion subscale). One limitation of the instrument is that it was only tested on women who were seeking to avoid pregnancy; there is no validation data for women who are seeking pregnancy. Though further psychometric testing is indicated for both instruments, both the reproductive coercion and reproductive autonomy measures are promising and reliable instruments for researchers.

Reproductive Coercion – General

Thirteen of the reviewed studies contained findings regarding the general phenomenon of reproductive coercion. Three of the studies aimed to examine related phenomena (IPV, sexual minority status, pregnancy intentionality), and had incidental findings related to reproductive coercion (Borrero et al., 2015; Hathaway et al., 2005; McCauley et al., 2014), while aims in the remaining studies were focused on a reproductive coercion research question.

Summary of Findings. The quantitative studies with findings in this area report prevalence of reproductive coercion ranging from 5-13 percent in a samples of 16-29 year olds attending family planning clinics (Kazmerski et al., 2015; Miller, Decker, et al., 2010). Some studies reported on factors that were associated with reproductive coercion. Three studies found it to be significantly more common among women with less education (Miller et al., 2014; Miller, Decker, et al., 2010; Upadhyay et al., 2014) and significantly less associated with younger age (Upadhyay et al., 2014). Five studies found reproductive coercion to be more prevalent among non-Hispanic Black, multiracial or Latina women, or women born in the United States when compared to those born elsewhere (Clark et al., 2014; Miller et al., 2014; Miller, Decker, et al., 2010; Sutherland et al., 2015; Upadhyay et al., 2014), and one found the highest odds of experiencing reproductive coercion among multiracial women (AOR 2.5, 95% CI 1.04-5.99) (Clark et al., 2014). Two studies found being single or in a dating relationship were significantly associated with experiencing reproductive coercion (Clark et al., 2014; Miller et al., 2014), while one found no significant difference based on marital status (Upadhyay et al., 2014). One study found lack of health insurance (a marker for socioeconomic status) to be significantly associated (Clark et al., 2014). One study found that women who have sex with both women and men were 75% more likely to have experienced recent (past 3 months) reproductive coercion from a male partner (McCauley et al., 2015). One study of college students found reproductive coercion significantly associated with living with a partner (as opposed to living in a dormitory or with

parents) (Sutherland et al., 2015). One study's results had clear and direct implications for healthcare providers: women who experienced reproductive coercion were significantly more likely to have visited a healthcare provider for one or multiple pregnancy tests, sexually transmitted infection tests, or for emergency contraception (Kazmerski et al., 2015). Another study reported a stronger association between reproductive coercion and seeking services at abortion facilities as compared to family planning facilities, though this difference was not significant (Upadhyay et al., 2014).

Qualitative findings in this category described the experience of partners limiting women's ability to choose whether or not to have children (Hathaway et al., 2005), having a partner who actively tried to impregnate them, age differentials with older male partners, and illuminating examples of reproductive coercion (Miller et al., 2007).

Birth Control Sabotage

Thirteen studies reported findings relating to birth control sabotage. Eight studies specifically aimed to study reproductive coercion, and reported findings on birth control sabotage as a component of this (Hathaway et al., 2005; Miller et al., 2007, 2011, 2014; Miller, Decker, et al., 2010; Moore et al., 2010; Nikolajski et al., 2015; Sutherland et al., 2015). Two studies specifically aimed to study birth control sabotage (Teitelman et al., 2011; Thiel de Bocanegra et al., 2010). The remaining two studies reported findings on birth control sabotage that were incidental to the specified aims of the study (Borrero et al., 2015; Miller et al., 2012; Silverman et al., 2011).

Summary of Findings. A wide range of birth control sabotage was examined in quantitative studies. Miller et al. (2010) reported a prevalence of 15 percent for this general finding, and Miller et al. (2011) reported a range of 7 percent (control group) to 11 percent (intervention group) for recent birth control sabotage (past three months). Miller et al. (2014) found very low prevalence (less than 1% each) of putting holes in a condom, breaking condoms

on purpose, restricting access to birth control or to family planning clinics, though these data are for past 3 months prevalence only. Prevalence of being made to have sex without a condom ranged from 0.5 percent (past 3 months) to 20 percent (Miller et al., 2014; Silverman et al., 2011). Prevalence of having a partner remove a condom during sex ranged from 1 to 2 percent (Miller et al., 2014; Sutherland et al., 2015). Birth control sabotage was found to be most prevalent among non-Hispanic Black women (27 percent), and also more prevalent among women born in the United States when compared to those born elsewhere (Miller, Decker, et al., 2010).

Qualitative studies described findings regarding specific methods of birth control sabotage: women were prevented from obtaining birth control or getting refills on oral contraceptives (Hathaway et al., 2005; Miller et al., 2007; Thiel de Bocanegra et al., 2010), reported having sex without a condom despite asking their partners to wear one (Nikolajski et al., 2015; Teitelman et al., 2011), had partners lie about being infertile (Hathaway et al., 2005), tear, poke or bite holes in condoms (Hathaway et al., 2005; Miller et al., 2007; Moore et al., 2010), fail to withdraw when using the withdrawal method for contraception (Moore et al., 2010), throw contraceptive methods in the trash (Borrero et al., 2015; Miller et al., 2007; Nikolajski et al., 2015), scare them with exaggerated risks of oral contraceptives (Moore et al., 2010), refuse to wear condoms (Borrero et al., 2015; Hathaway et al., 2005; Moore et al., 2010; Nikolajski et al., 2015), tell them they were wearing a condom when they were not (Nikolajski et al., 2015), not tell them if a condom fell off or broke during sex (Moore et al., 2010), and remove condoms during sex without telling them (Miller et al., 2007; Moore et al., 2010; Nikolajski et al., 2015; Teitelman et al., 2011).

Pregnancy Coercion

Thirteen studies reported findings on pregnancy coercion, which for this analysis is considered coercion or pressure to get pregnant or not to get pregnant (coercion or pressure to terminate or not to terminate a pregnancy will be considered separately). The behavior of telling a

partner not to use birth control could be considered birth control sabotage or pregnancy coercion; for this review it is treated as pregnancy coercion (which is also how the measurement instrument classifies it (Miller, Decker, et al., 2010)). Eight studies specifically aimed to study reproductive coercion, and reported findings on pregnancy coercion as a component of this (Hathaway et al., 2005; Miller et al., 2007, 2011, 2014; Miller, Decker, et al., 2010; Moore et al., 2010; Nikolajski et al., 2015; Sutherland et al., 2015). No studies specifically aimed to study pregnancy coercion; 5 studies aimed to study aspects of intentionality in pregnancy (Herrman, 2007; Miller et al., 2012, 2014; Miller, Decker, et al., 2010; Patel et al., 2015). Some studies fell into multiple categories (Miller et al., 2014; Miller, Decker, et al., 2010).

Summary of Findings. Three quantitative studies reported prevalence rates for the broad category of pregnancy coercion, ranging from 1 to 19 percent (Miller, Decker, et al., 2010; Patel et al., 2015). Other studies reported prevalence rates of specific behaviors related to pregnancy coercion: prevalence of recent (past 3 months) experience of partner telling her not to use contraception was 3 percent (Miller et al., 2014), another study reported a prevalence of 6% (Sutherland et al., 2015). Prevalence of recent (past 3 months) experiencing a partner forcing or pressuring her to become pregnant was 2 percent, and less than one percent reported a partner telling the woman he would leave her if she didn't get pregnant, he would have a baby with someone else if she didn't get pregnant, and hurting her physically because she did not agree to get pregnant (Miller et al., 2014). Only one study examined the relationship between immigrant status and pregnancy coercion, and found that American-born women were more likely to experience pregnancy coercion than foreign-born (Miller, Decker, et al., 2010). One study reported that non-pregnant women who were ambivalent about pregnancy were more than twice as likely to have experienced pregnancy coercion (Patel et al., 2015). Pregnancy coercion was found to be most prevalent among multiracial women (27.5 percent) and non-Hispanic Black

women (25.9 percent), and among women born in the United States as comepared to those born elsewhere (Miller, Decker, et al., 2010).

Qualitative findings described specific tactics of pregnancy coercion, which included verbal threats (a partner telling a woman he was going to impregnate her) (Moore et al., 2010), coercing or pressuring sex (Hathaway et al., 2005; Herrman, 2007), refusing to use a male-controlled method of contraception (Hathaway et al., 2005; Herrman, 2007; Miller et al., 2007; Moore et al., 2010; Thiel de Bocanegra et al., 2010), accusations of infidelity if condoms were requested (Moore et al., 2010), refusing to allow or pressure not to use a woman-controlled method of contraception (Hathaway et al., 2005; Herrman, 2007; Miller et al., 2007; Moore et al., 2010; Nikolajski et al., 2015), monitoring of menstrual cycles and gynecology appointments (Nikolajski et al., 2015), purchasing of ovulation and pregnancy testing kits (Nikolajski et al., 2015), pressure to undergo tubal ligation (female sterilization) (Hathaway et al., 2005), and pressure not to undergo tubal ligation (Hathaway et al., 2005).

Several qualitative studies offered previously unreported information on pregnancy coercion. One study identified pressure specifically to produce male children (Thiel de Bocanegra et al., 2010). One study offered the perspective of a woman who experienced pregnancy pressure by her partner, which she interpreted as his commitment to the relationship (Teitelman et al., 2011). Others offered the perspective of participants that male partners who pressured them to get pregnant did so out of a desire for a "nuclear family" or to force them to stay in the relationship and ensure a permanent connection (Miller et al., 2012; Moore et al., 2010). Two studies identified connections between pregnancy coercion and male incarceration or housing and employment instability, reflecting that men facing incarceration would want to have a strong connection to someone on the outside, or would want to be assured of their fidelity (Moore et al., 2010; Nikolajski et al., 2015). Interestingly, this connection was limited to African American participants; White participants tended to connect pregnancy coercion to love and relationship

factors (Nikolajski et al., 2015). These findings merit further exploration with qualitative as well as quantitative research.

Abortion Coercion

Ten studies reported findings on abortion coercion, which for this analysis is considered coercion or pressure to control the outcome of a pregnancy by termination, or coercion or pressure not to terminate. Four of the studies specifically aimed to study reproductive coercion, and reported findings on abortion coercion as a component of this (Hathaway et al., 2005; Miller et al., 2007; Moore et al., 2010; Nikolajski et al., 2015). Four studies aimed to study abortion or reasons for seeking abortion (Chibber et al., 2014; Finer et al., 2005; Foster et al., 2012; Silverman et al., 2010). In the remaining studies, findings on abortion coercion were incidentally reported.

Summary of Findings. Findings in this area centered on how partners influenced the decision to terminate a pregnancy. Some studies found large numbers of abortions being influenced by male partners not wanting a child, or other non-coercive partner-related factors (i.e., partner being the wrong person to have a baby with, in some cases due to abuse, partner being unwilling or unable to support the baby, or new or unstable relationship with partner) (Chibber et al., 2014; Finer et al., 2005; Silverman et al., 2010). Few quantitative studies specifically identified partner coercion or pressure in the decision to terminate; those that did reported low prevalence, ranging from 0.1 percent to 4 percent (Chibber et al., 2014; Finer et al., 2005; Foster et al., 2012; Silverman et al., 2010). One study also reported findings about male partners pressuring women not to terminate, or preventing them from seeking abortion services, and this was reported at 8 percent prevalence (Silverman et al., 2010). Of note, the highest prevalence values in each of these categories come from an exclusively male sample (Silverman et al., 2010). These numbers are self-report of abortion pressure by the men themselves; the potential for social desirability bias here indicates these actual numbers may be even higher. One

study reported that when violence was present in the lives of women seeking abortion, it was not often used to coerce abortions or pregnancy continuation, but more often was part of the woman's reason for seeking an abortion, in an effort to end the relationship or to prevent a continuing connection to an abusive partner (Chibber et al., 2014).

Qualitative findings described male behaviors of pressuring women to have abortions (Hathaway et al., 2005; Miller et al., 2007; Moore et al., 2010; Nikolajski et al., 2015; Thiel de Bocanegra et al., 2010) as well as preventing women from having abortions or accessing abortion services (Hathaway et al., 2005; Herrman, 2007; Moore et al., 2010; Nikolajski et al., 2015; Thiel de Bocanegra et al., 2010). Two studies described women whose partners threatened to harm or kill them if they had abortions (Moore et al., 2010; Nikolajski et al., 2015), and one described women whose partners threatened to use violence to cause an abortion (Moore et al., 2010). Specific behaviors related to abortion coercion included excessive badgering and making promises to provide financial support for the baby when women wanted to terminate, making a woman eat on the day of her abortion so she would be ineligible for the procedure, being disruptive at the abortion clinic to get the woman to leave, and refusing to provide money for an abortion or for transportation to the abortion clinic (Moore et al., 2010).

Intersection with Intimate Partner Violence

Eleven studies reported findings on the intersection of reproductive coercion and IPV. Six studies specifically aimed to study reproductive coercion or reproductive coercion and IPV (Clark et al., 2014; Kazmerski et al., 2015; Miller, Decker, et al., 2010; Miller et al., 2011, 2014; Sutherland et al., 2015). The remaining studies all had aims relating to IPV (Dick et al., 2014; Gee et al., 2009; McCauley et al., 2014; Silverman et al., 2010, 2011).

Summary of Findings. All studies with findings in this area found associations between reporting reproductive coercion and reporting IPV. Synthesizing the findings is challenging as some studies examined reproductive coercion as a risk factor for IPV and others reversed the

directionality of the relationship. Two studies reported on the prevalence of reproductive coercion without concomitant IPV, with a prevalence of 7-9 percent (compared to 24 percent with concomitant IPV (McCauley et al., 2014)), and one hypothesized that there might be a temporal relationship, with reproductive coercion preceding IPV in an abusive relationship (Kazmerski et al., 2015; Miller, Decker, et al., 2010). Six of the 11 studies found a higher prevalence or higher risk of reproductive coercion among women who had experienced IPV compared to participants who had not experienced IPV (Dick et al., 2014; Gee et al., 2009; McCauley et al., 2014; Miller, Decker, et al., 2010; Silverman et al., 2010, 2011), and one study found a higher prevalence of women experiencing reproductive coercion without concomitant IPV (9 percent) than with IPV (4.4 percent), though this may have been due to the study asking only about episodes of each in the 3 months prior to reproductive healthcare clinic visits (Kazmerski et al., 2015). This relationship was significant in both directions; two studies also found that women who experienced reproductive coercion had increased odds or prevalence of experiencing IPV (Gee et al., 2009; Miller, Decker, et al., 2010). Two studies found that large percentages of women who had experienced reproductive coercion had also experienced IPV (Clark et al., 2014; Sutherland et al., 2015). When reproductive coercion occurred without IPV it was more likely to be reported by Black women (Clark et al., 2014). One study found a dose-response relationship, with greater frequency of IPV (in this case cyber-dating abuse) increasing odds of experiencing reproductive coercion (Dick et al., 2014). A synergistic effect of reproductive coercion and IPV was found, with one study noting that while reproductive coercion and IPV separately increased the odds of seeking various reproductive health services, the combined effect of both reproductive coercion and IPV further increased the odds (Kazmerski et al., 2015), and the one intervention study in this review finding a greater impact in reduction of pregnancy coercion among women who had experienced IPV than among those who had not (Miller et al., 2011). Miller et al. (2014) reported on the intersection between reproductive coercion and IPV in relation to the additional

intersection with unintended pregnancy (see unintended pregnancy section for those results). IPV findings are further summarized on Table 2-3.

Intersection with Unintended Pregnancy

Five studies reported findings on the intersection between reproductive coercion and unintended pregnancy. Three of the studies specifically aimed to study either reproductive coercion or reproductive coercion and unintended pregnancy (Miller et al., 2014; Miller, Decker, et al., 2010; Sutherland et al., 2015). Two studies specifically aimed to study intentionality in pregnancy (Borrero et al., 2015; Miller et al., 2012).

Summary of Findings. In general, studies with findings in this area reported more unintended pregnancies in women who had experienced reproductive coercion. Two of the three quantitative studies also found IPV to be a factor in this relationship (Miller et al., 2014; Miller, Decker, et al., 2010). Miller et al. (2010) found an association between reproductive coercion and its individual components with unintended pregnancy, though this association did not hold up among participants who did not also experience IPV, when compared to those who did. This same study found that pregnancy coercion increased the odds of unintended pregnancy (OR: 1.83), though this impact was twice as strong when comparing IPV to no IPV groups (OR: 2.22). Birth control sabotage increased the odds of unintended pregnancy by 58 percent in the entire sample, and 77 percent among women experiencing IPV. This moderation effect was not significant. Miller et al. (2014) found the odds of unintended pregnancy increased among women with a recent history (past 3 months) of reproductive coercion by 79 percent, but again, a higher odds ratio (2.00) among women who also had a history of IPV. They reported a prevalence of unintended pregnancy (past year) among women with a recent history of reproductive coercion (past 3 months) of 21 percent, which is comparable to the prevalence of approximately 20 percent found by Sutherland et al. (2015) (a significant difference from those who did not experience reproductive coercion). Findings are summarized in Table 2-4.

Qualitative findings on the intersection of reproductive coercion and unintended pregnancy supported the quantitative findings above. They reported pregnancy coercion and birth control sabotage as factors impacting unintended pregnancy (Borrero et al., 2015; Miller et al., 2012).

Resistance Strategies

Six studies addressed strategies women used to resist reproductive coercion from male partners. None of the studies specifically aimed to study resistance strategies, but five of the six studies specifically aimed to study reproductive coercion (Miller et al., 2007; Moore et al., 2010; Nikolajski et al., 2015; Sutherland et al., 2015; Thiel de Bocanegra et al., 2010).

Summary of Findings. The quantitative study of college women with findings in this area reported that women who experienced reproductive coercion were more likely than those who did not to use an injectable method of contraception. The total number of women who fell into this category was only 4 (5.3% of those experiencing reproductive coercion), but this was statistically significant ($p=0.001$) (Sutherland et al., 2015).

Qualitative studies reported that strategies women used to resist reproductive coercion included hiding contraceptive or emergency contraceptive use (Miller et al., 2007; Nikolajski et al., 2015; Thiel de Bocanegra et al., 2010), obtaining birth control pills in another country so that a partner could not read the label (Thiel de Bocanegra et al., 2010), lying about being pregnant (Miller et al., 2007), having abortions against their partners' wishes (Moore et al., 2010), lying to a partner about non-existent fines for an IUD insertion appointment (Thiel de Bocanegra et al., 2010), checking condom placement during sex (Teitelman et al., 2011), promising a partner who pressured for termination that he would not have to pay child support (Thiel de Bocanegra et al., 2010), and secretly leaving the abortion clinic after a pressuring partner dropped her off (Thiel de Bocanegra et al., 2010). One focus group of women suggested establishing group norms of not having sex without condoms, in order to "cut the supply" (Teitelman et al., 2011).

Clinical Interventions

Three studies reviewed for this paper addressed clinical interventions for reproductive coercion (Burton & Carlyle, 2015; Clark et al., 2014; Miller et al., 2011). All had specific aims related to reproductive coercion.

Summary of Findings. Clark et al. (2014) reported that 20 percent of women who experienced reproductive coercion felt it would have been helpful had a healthcare provider discussed non-detectable methods of contraception with them, 14 percent felt it would have been helpful had providers asked about pregnancy coercion, and 3 percent felt it would have been helpful had providers asked about birth control sabotage.

Miller et al. (2011) pilot tested an intervention to reduce reproductive coercion consisting of enhanced IPV screening, which encompassed reproductive coercion screening and education, as well as an informational card with information and resources on reproductive coercion. In this cluster randomization trial, the intervention group was significantly more likely to end a relationship in the three month follow-up period (37.1 percent vs. 26.8 percent, $p<0.001$) and more likely to do so due to feeling the relationship was unhealthy or unsafe (13 percent vs. 8 percent, $p=0.013$). Other effects were only significant for women who were also experiencing IPV; these women had a significant (71 percent) reduction in the odds of experiencing pregnancy coercion at three months follow-up, while women who were not experiencing IPV had a non-significant change in odds. Effects were non-significant for both IPV groups for the outcome of birth control sabotage.

Burton & Carlyle (2015) evaluated the implementation of an IPV and reproductive coercion screening and response initiative, through qualitative focus groups and interviews with healthcare providers. Researchers found that providing specific screening skills and tools assisted providers in feeling comfortable screening for and responding to reproductive coercion, though time constraints remained a barrier, as well as lack of tools for non-English-speaking clients.

Discussion

Quality of evidence

Overall, the quality of studies reviewed was very high. The majority of qualitative studies were rated QI, the highest category of quality. Weaknesses were in the areas of theoretical connectedness and procedural rigor, such as using member checking to validate findings and mentioning saturation in data collection. Two qualitative studies reported on the same study; part way through data collection on the parent study (Borrero et al., 2015), when themes of reproductive coercion began to emerge, questions were added to specifically address this topic for the secondary study (Nikolajski et al., 2015). While this introduces potential for weakness in data analysis, the authors felt this did not impact their conclusions.

Quantitative studies also rated very high, with the majority rated QI, the highest category of quality. Few studies discussed power analysis in the determination of sample size. In one study, there appears to be an error in presentation of data, so the true prevalence is difficult to interpret (Sutherland et al., 2015). In another study, the measurement of unintended pregnancy with the question "How many times have you been pregnant when you didn't want to be?" reflects the difficulty in defining constructs such as unintended as opposed to unwanted pregnancy (Miller, Decker, et al., 2010). Studies may have been biased by sampling strategies (no study used a random sampling technique), reliance on self-report, recall, women's depictions of male behavior, or social desirability. Bias may have influenced women's emphasis on reproductive coercion, depending on whether they were interviewed before getting an abortion (when they may be likely to overemphasize if they feel they will be judged) or when describing a pregnancy they continued or are planning to continue (when they may be likely to underemphasize coercion). Bias may also be introduced by sampling from reproductive healthcare facilities, as women who are empowered enough to access those facilities may have greater reproductive autonomy, or be experiencing less reproductive coercion. All studies were

limited in their generalizability. Almost all quantitative studies were descriptive, and thus were unable to draw conclusions about causality in relationships such as with unintended pregnancy and IPV. Likewise, conclusions cannot be made about chronology of reproductive coercion in an abusive relationship. Physical violence and reproductive coercion may begin concurrently, with reproductive coercion being one of many coercive tactics, or reproductive coercion may possibly be an indicator of impending abuse.

Analysis of Ethnocentrism

A strength of the studies in this review was the diversity of samples by race, ethnicity, non-English speaking status, and socioeconomic status. Despite this diversity, few studies examined race or ethnicity as important variables in analysis. Several studies adjusted for all demographic characteristics in their regression analyses, which precludes any inference regarding racial/ethnic findings. Examination of these factors as potential modifiers would be a strength of future research. Only two studies reported whether attrition or response rates were different by demographic group (Miller et al., 2011, 2014).

Since reproductive coercion is an inherently gendered phenomenon, no analysis of androcentricity is discussed. However, it is noteworthy that most studies focused exclusively on female participants, with the exception of two that included males (Dick et al., 2014; Silverman et al., 2010). Likewise, as this review was limited to male partner reproductive coercion of women, no analysis of heterocentricity is discussed, but it is noted that two studies in this review aimed specifically to study sexual minority status in the context of IPV and/or reproductive coercion (McCauley et al., 2014, 2015), and one study did include over 15 percent non-heterosexual participants (Dick et al., 2014).

Summary of evidence

The evidence reviewed in this article and the chronological display of findings (Tables 1-4) describes an emerging field of research of enormous importance to women's healthcare that

has been rigorously examined, but is in need of further study. Instruments for measuring reproductive coercion and reproductive autonomy are a valuable addition to the field, but these tools require further validation, as well as testing in different populations. The Reproductive Autonomy Scale was tested in a large and ethnically diverse sample, but has not been used in a research setting beyond this development study. Thirteen of 27 articles reviewed for this article specifically aimed to study reproductive coercion, and the remainder reported incidental findings on its components. Studies were set in a wide variety of urban and suburban settings across the United States, though most were in the northeast or California, and few were set in rural areas.

This review describes reproductive coercion as a phenomenon that disproportionately affects women experiencing concurrent IPV, women of lower socioeconomic status, single women, and African American, Latina and multiracial women. The strongest of these associations appears to be with IPV, though some women do experience reproductive coercion without concomitant IPV. Women who experience reproductive coercion were found to present frequently to reproductive healthcare providers for certain services. Immigrant women seemed to be less vulnerable to reproductive coercion, though findings on this are very limited.

A variety of tactics in the areas of birth control sabotage and pregnancy coercion were described in both quantitative and qualitative literature. Qualitative findings describe specific tactics by male perpetrators that may inform further refinement of the reproductive coercion measures. One study identified pressure specifically to produce male children; this finding may be more prevalent when examining the international literature on reproductive coercion.

Findings about abortion coercion described male partners figuring into the decision to have an abortion, but less often coercive in their influence. While women frequently reported non-coercive partner-related factors in the decision to have an abortion, prevalence of (male self-reported) partner pressure to terminate was as high as 4 percent, and pressure not to terminate was as high as 8 percent. Qualitative literature described specific coercive tactics for and against

abortion. The decision to have a baby or to have an abortion is one that can involve both a man and a woman, and male partners have a place in the decision-making process; the point at which their involvement in the decision becomes coercive can be difficult to discern. A woman making an autonomous decision to terminate a pregnancy because she does not have a supportive partner is different from a woman who would like to continue a pregnancy but feels pressured to terminate by her unsupportive partner. Similarly, findings about other specific behaviors of reproductive coercion must be explored and interpreted with an aim of identifying where the boundaries of coercion lie. Within a romantic and/or sexual relationship, a male partner asking a woman to get pregnant may be meant as an indication of love or as a tactic of coercion and control, and may also be interpreted different ways by the female partner. Further research can help establish these boundaries to inform clinical interventions, but researchers and clinicians must take pains to maintain objectivity and to respect the woman's interpretation of the behaviors in question, and examples of reproductive coercion must be understood and viewed within the social context in which they occur. There is a broad continuum of pressure, coercion and persuasion and associated demands, threatening behaviors and consequences within a relationship (Dutton & Goodman, 2005); the point at which this behavior becomes coercive must be more clearly identified, taking into account context.

Findings in this review support a clear association among reproductive coercion, unintended pregnancy and IPV. Reproductive coercion and IPV appear to have a synergistic effect on unintended pregnancy, seeking reproductive health services, as well as likelihood of success with an intervention to decrease reproductive coercion. Unintended pregnancy and reproductive coercion were less strongly associated among women who did not experience IPV, indicating the experience of reproductive coercion may be different for women not also experiencing violence. Findings in the area of abortion coercion suggest that violence was less often used to coerce abortions or pregnancy continuation, and more often was given as a reason

by the woman seeking an abortion (to end the relationship or to prevent a continuing connection to an abusive partner).

This review revealed findings as well as speculation about the etiology of reproductive coercion, from the perspective of male and female participants. Women interpreted pregnancy coercion as commitment by their partner to the relationship, or as an attempt by partners to ensure connection, especially if the partner was facing incarceration or suffered other social instability. These data are qualitative, but authors did note that the findings were more common among African American participants, while White participants more commonly identified relationship factors as the underlying motivation.

Findings were limited on strategies used by women to resist reproductive coercion, but some were found in the qualitative literature. Likewise, findings on interventions for reproductive coercion are very limited. Participants made suggestions about what they thought might be effective, and one intervention was tested, with significant improvement especially among women who also experienced IPV mainly due to more of those women leaving the relationship.

Implications

The prospect of women being coerced into having abortions has been the subject of much politicization in the public arena of the abortion debate. Findings in this area do not support the assertion that women are frequently coerced into abortions, but rather, that they are more often coerced into continuing a pregnancy. Findings are limited, however, and in need of further investigation.

Results showing an association between reproductive coercion and frequent visits to a reproductive healthcare provider, as well as pregnancy ambivalence, indicate that midwives and other women's health care providers should have heightened vigilance when women present frequently for services or with ambivalence toward pregnancy. They also support the recommendations to routinely screen all women for reproductive coercion, in conjunction with

IPV screening (American College of Obstetricians and Gynecologists, 2013). These findings highlight the importance of screening a woman in private for at least a portion of her clinic visit. The findings on resistance strategies currently used by women indicate an interest in non-detectable methods of contraception that should be explored by providers during office visits. The Patient Protection and Affordable Care Act of 2010 (*Compilation of Patient Protection and Affordable Care Act*, 2010) facilitates access for women who previously could not afford such methods, but more work is needed to ensure that all women have access to unbiased contraceptive counseling and free or low-cost services. Women who may not have insurance or may not want to use insurance for fear of a partner or parent inadvertently receiving access to their contraceptive choices through this mechanism need to be considered in state and national policy and in funding decisions.

From the results on the association between reproductive coercion and IPV it is unclear whether violence precedes reproductive coercion, whether the reverse is true, or whether these events occur concurrently. Either chronology has implications for healthcare providers and advocates in counseling women who report reproductive coercion or IPV. Findings clearly support the need for providers to be prepared for screening and counseling on both reproductive coercion and IPV when encountering one of these in a patient visit, and also for providers to provide counseling on less detectable methods of contraception to help women avoid unintended pregnancy, when they report reproductive coercion. The co-occurrence of IPV and reproductive coercion also presents opportunities for healthcare providers and IPV service providers to collaborate to improve screening and response to both issues.

Reproductive coercion is an emerging area of research, reflecting disparate opinions on the exact definition of the point at which a behavior reflects normal disagreement between people in a relationship, as opposed to coercion. Additional research is needed to further define reproductive coercion and to clarify the phenomenon. This is increasingly important as policy

makers and enforcers attempt to implement reproductive coercion screening, intervention and policy. Implications for practice, policy and research are summarized in Table 2-5.

Limitations of this Review

This review used a broad search strategy and collected a sizable amount of literature on the topic of reproductive coercion. The search was limited to the five years before and after reproductive coercion began being studied in the literature, to make the integrative review manageable; removing time limits would potentially yield a larger number of relevant studies, but an informal search of literature prior to the 2005 cutoff did not yield any additional relevant studies. Limiting the search to domestic literature restricted findings as well; including international literature in the search (a total of 10 articles otherwise meeting the inclusion criteria for this review) would increase the depth and breadth of the review by revealing manifestation of reproductive coercion in diverse contexts, by examining other potential motivations for male partners such as a cultural preference for male children, and by exploring other influences on women's vulnerability such as the status of women's rights and restrictions on reproductive choices. The limitation of male partners as perpetrators excluded the rare occurrences of women mentioning pressure from a parent to terminate a pregnancy (Foster et al., 2012; Herrman, 2007). This was outside the scope of this review, but is a clear threat to women's reproductive autonomy worthy of further examination. Notably, the majority of articles initially located in the literature search for this review were excluded due to focusing exclusively on IPV, or government or sexual coercion. These concepts have significant overlap with reproductive coercion, but describe distinct phenomena, which may help inform the study of reproductive coercion but which we excluded from this review due to not directly addressing the specific behaviors that define reproductive coercion. Further analysis of these excluded articles may yield further knowledge about reproductive coercion as well as other threats to reproductive autonomy.

Suggestions for further research

There are no qualitative studies examining in depth the intersection of reproductive coercion and IPV, and only two with findings on the intersection of reproductive coercion and unintended pregnancy. Qualitative research in these areas would provide valuable insight into the nature of these intersections, and would help inform intervention studies. No studies aimed specifically to study resistance strategies currently used by women who experience reproductive coercion, and findings in this area are almost entirely qualitative. Further qualitative research would enable researchers to build on those existing strengths, and also to explain the quantitative findings about lack of success in women who are not experiencing IPV. Further research into how women understand the experience of reproductive coercion, especially in the absence of IPV, as well as the socio-cultural context of reproductive coercion from the perspective of both men and women, will be essential in understanding the phenomenon as well as developing interventions. Most research on pregnancy coercion focuses on pressure to get pregnant, with less emphasis on pressure to use contraception or to avoid pregnancy. Further exploration of this dynamic would contribute to better understanding of the diverse manifestations of reproductive coercion. Qualitative research can also contribute to further developing the conceptual construct of reproductive coercion and its specific behaviors. For instance, the behavior of telling a partner not to use birth control, which for this review was considered pregnancy coercion, could also be considered birth control sabotage. Clarification of the boundaries of these behaviors and the theoretical construct in which they fit will support high quality quantitative research as well as effective clinical interventions and potential legal remedies.

Existing quantitative literature illuminates several associations with reproductive coercion that merit further examination, such as immigrant status, race, sexual minority status, and pregnancy ambivalence. Existing qualitative literature illuminates many aspects of reproductive coercion that merit quantitative analysis, such as specific tactics of reproductive coercion, resistance strategies, and associations with male incarceration and housing instability.

Very few studies include male participants; there is a large knowledge gap in understanding the motivation of men who perpetrate reproductive coercion, as well as the factors that encourage men to use reproductive coercion to exert power and control over women. The primary prevention of reproductive coercion will depend on further research and interventions targeting men.

The development of the Reproductive Autonomy Scale and the continued refinement of the Miller et al. reproductive coercion assessment provide essential tools for continuing to describe and define the phenomenon of reproductive coercion, and for measuring the effect of interventions in improving a woman's resistance of coercion. Both instruments are in need of further validation; the Reproductive Autonomy Scale specifically should be tested in a broader sample of women than just those seeking to avoid pregnancy. Knowledge of reproductive coercion and autonomy would benefit, as well, from a systematic review of the reproductive autonomy literature.

More research is needed on interventions for women experiencing reproductive coercion. Current recommendations for healthcare providers who care for patients experiencing reproductive coercion are limited to harm reduction strategies (counseling on less-detectable methods of contraception and abortion) (American College of Obstetricians and Gynecologists, 2013). Limited research currently supports (or refutes) those recommendations (Miller et al., 2011), or looks at long-term outcomes as a result of them, and no research examines behavioral interventions that support healthy relationships, addressing men as well as women.

Conclusion

The abundance of cross-sectional data found in this review means that little is known about causality or chronology of events in the lives of women who experience reproductive coercion. Delving deeper into the aspects of reproductive coercion that are just beginning to be examined will illuminate unexplained relationships, and will inform interventions for providers

and advocates. This area of research has great potential to explain previously unexplained phenomena in the field of violence and unintended pregnancy, and to establish connections between the many factors that influence the reproductive health and safety of women.

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Tables

Table 2-1 Sample, Quality, and Prevalence of Types of Reproductive Coercion in Quantitative Studies

First Author (year)	Sample, Setting and Design	Race/Ethnicity and SES of Sample (if noted)	Subgroup(s)	Prevalence				Quality Rating
				Reproductive Coercion	Pregnancy Coercion	Birth Control Sabotage	Abortion Coercion	
Finer (2005)	1,209 abortion patients 11 locations in the United States Mixed methods	31% Black 19% Hispanic remainder not specified SES: 60% low-income	Partner wanting abortion was most important reason for abortion				0.5%	QI
Gee (2009)	1,463 women over age 18 Philadelphia, Pennsylvania Cross-sectional survey	57% White 23% Black 15% Other [Note: this data was not reported, but was calculated from other data provided in the study]	Partner makes it difficult to use birth control (past 4 months): No IPV Past year IPV Did not use birth control because partner did not want to/wanted participant to get pregnant: No IPV Past year IPV			4.6% 13.5% 6.1% 16.7%		QII

Miller (2010)	1,278 women ages 16–29 seeking care in 5 family planning clinics California Cross-sectional survey	29.9% Hispanic 28.1% Black 22.4% White 12.5% Asian/other 7.1% multiracial	Overall Hispanic Black White Asian/Other Multiracial	19.1% 16.8% 25.9% 13.3% 15.0% 27.5%	15% 11.5% 27.0% 7.3% 9.4% 15.4%		QI
Silverman (2010)	1,318 men ages 18-35 who had ever had sex Boston, Massachusetts Cross-sectional survey	48.5% Black 31.5% Hispanic 11.9% Other 8.1% White	Partner sought to compel abortion Partner sought to prevent abortion			4.1% 8%	QII
Miller (2011)	906 women ages 16–29 years Northern California Cluster randomized control trial	29.7% Hispanic 27.9% Black 22.9% White 12.9% Asian/Pacific Islander/other 6.7% multiracial	Past 3 months at baseline: Intervention group Control group	 9.3%, 7.9%	 10.7% 7.0%		QI
Silverman (2011)	356 women aged 14–20 who had ever had sex Boston, Massachusetts Cross-sectional survey	40% White 34% Hispanic 20% Black 6% other	Coerced into sex without a condom		20%		QI
Foster (2012)	5,109 women who sought abortions at one clinic United States Cross-sectional survey	56.1% White/Hispanic 38.8% Black 2.6% mixed/other 1.8% missing 0.7% Asian	Pushed to have an abortion against their wishes			2%	QI
Chibber (2014)	954 pregnant women, 15 years or older, meeting criteria for the parent study (the Turnaway Study) Multiple locations in the United States	37% White 29% Black 21% Hispanic 13% other SES: at least 68% low-income	Coerced to have abortion by partner			0.1%	QI

	Mixed methods				
Clark (2014)	641 women ages 18-44, literate Urban location Cross-sectional survey	41.8% Latina 27% White 16.4% Black 8.7% other 6.1% >1 race SES: 79% low-income	Overall Latina[1] Black White Other >1 race	16% 5.7% 3.2% 3% 1.7% 1.7%	QI
Dick (2014)	1,008 youth ages 14-18 (RC results from 769 female participants only) Northern California Cross-sectional survey	36.5% Hispanic 27.1% Black 15.5% Asian 10.7% Multiracial 5.2% White 5.1% Native Amer./ Pacific Islander	No cyber dating abuse Low cyber dating abuse High cyber dating abuse	4% 11.6% 21.6%	QI
Kazmerski (2014)	1,262 women ages 16–29 years seeking care in 5 family planning clinics Northern California Cross-sectional survey	30% Hispanic 27.9% Black 22.6% White 8.5% multiracial/other 5.7% Native Amer./Pacific Isl./Alaskan Native/Native Hawaiian 5.4% Asian	Past 3 months	13%	QI
McCauley (2014)	564 girls ages 14-19 seeking services at school-based health clinics, who completed questions on sexual minority status Northern California Cross-sectional survey	36.9% Hispanic 29.1% Black 15.6% Asian 8.9% multiracial 5% White 4.6% Amer. Indian/ Pacific Islander	Overall Sexual minority group females	12.4% 12.3%	QI

Miller (2014)	3539 women aged 16–29 seeking care in 24 rural and urban family planning clinics Pennsylvania Cross-sectional survey	80.3% White 13.3% Black 2.9% multiracial 1.6% Hispanic 1.6% Asian/other	Past 3 months	5%	1.7%		QI
			Past 3 months by race:				
			White	3.7%			
			Black	12.5%			
			Multiracial	5.9%			
			Hispanic	8.8%			
			Asian/Other	7.3%			
			Past 3 months:				
			Partner removing condom during sex			1.6%	
			Poking holes in condoms			0.2% 0.4%	
			Breaking condoms			0.4%	
			Preventing access to birth control			0.5%	
			Coerced into sex without a condom				
McCauley (2015)	3,455 women aged 16–29 years seeking care at family planning clinics, whose partners were equally men and women, or mostly or exclusively men Western Pennsylvania Cross-sectional survey	80.6% White 13.1% Black 2.9% Multiracial 1.6% Other 1.5% Hispanic/Latina	Past 3 months	5.1%			QI
			Women who have sex with women and men	9.3%			
			Women who have sex with men	4.6%			
Patel (2015)	1,388 non-pregnant women age 16–40 Southeast Texas Cross-sectional survey	21.3% White 35.2% Black 22.9% Hispanic Remainder not specified			1%		QI

Sutherland (2015)	972 women aged 18-25, enrolled at a large public university; sexually active Northeast United States Cross-sectional survey	SES: 80% low-income 75.3% White 10.3% Hispanic 9.6% Asian 4.8% Black	White Hispanic Asian Black	8% 6.6% 16.7% 6.7% 15.6%	6.8%	3.9%	QI

NOTE: SES = socioeconomic status, RC = reproductive coercion
Quality ratings for cross-sectional and mixed-methods studies are as follows [102]:
QI: Total score of 22.5–30 indicates that 75% to 100% of the total criteria were met.
QII: Total score of 15–22.4 indicates that 50% to 74% of the total criteria were met.
QIII: Total score of less than 15 indicates that less than 50% of the total criteria were met.
Quality ratings for randomized control studies are as follows [103]:
1 STRONG (no WEAK ratings)
2 MODERATE (one WEAK rating)
3 WEAK (two or more WEAK ratings)

[1]Racial and ethnic prevalence was calculated from data provided.

Table 2-2 Areas of Qualitative Findings Related to Reproductive Coercion

First Author (year)	Sample and Setting	Race/Ethnicity of Sample	Areas of Qualitative Findings Related to Reproductive Coercion							Quality Rating
			Reproductive Coercion	Pregnancy Coercion	Birth Control Sabotage	Abortion Coercion	Unintended Pregnancy	Resistance Strategies	Clinical Interventions	
Hathaway (2005)	38 women ages 23-62 participating in a hospital-based IPV program Massachusetts	47% White 42% Latina	X	X	X	X				QII
Herrman (2007)	12 teen mothers with a repeat pregnancy ages 16-19 Not listed	69% Black 6% Hispanic 25% not described		X		X				QII
Miller (2007)	53 sexually active adolescent females, ages 15-20, with history of IPV United States	37.7% Latina 37.7% White 20.8% Black 1.9% Asian/ Pacific Islander 1.9% multiple/ other	X	X	X	X		X		QI
Moore (2010)	71 women ages 18-49 with history of IPV	53% Black 33% White 11% Hispanic 1% American	X	X	X	X		X		QI

First Author (year)	Sample and Setting	Race/Ethnicity of Sample	Areas of Qualitative Findings Related to Reproductive Coercion							Quality Rating
			Reproductive Coercion	Pregnancy Coercion	Birth Control Sabotage	Abortion Coercion	Unintended Pregnancy	Resistance Strategies	Clinical Interventions	
	Midwestern and Eastern united States	Indian/Alaska Native 1% other								
Thiel de Bocanegra (2010)	53 women age 18 and older, living in an IPV shelter San Francisco, California	45% Hispanic 26% White 17% Asian 9% Black 2% Native Amer.		X	X	X		X		QI
Teitelman (2011)	64 adolescent girls ages 14-17, sexually active Northeastern United States	100% Black		X	X			X		QI
Miller (2012)	20 women ages 18-34, with gang involvement Los Angeles, California	100% Latina		X	X		X			QI
Borrero (2015)	66 low- income women, ages 18-45 Western Pennsylvania	55% White 45% Black	X		X		X			QI

First Author (year)	Sample and Setting	Race/Ethnicity of Sample	Areas of Qualitative Findings Related to Reproductive Coercion							Quality Rating
			Reproductive Coercion	Pregnancy Coercion	Birth Control Sabotage	Abortion Coercion	Unintended Pregnancy	Resistance Strategies	Clinical Interventions	
Burton (2015)	47 providers Virginia	53.2% White 31.9% Black 6.4% Hispanic/ Latino 4.3% Other 2.1% Multiracial 2.1% Asian							X	QI
Nikolajski (2015)	66 low- income women, ages 18-45 Western Pennsylvania	55% White 45% Black	X	X	X	X		X		QI

Note:
Quality ratings for qualitative studies are as follows [102]:
QI: Total score of 22.5–30 indicates that 75% to 100% of the total criteria were met.
QII: Total score of 15–22.4 indicates that 50% to 74% of the total criteria were met.
QIII: Total score of less than 15 indicates that less than 50% of the total criteria were met.

Table 2-3 Quantitative Results on the Intersection of Reproductive Coercion and Intimate Partner Violence

First Author (year)	Findings on Intersection with IPV	
Gee (2009)	Women with history of IPV more likely to report no birth control use because of partner unwillingness or pregnancy pressure	16.7% with IPV vs 6.1% without IPV

First Author (year)	Findings on Intersection with IPV	
	Women with history IPV more likely to agree with: "my partner makes it difficult to use birth control"	13.5% with IPV vs. 4.6% without IPV
	Increased odds of IPV for women reporting partner unwillingness to use birth control or pregnancy pressure	OR 2.34, 95% CI 1.41-3.89
	Increased odds of IPV for women agreeing with the statement: "my partner makes it difficult for me to use birth control"	OR 2.78, 95% CI 1.68-4.63
Miller (2010)	RC prevalence without IPV	7%
	RC prevalence with IPV	18.5%
	Women reporting birth control sabotage who also reported IPV	79%
	Women reporting pregnancy coercion who also reported IPV	74%
Silverman (2010)	IPV was associated with both:	
	abortion pressure	ARR 2.41, 95% CI 1.38-4.20
	and men preventing abortion	ARR 2.60, 95% CI 1.76-3.87
Miller (2011)	Among women with recent IPV (past 3 months) exposure to intervention had a 71% reduction in the odds of pregnancy coercion compared to control group	AOR 0.29, 95% CI 0.09–0.91
	Among women *without* recent IPV (past 3 months) exposure to the intervention had no significant impact on pregnancy coercion	AOR 1.63, 95% CI 0.80–3.34
Silverman (2011)	Women who experienced IPV had significantly higher odds of having coerced sex without a condom than women without IPV	AOR 4.9, 95% CI 2.6-8.9
Clark (2014)	Of women who experienced RC percent who also experienced IPV in the same relationship	32% (95% CI 23-41%)

First Author (year)	Findings on Intersection with IPV	
Dick (2014)	Exposure to cyber-dating abuse increased odds of reporting RC:	
	Low exposure to CDA	AOR 3.0, 95% CI 1.4–6.2
	Higher exposure to CDA	AOR 5.7, 95% CI 2.8–11.6
Kazmerski (2014)	Reported both RC and IPV	4.4%
	Reported RC only	9%
	Recent RC (past 3 months) in the absence of IPV increased odds of using emergency contraception:	
	once	AOR 2.6, 95 % CI 1.2–5.8
	and two or more times	AOR 2.2, 95 % CI 1.7–2.7
	Recent IPV in the absence of RC increased odds of seeking pregnancy testing:	AOR 1.4, 95 % CI 1.1–1.7
	one pregnancy test	AOR 2.2, 95 % CI 1.4–3.2
	and two or more pregnancy tests	AOR 1.6, 95 % CI 1.3–2.0
	and using emergency contraception once	
	Combined effect of both recent IPV and RC increased odds of::	AOR 3.6, 95% CI 3.3–3.8
	seeking two or more pregnancy tests	AOR 2.4, 95% CI 1.5–4.1
	using emergency contraception two or more times	AOR 2.5, 95 % CI 1.6–3.9
	seeking STI testing once	AOR 2.9, 95 % CI 1.02–8.5
	seeking STI testing two or more times	
McCauley (2014)	Prevalence of RC:	
	in overall sample	12.4%
	of those with recent IPV	24%
	Recent IPV increased odds of RC	AOR, 3.32, 95% CI, 1.87-5.92
Miller (2014)	Increased odds of past-year unintended pregnancy in women with IPV and RC	AOR 2.00, 95% CI 1.15–3.48

First Author (year)	Findings on Intersection with IPV	
Sutherland (2015)	Of women who reported RC, percent who also reported IPV	57.9% (95% CI 2.74-7.29) [sic]
	Of women who reported birth control sabotage, percent who also reported IPV	67.9% (95% CI 2.75-13.93) [sic]
	Of women who reported pregnancy coercion, percent who also reported IPV	59.1% (95% CI 2.73-7.75) [sic]

NOTE: SES = socioeconomic status, IPV = intimate partner violence, RC = reproductive coercion, AOR = adjusted odds ratio

Table 2-4 Quantitative Results on the Intersection of Reproductive Coercion and Unintended Pregnancy

First Author (year)	Findings on Intersection with Unintended Pregnancy	
Miller (2010)	RC increased the odds of unintended pregnancy	AOR 1.60, 95% CI 1.22–2.09
	RC increased the odds of unintended pregnancy among those exposed to IPV	AOR 2.02, 95% CI 1.45–2.82
	RC *did not* increase the odds of unintended pregnancy among those *not* exposed to IPV	AOR 1.00, 95% CI 0.62–1.63
	Interaction effect of IPV and RC increased the odds of unintended pregnancy	AOR 1.99, 95% CI 1.11–3.58
	Pregnancy coercion increased the odds of with unintended pregnancy	AOR 1.83, 95% CI 1.36–2.46
	Pregnancy coercion increased the odds of unintended pregnancy among those reporting IPV	AOR 2.35, 95% CI 1.63–3.38
		AOR 1.03, 95% CI 0.59–1.81
	Pregnancy coercion *did not* increase the odds of unintended pregnancy for those not exposed to IPV	AOR 2.22, 95% CI 1.14-4.32
	Interaction effect of IPV and pregnancy coercion increased the odds of unintended pregnancy	AOR 1.58, 95% CI 1.14–2.20

First Author (year)	Findings on Intersection with Unintended Pregnancy	
		AOR 1.77, 95% CI 1.21–2.59
	Birth control sabotage increased the odds of unintended pregnancy	AOR 1.11, 95% CI 0.56-2.19
	Birth control sabotage increased the odds of unintended pregnancy among those exposed to IPV	AOR 1.60, 95% CI 0.73–3.48
	Birth control sabotage *did not* increase the odds of unintended pregnancy among those exposed to IPV	
	Interaction effect of IPV and birth control sabotage *did not* increase the odds of unintended pregnancy	
Miller (2014)	Among women exposed to recent (past 3 months) RC, past year unintended pregnancy prevalence	20.9%
		AOR 1.79, 95%CI 1.06–2.03
	Increased odds of past year unintended pregnancy among those experiencing RC	AOR 2.00, 95%CI 1.15–3.48
	Increased odds of past year unintended pregnancy among those experiencing RC and IPV	
Sutherland (2015)	Women who experienced RC were more likely to report a history of unintended pregnancy	19.7%, $p < .001$ [Note: comparison proportion not provided]

NOTE: SES = socioeconomic status, IPV = intimate partner violence, RC = reproductive coercion, AOR = adjusted odds ratio, ARR = adjusted risk ratio

Table 2-5 Implications for Practice, Policy and Research

Practice	• Brief screening intervention appears to be promising in decreasing rates of unintended pregnancy among women experiencing IPV and reproductive coercion • Findings related to long-acting and less detectable methods of contraception as resistance strategies suggest a need for private conversations between a woman and her healthcare provider regarding contraceptive options • Findings about association between seeking pregnancy/STI testing and reproductive coercion suggest need for heightened awareness when women present for these services • The association between reproductive coercion, IPV and unintended pregnancy provides an opportunity for target screening and intervention, but also shows the need for earlier prevention, identification and intervention strategies • Associations between IPV and reproductive coercion offer opportunities for collaboration between healthcare and violence-related service providers
Policy	• Multiple methods of contraception, including long-acting and covert methods must be included services in insurance plans, as well as available to women who may not have or be using insurance (i.e.: immigrant women, girls under 18 presenting without parental involvement) • Reproductive coercion should be included in discussion regarding legal definitions of sexual and IPV
Research	• Consistency in definitions of reproductive coercion and its subdomains is needed • Validation of a measurement tool for reproductive coercion is imperative • Population-based studies are needed to further examine the phenomena in women who are not actively in school or healthcare settings • Longitudinal studies to examine temporal relationship between reproductive coercion and IPV, as well as to evaluate prevention and intervention strategies are needed

Note: IPV = intimate partner violence

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Chapter 2: ADDENDUM

A literature search was repeated on 10/15/2018, using the same search strategies that had previously been employed for Manuscript 1, in order to update the literature review findings from the 2015 search. This search revealed 419 articles, of which 314 remained after eliminating duplicates. Titles and abstracts were reviewed for relevance which eliminated 247, leaving 67 references. Seven of these were already included in the initial literature review. Articles that were not research (i.e., abstracts, reviews, opinions, etc.) were removed (17), as was international literature (6). Of the remaining 37, 12 were not relevant after closer review, which left 25 articles. A hand search of reference lists and personally collected articles was then completed and allowed for the discovery of articles outside the date parameters that may have been missed in the first review, as well as non-peer reviewed reports from research organizations, which added 23 articles. A final count of 48 new articles were discovered: 8 mixed methods, 27 quantitative and 13 qualitative studies. New findings are summarized according to type of research.

Findings

Mixed Methods Studies

Findings from mixed methods studies are included according to type of data (quantitative and/or qualitative), in their respective sections.

Quantitative Studies

Quantitative findings consisted primarily of cross sectional data (23; 1 of these was instrument validation[1]). Two studies were randomized control trials.[2,3] One presented longitudinal data,[4] and one study was retrospective.[5] Five studies analyzed large, publicly available datasets.[5–9] Participants were recruited at community service organizations,[10,11] health clinics,[1,2,18,19,3,4,12–17] an IPV shelter,[20] a juvenile detention facility,[21] and colleges or universities.[22–24] Geographically, studies were conducted in the southern United States (including southwest, Texas and Florida),[4,5,15,18,21,24] the mid-Atlantic,[5,13] the northeast,[5,15–17,22] the Midwest including Pennsylvania,[1–3,5,6,12,15,19,25] and California.[1,15,26] In addition to community samples, participants

included adolescents,[4,16] incarcerated girls,[21] healthcare providers,[18] IPV service providers,[27] IPV survivors,[20] men,[24] college students,[22–24] women veterans,[9] women with HIV,[13] women with a history of abortion,[15] and behaviorally bisexual women.[10]

RC behaviors were measured with numerous adaptations of the Reproductive Coercion Scale, ranging from 3 questions[9] to 12 questions that were adapted to remove perpetrator's intent.[22] Some studies used original investigator-developed questions, ranging from one question[5] to 24[20]. Two studies used the Reproductive Autonomy Scale, which includes measures of freedom from coercion.[15,24] Timeframe of RC measurement included past 3 months,[1–3,12,18,19] past year[5,9,13] and lifetime.[7,10,26,11,16–18,20–23]

Quantitative findings are summarized in Table 2A-1. Prevalence of RC ranged from 1.1% in population-based data that measured past-year RC with one question[5] to 51% of adolescent mothers when past-year RC was measured with 13 investigator-developed questions.[28]

Findings on the intersection of RC and IPV are summarized in Table 2A-2. A strong association between RC and IPV continues to be supported by most reviewed studies. Exceptions include one that studied women with HIV in which over half the sample had experienced past-year IPV,[13] one which found minor physical violence was not more common in relationships with condom interference as compared with other relationships (though there was an association between IPV and psychological abuse),[23] one which found RC was not associated with personal violence in the past year or a current controlling partner (but was associated with a feeling of lack of personal safety),[17] and one which found no association between lifetime or past-3 months RC and IPV in a community sample of 84 women attending a health clinic.[18]

Findings on the intersection of RC and unintended pregnancy are summarized in Table 2A-3. A strong association between RC and unintended pregnancy continues to be supported. One study of a large community-based sample (N=1,234) identified race-specific effects of this relationship, finding that the association between RC and unintended pregnancy only held for Black and White women, while Hispanic/Latina, multiracial, other women did not experience this

association.[26] One study of 282 IPV survivors (57.8 percent of whom identified as Hispanic/Spanish) did not support this relationship, finding that "women's fertility control" (a concept that encompasses many RC behaviors) was associated with premature birth and miscarriage, but not with unintended pregnancy or stillbirth.[20] And another (large population-based) study found the relationship between RC (measured with one question) and unintended pregnancy did not remain in their adjusted regression model.[5]

Other variables found to be associated with RC are presented in Table 2A-4. Demographic factors included younger age,[9,28] greater age discrepancy with partner,[4,28] higher likelihood of employment,[17] cohabitation,[4] not being married,[5,9] less education,[5] low income,[5] higher religious activity,[24] Latina ethnicity (increased risk in one study[29] and decreased in another[17]), Black race,[9,26] multi-racial or other race,[9,26] White race,[17] and non-White race.[18] Mental health factors included PTSD[13,21] and depression.[13,21] Psychosocial factors included less progressive gender beliefs,[24] reduced condom negotiation self-efficacy,[12] reduced contraceptive and sexual self-efficacy,[22] decreased comfort communicating with sexual partners,[16] and decreased relationship trust.[30] Factors related to sex and pregnancy included partner rape resulting in pregnancy,[7] abortion,[8] early sexual initiation,[21] sex without a condom[21] or reliable contraception,[22] multiple sex/dating partners,[21,22,30] having sex with both women and men,[11] sexually transmitted infection,[12,16,21] preterm birth,[20] decreased breastfeeding[31] and transactional sex.[17] Factors related to partner or relationship characteristics included having a partner who was a source of spending money or who had job, car, or earned more money than the participant.[4] And factors related to healthcare included willingness to use pre-exposure HIV prophylaxis (PrEP)[11] and longer travel time to a healthcare provider.[24]

Nine studies with quantitative findings addressed safety and harm reduction strategies used by women who experience RC (or safety strategies in women experiencing IPV that pertain to reducing harm from RC behaviors) or RC interventions. In population-based data, women who experienced abuse were more likely to continue use of long acting reversible contraception

(LARC) methods (i.e., IUDs and implants) than non-LARC methods (any differences by race and ethnicity were not reported).[6] Similar findings were presented from a community-based sample of 130 women who, when they had previously experienced birth control sabotage, had increased odds of later using a highly effective method of contraception (i.e., LARC method, injectable, pills, patch or ring).[32] In another study of 278 women, IPV survivors were more likely to use tubal ligation than women who were not IPV survivors.[14] Another large community sample of 2,108 women found 1.9% of participants were hiding birth control from their partners in order to avoid pregnancy (when screened for this by providers).[18]

One study examined provider barriers to addressing RC, and found that most commonly they reported the need for more training.[27] Four studies addressed the Addressing Reproductive Coercion in Health Settings (ARCHES) intervention, which includes (1) universal IPV/RC education and assessment, (2) harm reduction counseling, and (3) universal supported referrals to victim services. One protocol article on this intervention study was published,[3] and one implementation study which found the intervention better implemented at higher-volume urban sites than suburban sites.[33] The intervention itself was studied in a cluster randomized control trial, and was found to increase self-efficacy to implement harm reduction behaviors, as well as knowledge of, use of, and likelihood of sharing information about IPV resources, though effects on decreasing RC and IPV were not significant.[2] One additional study examined the knowledge-based provider training method used in the ARCHES intervention and found that it was more effective than a communication-skills-based training, though both were effective training methods.[19]

Qualitative Studies

The 13 qualitative studies were conducted in geographically diverse locations: the Bronx, NY,[34] mid-Atlantic and the Southern US[30,35,36] and the Midwest US including western Pennsylvania.[28,37–42] Samples were recruited primarily from health clinics,[28,30,34,39–42] but also from IPV shelters[35,37] and a community based organization.[43] In addition to community-based samples

of women, the diverse group of samples included providers and clinic staff,[34,40] IPV survivors,[35,37] men,[38,44,45] Twitter posts,[46] song lyrics,[47] Black behaviorally bisexual women,[43] teen mothers[28,42] and homeless women.[41]

Qualitative studies revealed a wide variety of RC behaviors that are experienced by women. These included pregnancy pressure,[35] throwing oral contraceptive pills (OCPs) in the trash or flushing down the toilet,[28,35,39] partner bringing OCPs to work with him,[35] condom refusal or removal,[35,39,41,46] poking holes in condoms,[41] forced sterilization (by partner),[37] forced sex (while asleep or intoxicated) in order to impregnate,[39] preventing attendance at clinic appointments,[39] using violence to cause a miscarriage,[37] physical violence when use of birth control is discovered,[28,41] sabotaging attempts to get an abortion,[45] not withdrawing when withdrawal was agreed upon method,[45] partners making all decisions about whether to use birth control and whether to continue a pregnancy,[42] and threats to end the relationship if the woman did not get abortion.[42] Additionally, one study reported on a theoretical concern by patients and providers that a hypothetical patient-removable IUD would put women at risk from coercive partners trying to sabotage their birth control.[34]

Two studies of men detail self-reports of RC behaviors such as lying about not having a condom even when they do,[44] lying about having latex allergy,[44] lying about plans to withdraw before ejaculation,[38,44] and sabotaging condoms by removing or breaking them.[38,44] A study of racial and ethnic differences in RC identified claims about infertility and about side effects of contraception as RC behaviors that were specific to Black women.[39] A study of a Black lesbian community noted masculine-identified women forcing girlfriends to get pregnant and determine the timing of pregnancy, though the girlfriends did not always perceive this as coercive.[43] And one study of song lyrics identified pressure to get an abortion as a common theme in contemporary hip hop.[47] Two studies reported on perpetration of RC behaviors by women's or partners' family members.[30,37] No studies specifically focused on Latina women.

Some studies addressed possible and perceived motivations for RC behaviors. Women reported that their partners pressure them to get pregnant in order to control them and make them dependent,[35,37] and to ensure the relationship will continue[46] especially in the context of male incarceration and especially among Black women.[39] Men reported their motivations for RC behaviors were to ensure the relationship will continue[38] and desire for family and legacy.[48] Masculine-identified Black lesbian women in one study also coerced pregnancy due to their desire to have a family.[43] One participant in one qualitative study screened positive for RC but did not interpret the behavior as coercive – in this case her partner told her not to take OCPs due to a risk of weight gain.[30]

Safety strategies used by women who experienced RC behaviors included keeping multiple diaphragms as backup when a partner threw one away,[35] tubal ligation, especially when immediately postpartum and covered by Medicaid,[37] hiding birth control[41,46] (identified as more common among Black women in one study[39]), and the use of less detectable methods of birth control.[28,30] One study, however, reported that a woman specifically indicated she would not use an implant or IUD (usually recommended as less detectable methods along with injectables) due to fear of detection by her partner.[41] One study evaluated the implementation of ARCHES (Addressing Reproductive Coercion in Health Settings), a brief trauma-informed education and counseling intervention (detailed in quantitative findings above), and found that it appeared to be feasible and successfully implemented.[40]

Tables

Table 2A-1 Findings on RC Prevalence

Study, 1st Author & Year	Setting	Sample	Measurement	Time frame	Prevalence		
					Reproductive Coercion	Pregnancy Pressure	Birth control sabotage
Alexander, 2016	Community services organizations	149 Behaviorally bisexual women 98% Black/African American 1.3% Multiracial 0.7% American Indian	RCS 10	Lifetime		Forced or pressured to become pregnant 16.8% Told not to use birth control 16.3%	Removed condom during sex so you would get pregnant 23.1%
Anderson, 2017	HIV Clinic	67 Women with HIV 79.1% Black/ African American 9.0% White/ Caucasian 3.0% Native American/American Indian 3.0% Other/ Multiple	RCS 9	Past year		Any pregnancy coercion 11.9% Told you not to use any birth control? 4.5% Said he would leave you if you did not get	Any birth control sabotage 10.4% Taken off the condom while you were having sex so that you would get pregnant? 9.0% Put holes in the condom so you

Study, 1st Author & Year	Setting	Sample	Measurement	Time frame	Prevalence		
					Reproductive Coercion	Pregnancy Pressure	Birth control sabotage
						pregnant? 4.5% Told you he would have a baby with someone else if you did not get pregnant? 9.0% Hurt you physically because you did not agree to get pregnant? 3.0 %	would get pregnant? 6.0% Broken a condom on purpose while you were having sex so you would get pregnant? 4.5% Taken your birth control away or kept you from going to the clinic to get birth control so that you would get pregnant? 3.0% Made you have sex without a condom so you would get pregnant? 7.5%
Center for Impact Research, 2000	Teen parent services and health clinics	474 Teen parents 95% Black 4% Latina	13 Investigator developed questions	Past year	Prevalence of RC: 51%	Prevalence of "verbal birth control sabotage"	Prevalence of "behavioral birth control sabotage" 14%

Study, 1st Author & Year	Setting	Sample	Measurement	Time frame	Prevalence		
					Reproductive Coercion	Pregnancy Pressure	Birth control sabotage
		1% other				(pregnancy coercion): 48%	
Cha, 2016	National data	Population-based (NSFG) (N=4,263) 59.1% White 14.3% Black 17.7% Hispanic 8.8% Other	Measured discordant pregnancy intentions (treated as proxy for RC when male partner intended pregnancy and woman did not)	Lifetime		Women reporting discordant pregnancy intentions, in which male partner intended pregnancy but woman did not: 10.1%	
Decker, 2017	Family planning clinics	Community sample (N=146) 50.8% Black 37.9% White 11.4% other	RCS 10	Lifetime	Prevalence of RC: 14%		
Hess, 2018	Nationwide through various networks, organizations and internet sources	164 IPV survivors 12% Black 43% Latinx 28% White 11% Other	Not reported, appears to be 2 questions based on responses	Not reported (but IPV was lifetime)	Prevalence of RC: 40%		

Study, 1st Author & Year	Setting	Sample	Measurement	Time frame	Prevalence		
					Reproductive Coercion	Pregnancy Pressure	Birth control sabotage
Holliday, 2017	Family planning clinics	Community sample (N=1,234) 22.9% White 27.7% Black 29.3% Latina 7.2% multiracial 12.8 API/other	RCS 11	Lifetime	Prevalence of RC: 25.9%		
Holliday & Morse, 2018	Abuser intervention program	28 Men participating in abuser intervention program 88% Black 4% White 8% Other	Not reported	Lifetime		Used deception to get partner pregnant: 8%	
Jones, 2016	Family planning clinics	Community sample (N=2,228) 14.1% Black 79.5% White 6% other	RCS 10	Past 3 months	Prevalence of RC: 6.2% Prevalence of RC in adolescents: 6.9% Prevalence of RC in young adults: 5.7%		
Katz & Sutherland, 2017	College	146 Undergraduate students 83.4% White	RCS 6 questions adapted to remove intent	Lifetime			Prevalence of condom interference: 25.3%

Study, 1st Author & Year	Setting	Sample	Measurement	Time frame	Prevalence		
					Reproductive Coercion	Pregnancy Pressure	Birth control sabotage
		7.6% Asian or Asian-American 3.4% Hispanic/ Latina 2.8% Black or African-American 2.8% other					Made to have sex without a condom 19.2% Took off the condom while having sex 11.6% Took condoms or other birth control away from you 2.1% Broke condoms on purpose while having sex 0.6%
Katz, 2017	College	233 Undergraduate women 80.3% Caucasian/ White 6.3% Asian 5.8% Hispanic/ Latina 4.9% African American/Black 2.7% Other	RCS 12 adapted to remove intent	Lifetime	Prevalence of RC: 29.6% (n = 66)	Made you have sex without a condom 14% Told you not to use any birth control (such as the pill, shot, ring, etc.)? 7% Tried to force or pressure	Took off the condom while you were having sex 21% Broke condoms on purpose while you were having sex 1% Kept you from going to the doctor's office or clinic to get

Study, 1st Author & Year	Setting	Sample	Measurement	Time frame	Prevalence		
					Reproductive Coercion	Pregnancy Pressure	Birth control sabotage
						you to become pregnant? 1% You hid birth control because you were afraid they would get upset with you for using it 1% Told you they would have a baby with someone else if you did not get pregnant <1% Said they would leave you if you did not get pregnant? <1%	birth control <1% Took your birth control away from you <1%
McCauley, 2017	Family planning clinics	Community sample (N=4,674)	RCS 9 and Refined RCS	Past 3 months	Prevalence of any RC:	Told you not to use any	Taken your birth control away from you

Study, 1st Author & Year	Setting	Sample	Measurement	Time frame	Prevalence		
					Reproductive Coercion	Pregnancy Pressure	Birth control sabotage
		65% White 17% Black 9% Latina 2% Asian 2% NH/PINA/AN 5% multiracial/ other			6.3% (refined RCS) 6.7% (RCS 9)	birth control 3.9% Said he would leave you if you didn't get pregnant 0.5% Told you he would have a baby with someone else if you didn't get pregnant 0.5% Hurt you physically because you did not agree to get pregnant 0.2%	or kept you from going to the clinic to get birth control 0.4% Made you have sex without a condom so you would get pregnant 0.8% Taken off the condom while you were having sex, so you would get pregnant 2.7% Put holes in the condom so you would get pregnant 0.4% Broken the condom on purpose while you were having sex so

Study, 1st Author & Year	Setting	Sample	Measurement	Time frame	Prevalence		
					Reproductive Coercion	Pregnancy Pressure	Birth control sabotage
							you would get pregnant 0.6%
Northridge, 2017	Health clinics	149 High school girls 51% Hispanic 27% Black 22% Other	RCS 9	Lifetime	Prevalence of RC 19%	Told you not to use any birth control: 15.4% Said he would leave you if you did not get pregnant: 4.0%	Took off a condom during sex so you would get pregnant: 8.1%
Paterno, 2017	Health clinics	Community sample (N=130) 84% African American/ Black 16% other	RCS 9	Past 3 months	Prevalence of RC: 15.4%		
Paterno, 2018	Health clinics	Community sample (N=130) 84% African American/ Black 16% other	RCS 9	Past 3 months and past year	Prevalence of past 3 months RC: 15.4% Prevalence of past year RC: 27.7%		
Phillips, 2016	Community health center	Community sample (N=97) 51% Latina/ Hispanic	RCS 5	Lifetime	Prevalence of at least 1 type of RC behavior: 24%	Told you not to use birth control: 16%	Made you have sex without a condom in order to get you pregnant 7%

Study, 1st Author & Year	Setting	Sample	Measurement	Time frame	Prevalence		
					Reproductive Coercion	Pregnancy Pressure	Birth control sabotage
		27% African American 7% white 7% Asian 7% multiracial or other				Said he would leave if you did not get pregnant: 10%	Partner removed a condom to get you pregnant: 6% Partner took away birth control so that you would get pregnant: 1%
Rosenfeld, 2017	United States, phone survey	2,302 Women veterans 51% non-Hispanic white 28% non-Hispanic black 13% Hispanic 8% "other"	RCS 3	Past year	Prevalence of RC: 11%		Partner removed, broke, or refused to use a condom during sex: 7% Partner took your birth control: less than 1% Partner told you not to use birth control: 6%
Samankasikorn, 2018	Population-based data (PRAMS)	20,252 Women who gave birth within past 9 months	1 question, confusing wording	Past year	Prevalence of RC: 1.1%		

Study, 1st Author & Year	Setting	Sample	Measurement	Time frame	Prevalence		
					Reproductive Coercion	Pregnancy Pressure	Birth control sabotage
		(race/ethnicity of sample not reported)					
Thaller & Messing, 2014	Health clinics	Community samples: 1. screened by providers (N=2,108) 2. Completed survey (N=84) Provider screening: 45.2% Latina 42.0% white Survey: 76.2% white 17.9% Hispanic or Latina 2.4% American Indian 1.2 black or African American 1.2% Native Hawaiian or other Pacific Islander 1.2% multiracial	Providers: 2 questions Survey RCS 10	Lifetime and past 3-months (survey)	Providers in study who screened for RC (with 1 question) detected prevalence of RC: 3.3% Survey: Prevalence of lifetime RC: 15.5% Prevalence of past-3 months RC: 8.3%	Prevalence of pregnancy coercion on survey [*timeframe not specified*]: 11.9%	Prevalence of birth control sabotage on survey [*timeframe not specified*]: 7.1%
Wallenborn, 2018	National data	Population-based (NSFG) (N=2,231)			Discordant pregnancy		

Study, 1st Author & Year	Setting	Sample	Measurement	Time frame	Prevalence		
					Reproductive Coercion	Pregnancy Pressure	Birth control sabotage
		14.1% White 54% Black 31.9% Hispanic			intention that was father intended, mother unintended (considered an example of RC) was 8.9% of sample		
Willie, 2017	Community organizations	Black/African American women (N=147)	RCS 9	Lifetime	19% reported experiencing both types of reproductive coercion (pregnancy coercion and birth control sabotage)	Prevalence of pregnancy coercion: 21%	Prevalence of birth control sabotage: 29%
Zachor, 2018	Family planning clinics	Community sample (N=103, 600 historical controls) *(historical controls, arm 1, arm 2)* 1.3, 1.9, 0 Asian 10.3, 15.1, 8.0 Black/ African-American 82.8, 71.7, 88.0 White	RCS 10	Past 3 months	Prevalence of RC among the 3 arms of study groups ranged 4.4%-7.1%		

Study, 1st Author & Year	Setting	Sample	Measurement	Time frame	Prevalence		
					Reproductive Coercion	Pregnancy Pressure	Birth control sabotage
		1.2, 3.8, 2.0 Hispanic or Latina 3.7, 7.6, 2.0 Multiracial/ other					

Table 2A-2 Intersection with IPV

Study	Setting	Sample	Measurement	Time frame	Findings
Anderson, 2017	HIV Clinic	67 Women with HIV 79.1% Black/ African American 9.0% White/ Caucasian 3.0% Native American/American Indian 3.0% Other/ Multiple	RCS 9	Past year	RC NOT significantly associated with IPV.
Barber, 2018	Random sample in Michigan	18-19-year-olds in the Relationship Dynamics & Social Life study (N=867) 35% African American, "some of	Investigator-developed questions about pregnancy desire for self and partner	Current and future pregnancy desire	Establishes statistical correlation between IPV and pregnancy, using an RC framework.

Study	Setting	Sample	Measurement	Time frame	Findings
		whom were also Latina."			
Center for Impact Research, 2000	Teen parent services and health clinics	474 Teen parents 95% Black 4% Latina 1% other	13 Investigator developed questions	Past year	66% of IPV survivors experienced RC 62% experienced pregnancy pressure 22% experienced birth control sabotage significantly higher than teens without IPV (34%, 31%, 5% respectively) Strong correlation between IPV and birth control sabotage (r=.361***)
Decker, 2017	Family planning clinics	Community sample (N=146) 50.8% Black 37.9% White 11.4% other	RCS 10	Lifetime	Prevalence of RC among: those reporting IPV: 68.4% those not reporting IPV: 31.6% p<0.01
Fasula, 2018	Juvenile detention facility	188 Adolescents in juvenile detention 100% African American	RCS 9	Lifetime	Lifetime history of physical abuse increased OR of RC: (1.85 (1.01-3.38) p<0.05) Lifetime history of sexual abuse increased OR of RC: (2.08 (1.05-4.12) p<0.05)
Jones, 2016	Family planning clinics	Community sample (N=2,228) 14.1% Black 79.5% White 6% other	RCS 10	Past 3 months	Experienced both RC and IPV in past 3 months: 2%
Katz & Sutherland, 2017	College	146 Undergraduate students 83.4% White	RCS 6 questions adapted to remove intent	Lifetime	Positive associations between condom interference and psychological abuse Minor physical violence was NOT more common in relationships with condom

Study	Setting	Sample	Measurement	Time frame	Findings
		7.6% Asian or Asian-American 3.4% Hispanic/ Latina 2.8% Black or African-American 2.8% other			interference as compared with other relationships
Katz, 2017	College	233 Undergraduate women 80.3% Caucasian/ White 6.3% Asian 5.8% Hispanic/ Latina 4.9% African American/Black 2.7% Other	RCS 12 adapted to remove intent	Lifetime	Among women who reported past RC, those who also reported IPV: 50.0%, n = 33 Among women who did not report past RC, those who also reported IPV: 24.8%, n = 39 $\chi 2(1) = 13.45$, **p = .01.**
Liu, 2016	IPV shelters and services	282 IPV survivors 57.8% Hispanic or Spanish (remainder not reported)	investigator-developed fertility control questionnaire, 24 items	Lifetime	Women abused because of birth control use: 6.7% (n = 20)
McCauley, 2017	Family planning clinics	Community sample (N=4,674) 65% White 17% Black 9% Latina 2% Asian	RCS 9 and Refined RCS	Past 3 months	RC increased odds of IPV: OR 4.05 (3.09-5.30) (refined RCS) OR 4.21 (3.24-5.47) (RCS 9)

Study	Setting	Sample	Measurement	Time frame	Findings
		2% NH/PINA/AN 5% multiracial/ other			
Northridge, 2017	Health clinics	149 High school girls 51% Hispanic 27% Black 22% Other	RCS 9	Lifetime	Odds of experiencing IPV among those reporting RC compared to those not reporting RC: OR, 4.8; 95% CI, 2.0-11.8 Odds of recognizing abusive behaviors among those reporting RC compared to those not reporting RC: OR, 0.10; 95% CI, 0.01-0.8
Paterno, 2018	Health clinics	Community sample (N=130) 84% African American/ Black 16% other	RCS 9	Past 3 months and past year	IPV in the past year was associated with past year RC (Fisher's exact test, p = .005) not associated with past 90 days RC (Fisher's exact test, p = .18) Odds of past-year RC among those with past-year IPV: AOR = 4.74; 95% CI = [1.07, 20.86]
Phillips, 2016	Community health center	Community sample (N=97) 51% Latina/ Hispanic 27% African American 7% white 7% Asian 7% multiracial or other	RCS 5	Lifetime	RC was associated with current "lack of personal safety" (RR = 3.51, 95% CI 1.87–6.60, P < 0.01). RC NOT associated with personal violence in the past year or a current controlling partner
Rosenfeld, 2017	United States, phone survey	2,302 Women veterans	RCS 3	Past year	Women who experienced military sexual trauma were more likely to report RC compared with

Study	Setting	Sample	Measurement	Time frame	Findings
		51% non-Hispanic white 28% non-Hispanic black 13% Hispanic 8% "other"			women who did not (14% vs 8%; aOR, 2.14; 95% CI, 1.40-3.27).
Samankasikorn, 2018	Population-based data	20,252 Women who gave birth within past 9 months (race/ethnicity of sample not reported)	1 question, confusing wording	Past year	0.3% reported both IPV and RC Participants less than 30 years old had greater risk of RC and IPV than those older than 30 years ($p < .0001$) Odds of experiencing RC among those who experienced IPV compared to those who did not experience IPV aOR 7.98, 95% CI [4.68 - 13.59]
Thaller & Messing, 2014	Health clinics	Community samples: 1. screened by providers (N=2,108) 2. Completed survey (N=84) Provider screening: 45.2% Latina 42.0% white Survey: 76.2% white	Providers: 2 questions Survey RCS 10	Lifetime and past 3-months (survey)	IPV NOT associated with RC in survey data

Study	Setting	Sample	Measurement	Time frame	Findings
		17.9% Hispanic or Latina 2.4% American Indian 1.2 black or African American 1.2% Native Hawaiian or other Pacific Islander 1.2% multiracial			
Willie, 2017	Community organizations	Black/African American women (N=147)	RCS 9	Lifetime	Women who reported physical or sexual IPV were more likely to report birth control sabotage ($p<0.01$) and pregnancy coercion ($p<0.01$) PrEP acceptability was mediated by experience of birth control sabotage among IPV survivors

Table 2A-3 Intersection of RC and Unintended Pregnancy

Study	Setting	Sample	Measurement	Time frame	Findings
Hess, 2018	Nationwide through various networks, organizations and internet sources	164 IPV survivors 12% Black 43% Latinx 28% White 11% Other	Not reported, appears to be 2 questions based on responses	Not reported (but IPV was lifetime)	84% of participants who reported RC also reported pregnancy as a result 60% of these experienced more than 1 pregnancy 19% of these experienced 5 or more pregnancies 83% of these had a forced pregnancy that resulted in a live birth

Study	Setting	Sample	Measurement	Time frame	Findings
Holliday, 2017	Family planning clinics	Community sample (N=1,234) 22.9% White 27.7% Black 29.3% Latina 7.2% multiracial 12.8 API/other	RCS 11	Lifetime	Black women had higher odds of experiencing unintended pregnancy, and when controlling for RC, the effect of Black race on UIP remained significant (AOR Black = 1.63, 95% CI = 1.02–2.60) (AOR RC= 1.59, 95% CI= 1.26–2.01). Controlling for IPV, effect of Black race on UIP was no longer significant (AOR Black = 1.67, 95% CI = 0.99–2.80) Controlling for race, effect of IPV on UIP was no longer significant (AOR=1.38, 95% CI =0.77–2.48) Controlling for RC, effect of API/other race on UIP was significant compared to White women (AOR API/other = 1.41, 95% CI= 1.15–1.73) Controlling for RC and IPV, effect of API/other race on UIP was significant compared to White women (AOR= 1.43, 95% CI= 1.13– 1.80) White women who experienced RC were significantly more likely to have a UIP than White women who did not experience RC (AOR= 2.06, 95% CI= 1.45–2.93) Black women who experienced RC were significantly more likely to have a UIP than Black women who did not experience RC (AOR=1.72, 95% CI= 1.14–2.60) Hispanic/Latina, multiracial, API/other women: no race-specific RC effects on UIP
Jones, 2016	Family planning clinics	Community sample (N=2,228)	RCS 10	Past 3 months	OR of UIP among adolescents with RC: 1.13 (1.05-1.21) $p<0.01$

Study	Setting	Sample	Measurement	Time frame	Findings
		14.1% Black 79.5% White 6% other			OR of UIP among young adults with RC: 1.08 (1.01-1.16) p<0.05 Condom negotiation self-efficacy mediated this association in young adults, not in adolescents
Liu, 2016	IPV shelters and services	282 IPV survivors 57.8% Hispanic or Spanish (remainder not reported)	investigator-developed fertility control questionnaire, 24 items	Lifetime	Rates of UIP due to abusers who did not allow use of birth control: 14.3% (n = 43) Women's fertility control (covers many RC behaviors) associated with premature birth and miscarriage, *not* with unintended pregnancy and stillbirth
McCauley, 2017	Family planning clinics	Community sample (N=4,674) 65% White 17% Black 9% Latina 2% Asian 2% NH/PINA/AN 5% multiracial/ other	RCS 9 and Refined RCS	Past 3 months	RC increased odds of unwanted pregnancy: OR 1.46 (1.12-1.91) (refined RCS) OR 1.58 (1.21-2.04) (RCS 9)
Rosenfeld, 2017	United States, phone survey	2,302 Women veterans 51% non-Hispanic white 28% non-Hispanic black	RCS 3	Past year	Women who experienced RC compared with women who did not were more likely to have a pregnancy in the last year (14% vs 10%; aOR, 2.07, 95% CI, 1.17-3.64) (not significantly more likely to have an unintended pregnancy (6% vs 4%; aOR, 1.63, 95% CI, 0.71-3.76))

Study	Setting	Sample	Measurement	Time frame	Findings
		13% Hispanic 8% "other"			Women who experienced RC compared with women who did not were less likely to use: any contraceptive method at last sex (76% vs 80%; aOR, 0.61, 95% CI, 0.38-0.96) any prescription contraceptive method (43% vs 55%; aOR, 0.62, 95% CI, 0.43-0.91) their ideal method of contraception (35% vs 45%; aOR, 0.63, 95%CI, 0.43-0.93)
Samankasikorn, 2018	Population-based data	20,252 Women who gave birth within past 9 months (race/ethnicity of sample not reported)	1 question, confusing wording	Past year	Odds of UIP among participants who reported: RC only (OR 2.18, 95% CI [1.38, 3.44]) IPV only (OR 2.36, 95% CI [1.75, 3.19]) RC and IPV (OR 3.55, 95% CI [1.56, 8.06]) compared with participants who reported neither RC nor IPV (No longer statistically significant in adjusted model)

Table 2A-4 Other factors associated with RC

Study	Setting	Sample	Measurement	Time frame	Findings
Anderson, 2017	HIV Clinic	67 Women with HIV 79.1% Black/ African American 9.0% White/ Caucasian	RCS 9	Past year	64% of women who reported RC had positive **PTSD** score 27% of women who did not report RC had positive PTSD score (**Fisher's exact P=0.033**) 55% of women who reported RC had **depressive symptoms** 33% of women who did not report RC had depressive symptoms (**Fisher's exact P=0.189**).

Study	Setting	Sample	Measurement	Time frame	Findings
		3.0% Native American/American Indian 3.0% Other/ Multiple			
Basile, 2018	National data	Population-based (NISVS) (N=22,590) (race and ethnicity of sample not reported)	2 items	Lifetime	30.0% of women who were **raped by partner** also experienced RC from same partner. 19.6% of women who were raped by partner reported partner tried to get them pregnant or tried to stop them from using birth control 23.3% of women who were raped by partner reported partner refused condom use 51.8% of women who reported **partner rape resulting in pregnancy** experienced RC 22.1% of women who reported partner rape not resulting in pregnancy experienced RC (p< **0.001**) 38.9% of women who reported partner rape resulting in pregnancy experienced pregnancy pressure or blocked access to birth control 12.4% of women who reported partner rape not resulting in pregnancy experienced pregnancy pressure or blocked access to birth control (p< **0.001**) 44.0% of women who reported partner rape resulting in pregnancy experienced partner condom refusal 16.1% of women who reported partner rape not resulting in pregnancy experienced partner condom refusal (p< 0.001)

Study	Setting	Sample	Measurement	Time frame	Findings
Center for Impact Research, 2000	Teen parent services and health clinics	474 Teen parents 95% Black 4% Latina 1% other	13 Investigator developed questions	Past year	RC more prevalent and more severe in **younger** girls (p=0.038) girls with greater **partner age discrepancy** (p=0.101)
Cha, 2016	National data	Population-based (NSFG) (N=4,263) 59.1% White 14.3% Black 17.7% Hispanic 8.8% Other	Measured discordant pregnancy intentions (treated as proxy for RC when male partner intended pregnancy and woman did not)	Lifetime	Pregnancies where the male partner intended pregnancy and the woman did not were significantly more likely to end in **abortion** than those where both partners intended the pregnancy 6.9 AOR (1.5-32.9)
Fasula, 2018	Juvenile detention facility	188 Adolescents in juvenile detention 100% African American	RCS 9	Lifetime	Girls who experienced RC had increased odds of: **early sexual initiation** (OR=2.34; CI=1.26–4.33; p≤0.01) **sex without a condom** (OR=2.16; CI=1.15–4.07; p < 0.05) **multiple sex partners** (OR=2.27; CI=1.23–4.17; p≤0.01) previous **STD** diagnosis (OR=3.22; CI=1.70–6.11; p≤0.001) **depressive symptoms** (2.30 (1.23-4.28) p<= 0.01) **PTSD** (2.03 (1.11-3.73) p<0.05)
Hess, 2018	Nationwide through various	164 IPV survivors 12% Black	Not reported, appears to be 2 questions	Not reported (but IPV	RC more common among **Latina** participants: 45% of Latina survivors 36% of other survivors

Study	Setting	Sample	Measurement	Time frame	Findings
	networks, organizations and internet sources	43% Latinx 28% White 11% Other	based on responses	was lifetime)	(significance level not reported)
Holliday, 2017	Family planning clinics	Community sample (N=1,234) 22.9% White 27.7% Black 29.3% Latina 7.2% multiracial 12.8 API/other	RCS 11	Lifetime	**Black and multiracial** women had significantly higher odds of experiencing RC relative to White women [OR Black = 2.69, 95% CI = 1.90–3.79 and OR multiracial = 1.88, 95% CI = 1.46–2.41] Prevalence of RC by race/ethnicity: 18% white 37.1% Black 24% Latina 29.2% Multiracial 18.4% API/other chi-square **p=<0.001**
Jones, 2016	Family planning clinics	Community sample (N=2,228) 14.1% Black 79.5% White 6% other	RCS 10	Past 3 months	adolescents and young adults with recent RC had reduced **condom negotiation self-efficacy** (–0.27 and –0.20) OR of **STD** among adolescents with RC: 1.12 (1.07-1.17) p<0.001 OR of **STD** among young adults with RC: 1.08 (1.04-1.11) p<0.001 Condom negotiation self-efficacy did not mediate these associations
Katz, 2017	College	233 Undergraduate women 80.3% Caucasian/ White	RCS 12 adapted to remove intent	Lifetime	Women who reported RC and used reliable contraception at last vaginal sex: 81.8% (n = 54) women who did not report RC and used reliable contraception at last vaginal sex: 95.5% (n = 150) **p = .001**

Study	Setting	Sample	Measurement	Time frame	Findings
		6.3% Asian 5.8% Hispanic/ Latina 4.9% African American/Black 2.7% Other			Mean number of **dating partners** among women who experienced RC: (M = 4.02, SD = 3.03) Mean number of dating partners among women who did not experience RC: (M = 3.03, SD = 2.01) **p = .0005** Mean number of **vaginal sex partners** among women who experienced RC: (M = 4.30, SD = 3.97) Mean number of vaginal sex partners among women who did not experience RC: (M = 3.06, SD = 3.21) **p = .023** Mean number of **oral sex partners** among women who experienced RC: (M = 4.70, SD = 3.79) Mean number of oral sex partners among women who did not experience RC: (M = 3.46, SD = 3.76) **p = .03** Mean **contraceptive and sexual efficacy** among women who experienced RC: (M = 70.94, SD = 10.77) Mean contraceptive and sexual efficacy among women who did not experience RC: (M = 75.70, SD = 9.40) **p = .01**
Liu, 2016	IPV shelters and services	282 IPV survivors 57.8% Hispanic or Spanish	investigator-developed fertility control questionnaire, 24 items	Lifetime	Women who are abused because they used birth control have greater risk of **premature birth** (OR = 8.34, $p < .05$).

Study	Setting	Sample	Measurement	Time frame	Findings
		(remainder not reported)			
Mehta, 2018	Health centers	587 Women who ever had an abortion 40% non-Hispanic white 30% non-Hispanic black 18% Hispanic 5.3% Asian 6.8% other/multiracial	Reproductive Autonomy Scale		Coercion/freedom from coercion was not associated with **abortion stigma** - they were established as separate, unrelated entities
Northridge, 2017	Health clinics	149 High school girls 51% Hispanic 27% Black 22% Other	RCS 9	Lifetime	Odds of having high **comfort communicating with romantic or sexual partners** among those reporting RC compared to those not reporting RC: OR, 0.32; 95% CI, 0.1-0.7 Likelihood of past or current **chlamydia infection** among those reporting RC compared with those not reporting RC: (OR 2.7; 95% CI, 1.01-7.19).
Paterno, 2018	Health clinics	Community sample (N=130) 84% African American/ Black 16% other	RCS 9	Past 3 months and past year	**Relationship trust** scores were decreased when comparing women who reported past year RC with those who did not: 28.6 versus 22.4, t(128) = –3.01, p = .003, d = .59 [women who experienced RC had lower relationship trust score] Odds of past-year RC increased 4% with each 1-point increase in relationship trust score (adjusted odds

Study	Setting	Sample	Measurement	Time frame	Findings
					ratio [AOR] = 1.04; 95% confidence interval [CI] = [1.00, 1.08]) (This result indicates that, as trust decreased, the odds of reproductive coercion increased.) Odds of having **more than 1 partner** in past 3 months were increased when comparing women who reported past year (36.1 versus 19.6, $\chi 2(1) = 3.54$, p = .06) and past 3 months RC (35 versus 23, $\chi 2(1) = 1.37$, p = .241) with those who did not, neither significant No statistically significant relationships between RC and **relationship commitment**, perceived **partner attitude toward pregnancy**, **relationship duration**
Phillips, 2016	Community health center	Community sample (N=97) 51% Latina/ Hispanic 27% African American 7% white 7% Asian 7% multiracial or other	RCS 5	Lifetime	Risk of RC among **white** participants compared with non-white: RR = 2.82, 95% CI 1.32–6.06, P = 0.01 Risk of RC among **Latina** participants compared with non-Latina: RR = 0.36, 95% CI 0.15–0.84, P =0.02 Risk of RC among **employed** participants compared with unemployed: RR = 3.18, 95% CI 1.28–7.86, P = 0.01 RC positively associated with having had **sex in exchange for money** in the past year: RR = 2.36, 95% CI 1.12–4.96, P = 0.02

Study	Setting	Sample	Measurement	Time frame	Findings
					RC positively associated with having had **sex in exchange for place to stay** in the past year (RR = 2.7, *95% CI not reported*, P = 0.02).
Rosenbaum, 2016	Health clinics	715 African American adolescents	longitudinal		Identifies relationship factors likely to cause a woman not planning pregnancy to end up pregnant, calls these sources of relationship inequality and potential causes of RC, based on Theory of Gender & Power. Significant associations with measures of coercion were **cohabitation**, **partner is source of spending money**, **older partner**, **partner with job**, **car**, and who **earns more money** than participant. These were associated with unprotected sex and with getting pregnant as well.
Rosenfeld, 2017	United States, phone survey	2,302 Women veterans 51% non-Hispanic white 28% non-Hispanic black 13% Hispanic 8% "other"	RCS 3	Past year	**Non-Hispanic Black** women compared with white women: (prevalence 18%) aOR, 2.69; 95% CI, 1.69-4.27 **"Other" race groups** compared with white women: (prevalence 19%) aOR, 2.97; 95% CI, 1.54-5.71 White women: (prevalence 7%) Odds of RC among women who were **20-29, 30-34, and 35-39** years old compared to women who were 40-44 years old: aOR, 3.93; 95% CI, 1.80-8.57 aOR, 2.41; 95% CI, 1.14-5.09 aOR, 2.93; 95% CI, 1.38-6.24 Odds of RC among **single** and **divorced/separated/widowed** women compared with married women: aOR, 2.24; 95% CI, 1.33-3.78

Study	Setting	Sample	Measurement	Time frame	Findings
					aOR, 2.39; 95% CI, 1.49-3.83
Samankasikorn, 2018	Population-based data	20,252 Women who gave birth within past 9 months (race/ethnicity of sample not reported)	1 question, confusing wording	Past year	Black participants were more likely to experience RC (29.0% of those who experienced RC only were Black, p<0.0001) [note that data in table reflects 34.9% were White] Other characteristics associated with experiencing RC or IPV: less than a high school **education** (p < .0001) single **marital status** (p < .0001) household annual **income** less than $22,000 (p < .0001)
Thaller & Messing, 2014	Health clinics	Community samples: 1. screened by providers (N=2,108) 2. Completed survey (N=84) Provider screening: 45.2% Latina 42.0% white Survey: 76.2% white 17.9% Hispanic or Latina 2.4% American Indian	Providers: 2 questions Survey RCS 10	Lifetime and past 3-months (survey)	In provider screening women who were **non-white** were significantly more likely to report hiding birth control from partner to avoid pregnancy: $\chi 2$ (2, N = 1,911) = 13.30, p < .001 [not more likely to report RC] Non-white race significantly associated with experiencing RC in survey results: $\chi 2$ (1, N = 84) = 7.649, p < .006

Study	Setting	Sample	Measurement	Time frame	Findings
		1.2 black or African American 1.2% Native Hawaiian or other Pacific Islander 1.2% multiracial			
Wallenborn, 2018	National data	Population-based (NSFG) (N=2,231) 14.1% White 54% Black 31.9% Hispanic			Discordant pg intention that was father intended, mother unintended (considered an example of RC) increased odds of having a child who was **never breastfed** (aOR 1.98 (1.37-2.87)) or **breastfed less than six months** (aOR 1.43 (1.07-1.91))
Willie, 2017	Community organizations	Black/African American women (N=147)	RCS 9	Lifetime	**Behaviorally bisexual** women significantly more likely to experience pregnancy coercion (34% vs. 16%, p<0.01) **Behaviorally bisexual** women more likely but not significantly (39% vs. 25%, p=0.08) to experience birth control sabotage **Women willing to use PrEP** were more likely to have experienced birth control sabotage compared to women not willing or indecisive (33% vs. 15%, p = 0.05)
Wright, 2018	Rural university	468 Female and male students Minority 17% Nonminority 86.4%	RAS		Participants were significantly more likely to report freedom from coercion if: **male** t(220) = 2.042, p < .05 had less **travel time to a health care provider** t(220) = −2.289, p < .05 had **progressive gender beliefs** t(220) =2.935, p < .01

Study	Setting	Sample	Measurement	Time frame	Findings
					reported low **religious activity** t(220) = 2.544, p < .01

Table 2A-5 Safety and harm reduction strategies and interventions

Study	Setting	Sample	Safety strategies	Interventions
Allsworth, 2013	St Louis, MO	Population- based (CHOICE data) (N=7,170) 49% Black 43% White 8% other or multiracial	Women who experienced abuse were more likely to discontinue non-LARC methods, NOT more likely to discontinue LARC methods	
Decker, 2017	Family planning clinics	Community sample (N=146) 50.8% Black 37.9% White 11.4% other		Implementation study of: Addressing Reproductive Coercion in Health Settings (ARCHES) (provider-delivered intervention consisting of (1) universal education and assessment regarding IPV/RC, (2) harm reduction counseling, and (3) supported referrals to victim services (offered to all clients regardless of disclosure). Intervention was better implemented at higher-volume urban site than suburban site (72% vs. 56%, respectively, p = 0.048)
McCloskey, 2017	Health clinics	Community sample (N=309)	Odds of having tubal ligation among women with a past violent partner,	

Study	Setting	Sample	Safety strategies	Interventions
		42% Black 58% White or other	compared to without a past violent partner: OR=2.42, 95%CI=1.15–5.07, p=0.019)	
McGirr, 2017	IPV Agencies	731 IPV direct service providers 7.4% Black/African American 1.8% Asian 8.8% Hispanic or Latino 0.2% Middle Eastern 2.7% Native American/First Nation 0.6% Native Hawaiian/Pacific Islander 71.8% White 1.3% Other 5.4% Multiracial identified		Providers reported barriers to addressing RC with clients: “I feel I need more training” (59%) “I feel I need more support from my supervisor” (22%) “survivors don’t want to talk about reproductive coercion” (21%)
Miller, 2016	Family planning clinics	Community sample (N=3,687) 13.4% Black/ African American 1.6% Hispanic/ Latina 80.1% White		ARCHES Intervention (see above) Intervention increased self-efficacy to implement harm reduction behaviors, knowledge of, use of, and likelihood of sharing information about IPV resources. Effects on experiencing RC and IPV were not significant, for those who reported recent RC

Study	Setting	Sample	Safety strategies	Interventions
		4.1% Multiracial or other		or IPV, nor were effects on use of IPV resources or disclosing to a health care provider. Higher baseline RC score associated with greater reduction in RC for intervention group.
Paterno, 2017	Health clinics	Community sample (N=130) 84% African American/ Black 16% other	Experiencing birth control sabotage significantly increased the odds of using a highly effective method of birth control (OR 0.01 (<0.01-3.70) p=0.12) [*significance set at p<0.15*]	
Tancredi, 2015	Family planning clinics	Community sample (N=3,687) 80.1% White 13.4% Black/ African American 1.6% Hispanic/ Latina 3.0% Multi-racial 1.6% Other		Protocol for ARCHES intervention study (see above)
Thaller & Messing, 2014	Health clinics	Community samples: 1. screened by providers (N=2,108) 2. Completed survey (N=84) Provider screening: 45.2% Latina 42.0% white	Providers in study who screened for hiding birth control from partner to avoid pregnancy detected prevalence: 1.9%	

Study	Setting	Sample	Safety strategies	Interventions
		Survey: 76.2% white 17.9% Hispanic or Latina 2.4% American Indian 1.2 black or African American 1.2% Native Hawaiian or other Pacific Islander 1.2% multiracial		
Zachor, 2018	Family planning clinics	Community sample (N=103, 600 historical controls) *(historical controls, arm 1, arm 2)* 1.3, 1.9, 0 Asian 10.3, 15.1, 8.0 Black/ African-American 82.8, 71.7, 88.0 White 1.2, 3.8, 2.0 Hispanic or Latina 3.7, 7.6, 2.0 Multiracial/ other		Study of RC/IPV training program for providers using different training methods. Standard knowledge-based training was more effective in improving provider communication about RC and IPV.

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Chapter 3 : MANUSCRIPT TWO

"The path makes us strong": Experiences of reproductive coercion among Latina women and strategies for minimizing harm

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Abstract

Introduction

Latina women disproportionately report experiencing reproductive coercion (RC), a set of behaviors that interfere with autonomous reproductive decision-making. Given RC's associations with intimate partner violence (IPV) and unintended pregnancy, it is critical to identify and address RC to assist women to achieve safety, autonomy, and reproductive life plans. The purpose of this study was to describe RC and the use of RC safety strategies among Latina women receiving services at an urban clinic.

Methods

Qualitative descriptive methodology was used. Semi-structured interviews were conducted with a purposive sample of 13 Latina women recruited from a Federally Qualified Health Center in the Washington, DC area.

Results

Themes included RC Behaviors (with sub-themes Pregnancy Pressure, Birth Control Sabotage, and Controlling Pregnancy Outcome), Co-occurrence of RC and IPV, and RC Harm Reduction Strategies. New RC behaviors emerged, and immigration status was used as a method of coercive control. Cultural norms emerged as sources of vulnerability and resilience. Coercive partners were also violent. Harm reduction strategies included less detectable contraception; some sought community services but others resorted to deception and stalling as the only tools available to them.

Discussion

The importance of translation services and clearly stating immigration risks from seeking help was apparent. Less detectable methods of contraception remain useful harm reduction strategies. Midwives should inquire about method fit and be mindful of honoring the request when patients ask to change methods. Cultural norms of strength and resilience emerged as vital sources of power and endurance. Women's health providers and researchers must consider how to support

this and help women to access it. This diverse sample and the powerful voices of the women who participated make a significant contribution to the understanding of RC experienced by Latina women in the United States.

Introduction

While an estimated 45 percent of pregnancies in the United States are unintended, there is significant racial and ethnic disparity in this health concern.[1] Latina women have a 71% higher odds of unintended pregnancy compared to White women,[2] and have the second highest rate of unintended births.[1] Many factors underlie this disparity[2–12] but reproductive coercion (RC), behavior that interferes with women's autonomous reproductive decision-making and which is strongly correlated with unintended pregnancy[13–15] and differentially affects women of different races and ethnicities,[13–16] may be another cause of this disparity, and is important to explore.

Partners may exert coercive reproductive control over women by sabotaging contraceptive methods, verbally pressuring them to get pregnant or to end a pregnancy, threatening violence if the woman does not get pregnant or end a pregnancy, or blocking access to contraceptive, abortion, or prenatal services. These behaviors may be interpreted by women as threatening, coercive actions, or as indications of commitment and affection, and these interpretations may change over time as relationship dynamics change. Aspects of RC overlap with intimate partner violence (IPV); power and coercive control are often motivating factors for both, and RC is one type of coercive behavior used by some abusers.

Existing literature points to population differences in the experience of RC. Some racial, ethnic and socioeconomic groups have a higher prevalence of RC[13,15–17] and qualitative research suggests etiologies and interpretation of RC behaviors may vary among populations as well. [18–21] Prevalence of RC in samples of Latina women is 14[16]–17[13,15] percent. In studies of Latino men, unique factors are identified as associated with IPV perpetration, including acculturation and acculturation stress, and patriarchal gender role attitudes.[22] These factors may also impact RC

among Latina women, but have not been studied. Two studies noted that Latina women with immigration concerns may be less likely to seek help or report IPV to police.[23,24]

Current recommendations for healthcare providers who work with women who experience RC are limited to trauma-informed care[25,26] and harm reduction strategies, including social services referral and less detectable methods of contraception and abortion.[27] Existing research provides some evidence for what women who experience RC are doing to minimize harm. This includes the use of surgical sterilization,[28,29] hiding or surreptitiously using contraception,[30–33] use of less detectable methods of contraception such as IUDs and injectables,[15,18] resisting a partner's pressure to terminate or not to terminate a pregnancy,[19] checking condom placement during sex[34] and deception and stalling.[32]

Latinas are a diverse ethnic group originating from many countries and influenced by different cultural norms. Cultural norms are generally accepted values stemming from culture that may be ascribed to a particular population. They are by no means universal to a population, but exploration of them may help to illuminate health behaviors and outcomes. The gender role norms of *Machismo* (strongly masculine, emphasizing bravery and virility) and *Marianismo* (strongly feminine, emphasizing submission and modesty) are suggested as strong cultural influences that may impact IPV vulnerability.[22] These same norms are identified as potential sources of strength and resilience for Latino communities, as *Machismo* also connotes courage, respect, and protection of family, and *Marianismo* also connotes maternal strength, central to the family.[35] The cultural norm of *Familismo* (importance of family)[36,37] may also influence IPV and RC vulnerability or resistance, and is explored in this study.

To assist women to achieve safety, autonomy and reproductive life plans, it is critical that practitioners identify and address RC. The purpose of this study was to describe RC experiences and RC safety and harm reduction strategies among Latina women receiving services at an urban clinic. We aimed to position this analysis within the Latina cultural context to ensure that current definitions of RC are inclusive of the cultural and social contexts described by Latina women.

Methods

This research is part of a larger mixed-methods study about RC and pregnancy intention among Latina women. The component described in this paper is a qualitative descriptive analysis of in-depth face-to-face or phone interviews.

Recruitment. A purposive sample of participants were recruited from a federally qualified health center (FQHC) with five clinic locations in the Washington, DC metropolitan area using several methods. Because of the known association between RC and IPV, women were referred by social services providers if they reported IPV during routine screening and expressed interest in the study. Women were also asked by clinic providers and staff if they were interested in talking to a researcher about a study when they sought health services. Flyers advertising the study were posted in several community locations. Eligible women were between the ages of 18 and 45, self-identified as Latina, Hispanic or Spanish, and answered "yes" to any of the lifetime RC screening questions.[13] Researchers screened women for study eligibility by phone or in-person. Recruitment continued until thematic saturation was reached.[38]

Data Collection

The primary researcher conducted interviews when participants preferred English, and bilingual research assistants conducted interviews when Spanish was the preferred language. Interviews were conducted between May 2017 and May 2018 at the health clinics, participants' homes, community locations, and by telephone, based on participant preference, and lasted approximately one hour. Interviews were audio recorded with participant consent, and recordings were transcribed by either the primary researcher (when done in English) or by a professional Spanish translator, who also translated the transcripts into English. Interviews were semi-structured and followed a suggested guide that covered cultural gender norms that may have affected childbearing decisions (e.g., What is the woman's role in the family? What is the man's role in the family?), pregnancy intention (e.g., What does it mean to be "ready" to have a baby?), and experiences with RC (e.g., Can you tell me about a time when someone you were dating or

going out with or married to told you not to use birth control?) and IPV (e.g., Has the partner we have been discussing ever been violent with you?).

Data Analysis

Transcripts were entered into Dedoose®, a web-based qualitative analysis program.[39] Using qualitative descriptive methodology,[40–42] the first author read each transcript multiple times to verify accuracy and gain an understanding of the overall responses to the interview, ensuring confirmability. A codebook of *a priori* codes was developed within the constructs of RC behaviors and harm reduction strategies that were aligned with the literature and was expanded during the analysis with emerging codes. Analytic memos to record thoughts and ideas as they developed were kept to ensure reflexivity in the research process. After preliminary readings, detailed reading of each transcript and line-by-line coding was completed by two authors, who independently coded all transcripts, applying the codebook. We compared our coding to resolve any discrepancies and discussed emerging themes throughout the coding process. Through pattern coding, codes were examined and grouped into categories, themes and theoretical constructs.[40,41,43] A third author with expertise in qualitative analysis was available to resolve any persisting discrepancies and to assist in the development of themes. Negative or disconfirming cases that did not fit with the emerging themes were analyzed in depth to consider alternative explanations and to broaden understanding of the theme. Careful analytic documentation was maintained during analysis regarding procedural steps, decision rules, and conclusions drawn, to create an audit trail.[44] Saturation of themes was reached after 13 interviews; no new codes or themes emerged and themes were fully developed at this point.

Ethical Review and Informed Consent

The study was approved by the Johns Hopkins Medicine Institutional Review Board (IRB00129418). Participants provided demographic information and provided oral informed consent prior to the interview and were provided with a $20 gift card to thank them for their time

at the completion of the interview. Participants were assigned pseudonyms to protect their anonymity.

Results

The sample consisted of 13 Latina women (see Table 3-1), ranging in age from 20 to 40 (mean = 30.7 years), who were either born in the United States (n=2) or immigrated from Central America (El Salvador (n=6), Mexico (n=2), Guatemala (n=2), or Honduras (n=1)). Of those who immigrated, their time living in the United States ranged from 11 months to 28 years (mean 12.3 years, median 12 years). Four interviews were conducted in English (corresponding to the four who had lived in the US the longest) and nine in Spanish.

Coded data were organized into themes: Reproductive Coercion Behaviors (with sub-themes of Pregnancy Pressure and Manipulation, Birth Control Sabotage, and Controlling Pregnancy Outcome), Co-occurrence of Reproductive Coercion and IPV, and Reproductive Coercion Safety/Harm Reduction Strategies. These were all analyzed with attention to the connections women made to cultural norms and the immigrant experience.

Types of Reproductive Coercion Behaviors

RC behaviors identified by this sample were grouped into categories consistent with established definitions of reproductive coercion.

Pregnancy Pressure and Manipulation

Women in this study described a variety of means by which partners pressured them to get pregnant. These included lying about being infertile, threatening to leave if they did not get pregnant, and threatening to have a baby with another woman if they did not get pregnant. Three women described sacrificing their education and career plans due to their partners' insistence on having a baby (Table 3-2, Quote 1). Carmen, age 29, described her partner lying to her about being infertile to trick her into a pregnancy (Table 3-2, Quote 2). Four women described threats by their partner that he would have a baby with another woman or would leave the relationship if they did not agree to get pregnant, for example, Araceli, age 32, stated, "He told me that… if I

didn't want to have children with him, someone else could do it." Three women reported experiencing pregnancy pressure which they either did not perceive as coercive or perceived as a positive statement about the status of their relationship (Table 3-2, Quote 3).

Pregnancy pressure and manipulation emerged frequently in the interviews and was culturally situated in many respects. Numerous women mentioned aspects of pregnancy pressure and manipulation that were attributed to cultural norms or to immigration/immigrant experience. Immigration/citizenship status in the United States was used as a tactic to pressure Susanna, age 30, to get pregnant (Table 3-2, Quote 4). The cultural norm of *machismo* was explicitly cited by three women in this study as a direct cause of their partner's pregnancy coercive behaviors. Carmen described how she interpreted her partner's behavior as motivated by *machismo* (Table 3-2, Quote 5).

Familismo, the importance of family and children in Latino culture, may be an influence on pregnancy pressure experienced by women in this study. In five cases, these sentiments emerged as possible motivators for pregnancy pressure, when women suggested their partners pressured them to get pregnant so that they could be happy or because being a father was so important to them. Susanna described the importance of having a family to her partner (Table 3-2, Quote 6).

The cultural norm of *marianismo which* emphasizes and celebrates femininity and virginity emerged as a potential motivation for pregnancy pressure. Anna, age 29, identified the source of her partner's desire for her to have a baby as motivated by his knowledge that other men would not show interest in her once she had had a baby (Table 3-2, Quote 7). This woman's partner recognized the importance of virginity and exploited it in an attempt to control her.

Birth Control Sabotage. Existing literature describes a spectrum of birth control sabotage behaviors as part of RC, ranging from physical tampering with a method to preventing access to the method, either physically or financially. The women's narratives described numerous instances of birth control sabotage consistent with this, with some nuances that are specific to this

sample. Threatening to tamper with implant contraception, was reported by Anna (Table 3-2, Quote 8). Five women reported instances of hiding or preventing access to birth control, including hiding or throwing away oral contraceptive pills, refusing to pay for birth control, pressuring women not to attend their appointments to receive injectable methods, and in one case, Carmen describes being physically restraining from attending her appointments (Table 3-2, Quote 9). Jessica, age 26, describes how her partner would create diversions to prevent her from attending her pill refill appointments (Table 3-2, Quote 10). One woman reported her partner not withdrawing when withdrawal had been the agreed-upon contraceptive method, and three women described refusal to use condoms.

Birth control sabotage was attributed to cultural norms or affected by immigration issues by fewer women than the theme of pregnancy pressure was. Birth control sabotage was explicitly attributed to *machismo* norms by Anna (Table 3-2, Quote 11). And Jessica attributed her partner's diversions to prevent her from accessing birth control to the sentiments of *familismo,* his importance of family (Table 3-2, Quote 12).

Birth control sabotage took the form of physical restraint from or creation of obstacles to accessing birth control in most cases. This form of RC also was attributed to some cultural norms, though to a lesser extent than pregnancy pressure.

Controlling Pregnancy Outcome

RC behaviors may include controlling the outcome of a pregnancy, whether by pressure to have or not have an abortion. In this study, three women experienced pressure to have an abortion, one woman experienced pressure not to have an abortion, and one woman experienced pressure not to place a baby for adoption. Two women reported experiencing violence from their partners that was intended to cause a miscarriage. In Anna's case, her partner was successful in his attempts (Table 3-2, Quote 13).

No women attributed the behaviors associated with controlling the outcome of a pregnancy to any cultural norm or aspect of the immigrant experience. Controlling pregnancy outcomes emerged less often in the interviews than other forms of RC.

Co-occurrence of RC and IPV

Most participants described episodes of physical or sexual violence or controlling behavior and emotional abuse with their partners. Maria, age 31, described continuing abuse despite giving in to her partner's demands that she get pregnant (Table 3-3, Quote 1). Anna described a harrowing and violent episode of sexual assault from her estranged husband, which resulted in a pregnancy, during a visit to bring her children some items they had left at her home (Table 3-3, Quote 2).

Violent behavior was explicitly attributed to the cultural norm of *machismo* by two women. Carmen describes how women who immigrate from Latin American countries may accept *machismo*-related behavior in the United States as the norm, thus increasing their vulnerability to violence (Table 3-3, Quote 3). Alicia, age 36, had experienced multiple miscarriages of pregnancies she desperately wanted, but her husband did not, but she nonetheless described how an abortion would allow her to escape his abuse (Table 3-3, Quote 4). Two women attributed their motivation to stay with an abusive and coercive partner as related to their primary goal of protecting and providing for their children, illustrating the cultural norm of *familismo* (Table 3-3, Quote 5).

In three cases, immigration status and the risk of deportation compounded the effect of IPV when it was used as a threat or means of controlling the woman by partners or even family members. Anna's husband was incarcerated due to IPV, and she received deportation threats from her sister-in-law if she did not drop the charges. Carmen described "constant fights, it was fighting day and night, screaming, threats, blackmail as well to a certain point, that he was going to take away my visa." And Isabella's partner, who had legal status, threatened her with deportation when she attempted separation.

Interviews revealed many instances of the co-occurrence of IPV and RC. The potential for immigrant status and culturally-situated masculinity to compound IPV and RC emerged in several cases.

RC Safety and Harm Reduction Strategies

To protect themselves from threats to their reproductive autonomy, women used a variety of strategies to stay safe or reduce the harm of coercive behaviors, and these were grouped into several general categories.

Less detectable contraception

Five women reported that they used a less detectable method of contraception in order to conceal its use. After experiencing side effects with an IUD, and then getting coerced into pregnancy by her husband, who later used violence to cause a miscarriage, Anna described switching to an implant method, and her attempts to conceal that from her partner (Table 3-4, Quote 1). When her husband previously refused to use a condom, Anna surreptitiously sought emergency contraception to avoid pregnancy (Table 3-4, Quote 2). Some women used injectable methods of contraception to avoid detection and described methods of keeping their partners from knowing about the appointments (Table 3-4, Quote 3).

Deception and stalling

With limited resources in many cases, women utilized the tools that were available to them to resist RC behaviors, and in three cases this included deception and stalling. Susanna used her knowledge of reproductive physiology to lie to her husband about not being able to have sex (Table 3-4, Quote 4). And Carmen pretended that her 3-month injectable method was supposed to be used every month, so that her partner would think she was not complying with appropriate use (Table 3-4, Quote 5). When her partner sabotaged her birth control method, Anna allowed him to think he had been successful, then surreptitiously took emergency contraception (Plan B) (Table 3-4, Quote 6).

Help seeking

Four women sought help from family members or from community services to resist or stay safe in the face of coercive or violent behaviors. One woman sought help from a school psychologist who had been working with her son, as well as a social worker at her health clinic, and Yeliny appreciated universal provision of social services to all patients at her health clinic, without having to ask for it (Table 3-4, Quote 7). One woman had family members drive her to her contraceptive clinic appointments when her partner tried to prevent her from going. One stayed with a family member to avoid a partner's forced sex after experiencing a miscarriage due to his violence. One woman had a cousin in her home country send her emergency contraception when she could not afford American prices. Unfortunately, language was a barrier for Isabella, age 35, who tried to seek help from an agency her clinic referred her to (Table 3-4, Quote 8).

Abortion

Two women in the study considered abortion as they planned to separate from their coercive partners, fearing that having a child would increase ties to the partner and prevent them from seeking safety (Table 3-4, Quote 9).

The cultural norm *marianismo* celebrates the strength and toughness of women, and though not cited by name, these characteristics were cited by five participants in this study as something that helped them to endure their coercive, often violent relationships and sometimes to find a way to leave those relationships. Maria described the bravery required to protect her daughter from her violent partner (Table 3-4, Quote 10). And Anna described the strength and bravery that she needed in order to care for her children (Table 3-4, Quote 11).
Isabella had a similar view of the strength that comes from hardship, in lessons she learned from her own mother (Table 3-4, Quote 12).

The use of harm reduction and safety strategies can be negatively affected by immigration status and the threat of deportation, as four women reported their status made them afraid or unable to seek help. For example, Isabella described her fear that disclosing abuse would

leave to legal action against her (Table 3-4, Quote 13). Being an immigrant also influenced women's vulnerability by virtue of being geographically far from sources of support.

Women used a variety of methods to minimize the harm caused by RC and IPV, and immigrant status increased vulnerability in some cases, by making women afraid to seek help.

Discussion

The purpose of this qualitative analysis was to examine RC and the use of safety and harm reduction strategies in the context of Latina culture and the immigrant experience. Descriptions of RC behaviors emerged that were similar to existing literature describing this phenomenon among other racial and ethnic groups, but some new behaviors emerged, including threats to break an implant contraceptive device, physically locking women up to prevent attendance at contraceptive appointments, and pressuring a woman not to place a baby for adoption. These behaviors are not necessarily specific to Latino populations or motivated by cultural norms that are unique to Latino culture, but these new behaviors add to a broader and more inclusive description of RC. Immigration status was used against some women as a method of coercive control. Cultural norms of *machismo*, *familismo*, and *marianismo* emerged as potential sources of increased vulnerability for Latina women. Pressure to have an abortion was perpetrated by partners, as well as pressure not to have an abortion, and abortion was cited by some women as a strategy for separating from a coercive partner.

Quantitative literature describes a strong statistical association between RC and IPV, and this was supported conceptually by our qualitative findings. Many coercive partners were also violent, supporting the suggestion that RC is one tactic used by violent men to exert power and control over women. *Machismo* and immigration status compounded the effect of IPV and RC on the lives of these women, and the importance of family was cited as a motivation for staying with abusive and coercive partners. While some authors have suggested that *machismo* can serve as a source of resilience for Latino communities, in its connotation of courage, respect, and protection of family,[35] *machismo* was only cited as a source of violent and coercive behavior by partners of

women in this study.. It is likely that these positive aspects of *machismo* would only emerge if women in healthy or non-coercive relationships were included in the sample. Likewise, *familismo* may emerge as a source of strength in healthy family relationships if those were studied.

Some women used strategies to resist RC that are also recommended by professional guidelines,[27,45] including less detectable methods of contraception, but it is important to note the caveats these women provide, that IUDs and implants can sometimes be detected, and a determined partner can prevent a woman from leaving the house to receive other methods such as injectables. Some women sought assistance from community services, as is also recommended by experts, but others had to resort to deception and stalling as the only tools available to them. The strength and bravery associated with *marianismo* emerged as powerful sources of resilience and endurance that many women called upon to survive their difficult or dangerous situations, inspiring them to leave or to employ the use of a safety strategy.

The current definition of RC is clearly applicable to Latina women, and findings emerged that will inform practice as well as research. Many of the descriptions of RC provided by the women in this study are overt and explicit in their depictions of coercive and violent behavior, and some women were very clear that their experiences were of being coerced into something that was against their wishes. But some women reported behaviors that had less obvious motivations behind them, or that the women themselves did not perceive as coercive. Specifically, this occurred when partners told them they wanted them to get pregnant and this was perceived as an expression of affection and planning for a future together. Whether the request to get pregnant was made as an effort to control the woman or simply expressed affection was not clear to the women and is not apparent to researchers. More significantly, it is not clear that this type of request has any harmful outcomes associated with it. The point at which behaviors cross a line into coercion and become harmful remains complex and difficult to identify.

Implications for research and clinical intervention

Our findings have implications for both research and clinical practice. We demonstrated that it remains difficult for women to draw a clear line where behaviors consistent with the definition of RC become coercive or harmful. This supports suggestions of some researchers that measures of RC should separate questions about behaviors from questions about intent.[46,47] While a woman may be able to accurately report a partner telling her not to use birth control or discarding her oral contraceptives, she may be unaware of whether his intent was to impregnate or some other reason, and this intent may be irrelevant in terms of harmful outcomes to the woman. Future research should examine outcomes associated with RC behaviors regardless of intent, to better inform counseling of RC survivors as well as future RC measures.

Health care settings and medical providers are important sources of assistance and refuge for women experiencing RC and IPV and this study suggests that there are concrete steps that clinics and medical providers can take to aid these women. The importance of translation services in all places non-English speaking women may seek help is clear. What also emerged is the importance of clearly stating what the legal risk of seeking help is and is not, as some women reported that they feared seeking help due to their undocumented status. Trauma-informed social support services that are integrated into health services and provided to all clients are a benefit for women who may not be comfortable asking for help, or who may not be sure if their partner's behaviors are coercive. As part of trauma-informed care, all women should receive information about IPV and RC and be assessed for both. It is clear from these findings that a report of or suspicion for IPV or RC should trigger screening for the other. Despite their flaws, less detectable methods of contraception remain useful strategies of harm reduction for some women experiencing RC, and this study highlights the importance of ensuring access to the full range of contraceptive options for all women, including women without insurance or legal status. Providers should be mindful of the importance of honoring the request when women ask to change methods, particularly when removing a method early is perceived as inconvenient or not cost effective. While some women may want to remove an implant early due to unrealistic

expectations about benign side effects, for example, others may have a partner who is threatening to break it.

Deception, lying and stalling may appear to be less-than-ideal safety strategies that a provider may be reluctant to suggest to women, but our findings suggest that these may be the only tools available to women with limited resources, power, and ability to seek help. As relationships are dynamic and situations change, women may need to use multiple harm reduction strategies, and some may not be ideal but are effective in the short-term as they make decisions for long-term safety. Women, including abused women without the language or the legal status to seek help, have tremendous resources and strength to mobilize when their options are limited. Healthcare providers who work with women, especially Latina and immigrant women, can honor this strength and resilience by listening and providing support and resources based on women's needs and priorities. Cultural norms of women's strength and resilience (*marianismo*) emerged as a vital source of power and endurance for Latina women in this study. Providers, researchers and policy makers must consider how to support this and capitalize on it, and possibly help women to access it.

Conclusion

Findings should be considered within several limitations. First, the purposive sampling strategy included Latina women living in an urban environment who reported experiencing RC. Thus, their experiences may differ from Latinas living in rural settings or with higher socioeconomic status. The sampling strategy of recruiting participants from a population of women who were already seeking social or health services may be biased toward the experience of women in this situation – the experience of women still enduring IPV or RC, without the ability or the resources to seek help, may not be reflected here. It may also be biased toward women experiencing severe enough coercion and abuse that they have ultimately had to seek help. The researchers were non-Latina, which may have influenced aspects of data collection or interpretation of findings. The sample was small but yielded rich data for analysis, and while only

women of Central American descent were interviewed, this reflects the experience of the majority of immigrant women in the study locale. Finally, participants were referred to the study by clinic staff, which was subject to their workload, attitudes, and commitment to the study goals. Despite these limitations, this diverse sample and the powerful voices of the women who participated make a significant contribution to the understanding of RC as experienced by Latina women in the United States.

This study is unique in its focus on a population of women who have not previously been studied in RC research. Future research should continue to explore the perception of coercion among women experiencing RC behaviors, to further define this complex phenomenon. Research is needed on Latino cultural norms as sources of strength and positive outcomes. More research is needed to establish risk factors for RC as well as strategies for safety and harm reduction. Longitudinal research is especially needed to establish if harmful outcomes are associated with RC behaviors regardless of perception of intent, and to establish the relative benefits of the safety strategies recommended by providers and utilized by women.

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Tables

Table 3-1 Participant Characteristics

	Pseudonym	Age	Country of birth	Time in the US	Children	Education	Employment status
1	Yeliny	20	United States	Life	0	High School	Part-time
2	Jocelyn	30	El Salvador	28 years	3	Some college	Unemployed
3	Alicia	36	Mexico	21 years	0	9th Grade	Part-time
4	Sofia	40	El Salvador	4 years	2	High School	Unemployed
5	Jessica	26	United States	Life	0	Associates Degree	Unemployed
6	Isabella	35	Mexico	18 years	3	11th grade	Full-time
7	Ximena	24	Guatemala	3 years	2		Unemployed
8	Glenda	37	Guatemala	19 years	3	Primary	Part-time
9	Maria	31	El Salvador	1 year	1	10th grade	Unemployed
10	Carmen	29	El Salvador	13 years	3	GED	Unemployed
11	Susanna	30	El Salvador	14 years	3	3rd grade	Full-time
12	Anna	29	Honduras	11 months	2	10th grade	Part-time
13	Araceli	32	El Salvador	13 years	2	9th Grade	Part-time

Table 3-2 Types of RC Behaviors - Participant Quotes

Quote Number	Participant	Quote
1	Carmen, age 29	I didn't want a baby… what I wanted… was to finish this, my high school. I was in ninth grade… He told me that yes, he was going to let me finish school and all that, while we were just going out, right? When we got married, well, things were different. Then he didn't want me to go to school, didn't want me to use family planning, wanted me completely to be a housewife.
2	Carmen, age 29	He told me… that he couldn't have children. And when I got pregnant I was scared because he had told me that if I got pregnant that it wasn't his… But when I told him that I was pregnant he got really happy and jumped around and we were excited and that's when he told me that it was a lie that he couldn't, no, that he *wanted* me to get pregnant.

3	Yeliny, age 20	I was in a relationship and he did say he wanted a baby with me, but it wasn't like in a forcing way. It was like, because he was happy to be with me…. it was just like, him saying that meant that he wanted something with me in the future, and I was okay with that
4	Susanna, age 30	And well, he says to me, since I didn't, didn't have any, any legal status, like [his other girlfriend], I was going to have his second [child].
5	Carmen, age 29	He lied so that I would get pregnant… Planning for children is something to plan between both of you, and not just one person… So for me, that's *machismo*. Not letting a woman decide whether she wants more children or not.
6	Susanna, age 30	The man was, at that time, almost forty. He was like thirty-eight, and he said to me that his partner before couldn't have children, and that they had tried. So, what he wanted most was to know a child. He was even going through the process of adopting a child from other countries. Because he wanted… to be a father.
7	Anna, age 29	I said to him all the time, "you force me all the time, you want to have relations all the time, you want a child", I say to him, "that's being *machista*". And he would say that… when a woman has a lot of children, no other man is going to approach her so easily…. He said it himself. That a woman with a lot of children, no other man is going to pay attention to her.
8	Anna, age 29	He had seen the bruise I had here. And he said to me, "what's happening, what's that, what's that in your arm?" And I said "they put in an implant, it's something new, I want to try it…" He touched it or sometimes… he would grab it like this and he said to me that he was going to break it. I didn't know what it was, until they took it out… I thought it was something metal, I was really afraid.
9	Carmen, age 29	And that's when he started locking me up, since then he realized that I was protecting myself, I was family planning… He would lock me in the house, he wouldn't let me out to get the shot.
10	Jessica, age 26	Whenever he knew it was time for me to go to my gyno and get a refill on the birth controls he found a way for me to miss my appointment… He knew after 3 missed appointments they will no longer see me… and I would have to look for a new doctor… His "car broke down"…He had a "flat tire" the other time, and I needed to go rescue him… but as soon as I would get to him, oh! The problem was already fixed.
11	Anna, age 29	For me, *machismo* is my husband. It's my husband because he is the person that doesn't let you use birth control... He's the person that says you're going to dress like this, eat like this, we're going to eat this. We're going to use this. He's the person who doesn't let you go out. Or doesn't want to share you with your family.
12	Jessica, age 26	So I guess just to ensure that I wouldn't get the pills anymore he did that, but I don't think it was just in a malicious way, I just think that he really wanted to grow with me and become a family with

		me.
13	Anna, age 29	He made me abort by kicking me. After he hit me, the very next minute I started to have contractions in my spine. And then I started to bleed…blood gushed out of me. And then he took me to the doctor and they did the curettage… He got me pregnant himself, that was his baby, and he hit me himself. And I said, "You killed that baby yourself."

Table 3-3 Co-occurrence of RC and IPV – Participant Quotes

Quote Number	Participant	Quote
1	Maria, age 31	When I was already pregnant he would still hit me, abuse me. After he was the one who wanted a baby.
2	Anna, age 29	I told him, "I'm here." "Okay", he told me, "…don't worry, nothing will happen, my mother is here." And my mother-in-law was *not* there. And then he started to talk with me, all calm. He said, "Look, I want this." …He had just gotten out of prison like a week before... "Look, calm down," I say to him, "I don't have money to take a pill right now…" And then he started to rip off my clothes, I was just wearing like a top that he pulled down and long pants. And so he ripped off everything and we started to struggle and we had relations but it was without my consent. It was forced.
3	Carmen, age 29	Sometimes when they come here with the ideas they had there, they also suffer the same thing here because they're already used to this kind of relationship. No? The violence, or *machismo*… So then even when they come here and keep the same partner from their country, they suffer here too… And many women come with that, that thought that this is normal, all that, no? That it's part of being a woman, that it has to be this way.
4	Alicia, age 36	If I am pregnant from my husband right now? I think I'm gonna abort. Because I don't want him anymore in my life, getting close to me.
5	Susanna, age 30	And the mother is afraid, she says I don't want my children to suffer, there's too many, it's better if we stay here. Even if he does what he wants with me but that doesn't matter because my children are here and they're going to be safe here.

Table 3-4 RC Safety and Harm Reduction Strategies – Participant Quotes

Quote Number	Participant	Quote
1	Anna, age 29	From then on I didn't family plan with the pill anymore. I got a thing that they put here in my arm, the implant… The IUD hurt me, so the last option for me was the one in the arm, the implant. I was taking care of myself with methods that weren't… the pill so that he couldn't destroy it because I really didn't feel good about wanting more children… I made the appointment at a health center near my house where I was living, and when the appointment came… I walked to the center, and they gave it to me... It hurt me a

		lot in my arm, they told me to rest, but I couldn't hide it. I had to cook, clean. I wore clothes so that he wouldn't notice it for a few days.
2	Anna, age 29	He didn't want to put on… the condom… and he would force me every night… The next day, then, I had to run… to get [Plan B] in the morning to take it when I went to work, so that I wouldn't get pregnant.
3	Araceli, age 32	I would go to the appointments, and he never realized. I mean, I would usually tell him that I was doing other things, not that.
4	Susanna, age 30	The woman, there are certain days when she's fertile… those days when you aren't fertile, are pretty few… He wanted to have relations every day... Sometimes I would say that I had my period, sometimes I even put on a pad and I would say "look, I'm not, I can't right now." So, I had to feed him little lies like that.
5	Carmen, age 29	He didn't know that it was every three months. So… I tried in that way to hide it… "oh no, this month they didn't give it to me," so that there weren't conflicts all the time, no?
6	Anna, age 29	It was the only way, the Plan B. Because he threw away my packet [of pills] for the month. So when I saw that I didn't have [the pills]… I would tell him that I wasn't using birth control. But it was a lie. I was using birth control in some hidden way with a pill on the other side.
7	Yeliny, age 20	I wanted to talk to somebody about this. And the fact that… [seeing a social worker is] the first thing that you have to do is good because I didn't even have to seek for it, it was just there.
8	Isabella, age 35	I took the number and called but… they only spoke English, so there was no way of understanding each other, and in fact they sent me a letter where they said they don't have people who speak Spanish. So, I never tried again.
9	Anna, age 29	My fear was the father of my children… I don't want another baby with him, I don't want to be like this, still tied to him by another child.
10	Maria, age 31	I feel that I was very brave to make the decision well, in the case of leaving him, and saying it doesn't matter what happens, but my daughter is not going to be in any danger… So, I feel that, not that I think I'm such a big thing, but I'm here, a woman, I feel that I'm strong, in fighting for my daughter.
11	Anna, age 29	Not all people are very strong. The path makes us strong. But we're made stronger by our children… You say to yourself, if I die, or if he ends up killing me, if I end up being a victim of my own husband, who's going to stay with my children? He's going to be in prison and I'm going to be dead. So, for them you make yourself brave.
12	Isabella, age 35	I remember my mother's words, she always said, "Look, daughter… we are not the first or the last humans in this world," she says. "But we're strong, we go through what we go through, the pain makes us stronger."
13	Isabella, age 35	It was my fear that I'm not from this country… I said I'm scared that, after everything I've put up with… I'm saying the problems we're having and maybe they're going to put him in jail, or put me

		in jail or both, and they're going to take my children away… In the clinic they would ask if you've been abused at home or verbally… or at work. I would say "No, everything's fine." But it was because I was afraid to talk.

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Chapter 3: ADDENDUM

This addendum includes additional results for Aim 1 that were not included in Manuscript 2 due to space limitations.

Aim 1: Describe the experience of reproductive coercion, the use of safety and harm reduction strategies for reproductive coercion, ***and pregnancy intention*** *among low-income Latina women seeking IPV services at an urban clinic.*

Historically, researchers and providers working to reduce unintended pregnancy rates have focused on a binary definition of pregnancy planning, in which pregnancy is either planned for or not. Over time, however, this definition has evolved to encompass a continuum of pregnancy planning, understanding that many women and couples are more ambivalent or fatalistic about pregnancy, as well as about planning and prevention.[1] The various forms of pregnancy intention can include active intention (planning to get pregnant, planning not to get pregnant) and passive non-intention or ambivalence (not planning to get pregnant). The pathways connecting "not planning to get pregnant" and "planning not to get pregnant" to the outcome of "pregnant" (likewise, "not planning to get pregnant" and "planning pregnancy" to the outcome of "not pregnant") in terms of decision-making and external forces on this decision pathway are essential to understand in order to create meaningful and effective interventions to assist women in formulating and realizing their reproductive life plans.

Qualitative data from Phase 1 of the study were analyzed as previously described in Chapter 3, with the goal of describing pregnancy intention among Latina women to help further elucidate this complex topic and inform the study of RC among Latina women. Data were organized into *a priori* categories of **Pregnancy Intention** and **Factors that Affect Pregnancy Intention and Pathway**. Pregnancy Intention was organized into themes as described above. Factors that Affect Pregnancy Intention and Pathway was organized into secondary categories based on existing pregnancy intention literature[2] and emerging themes; these categories were

Perceived Behavioral Control, Ready to Have a Baby, Reproductive Coercion and **Cultural Norms.** Data were further organized within these categories based on emerging themes.

Pregnancy intention

The women in this study had various ways of describing the planning of their pregnancies. Some described the active intention of "**Planning to get pregnant**", for example, Glenda stated, "and then there was a time when I wanted to have a baby, and I told him I did, and he said yes, and I stopped using the injection." And Carmen described the decision-making process: "I decide about my body. The girls were born because I decided they would be born. I mean, it was more, it was my decision now. With my two daughters, and with the oldest also, that was my decision." Pregnancy despite the active intention of "**Planning not to get pregnant**" was described by Susanna: "I have three children with him, but the second girl was, as we say, an accident. Because I was family planning and, and I didn't take one pill. And I got pregnant with the girl."

Other women described the passive intention of "**Not planning to get pregnant**", sometimes described as ambivalence, for example, Anna stated "We weren't careful because we were young, and we let it happen." And Jocelyn described the passivity of not planning for pregnancy, yet not taking steps to prevent it: "we weren't going to prevent it from happening, or take precautions, and just like let it happen when it happened."

Factors that affect pregnancy intention and pathway

Women in the study reported four categories of factors that affect pregnancy intention and/or the pathway between intention and outcome (pregnant or not-pregnant). **Perceived Behavioral Control** was one category of themes mentioned by several participants as affecting their pregnancy intention or actions they took to prevent or create pregnancy, encompassing low and high levels of fatalism and self-efficacy. Within this category, one theme was "**Birth control didn't work for me**". Two women offered descriptions of health reasons they were unable to use birth control, most of which did not strike researchers as physiologically accurate, such as "When

I was there, I hadn't used family planning at all. Because there was something wrong with my ovaries. I had problems in my ovaries," (Maria). And Jocelyn reported her belief that a medication interaction caused her oral contraceptives to be fertility-promoting: "But what ended up happening was that… the Plan B and my birth control and I was on another medication kind of like it all interfered with each other and it actually had the reverse effect that we wanted it to have." Four others described mistrust or fear of contraceptive methods, such as Susanna who stated, "the implant, half the time they don't put it in right," and Isabella, whose mother responded to her interest in intrauterine contraception with concern: "My mother said to me, 'look, daughter, don't do that because it's bad. Let him take care of not having any more children, he can take care of it.' My aunt, my mother's sister, passed away from this… it's just that they put it in and it formed a scar as it went in, and when she went to the doctor it was too late… it seemed it had given her cancer, and she passed away from that. [So] I didn't do it." And three women reported intolerable side effects from contraceptive methods that made them unable to use them, such as Anna who stated, "with the IUD sometimes you get a very heavy menstrual flow, and a lot of pain in your back. I started to have a lot of pain in my back."

Another theme categorized under perceived behavioral control was **perceived infertility**, which was mentioned by four women as reasons they did not plan their pregnancies or take actions to prevent them. Ximena's partner thought he was infertile: "I would tell him that no, I have to take my pills, and he would say no, what for?... He thought that he couldn't have children, according to him, because he did it with other women and the other women didn't get pregnant." And Jessica understood from her healthcare providers that she was infertile: "I was told that I couldn't get pregnant. And they told me that if I did get pregnant, 90 percent chance I was gonna lose the baby. And I believed it because I had, the first pregnancy was a miscarriage. So, I was in a big shock. I was happy but it was in a big shock."

Five women described fatalistic attitudes related to pregnancy intention, described in other literature as "**it just happens**"[3]. This reflected a belief that pregnancy would or would not

occur regardless of actions taken on their part, in some cases due to the will of God. For example, Jocelyn stated: "it just felt like that's how it was supposed to be… Like that's how things were supposed to happen. So, if it didn't happen in the past and now we had an opportunity for it to happen and like we weren't going to I guess prevent it from happening, or take precautions, and just like let it happen when it happened." And Isabella stated, "If God wanted me to be pregnant then I have to have it. I have to have it and be able to raise it."

Four women described **high perceived behavioral control** over whether or not they would get pregnant. For example, Carmen stated, "I feel free to plan and use the methods that I want. And I just let him know, 'This is what I'm going to do,' and there's no problem." And when asked how she might go about controlling her fertility if she did not want to become pregnant, Yeliny responded, "I would use any birth control that I think would be suitable for me."

The second category of factors that affect pregnancy intention and/or the pathway between intention and outcome was **Ready to Have a Baby,** which was divided into **Internal Readiness Factors** and **External Readiness Factors**. Internal readiness factors included **having planned for the pregnancy** which was mentioned by three women, including Susanna who stated, "I think that being ready is like…well normally when things are planned well, they turn out well." **Mental and physical health** was another internal factor, as mentioned by three women including Jocelyn: "you feel like completely ready like mentally you're ready and you have the mental stability to see it all the way through and physically you're ready like you, your body is up to it and, you know, so that's what I mean by you're like everything just aligns like you're in the right space overall." One woman described being "**old enough**" as an internal readiness factor. And three women described being **ready for the role**, as an internal readiness factor, described by Carmen as "being ready to take on the role of mother, the medical appointments and all that."

External readiness factors included **financial and economic stability**, as described by four participants. For example, Susanna stated, "at least an adequate place to live with… your partner, with the baby. To have… a plan for example for saving or… because having a baby

involves so much, so much dedicating time to them and financial expenses and all that. If you want, well, the baby to be alright, not lack the necessities, the basics. And you could also, well, have a job that, that has given you those necessities." **Having a strong relationship** was mentioned by one woman as an external readiness factor; Jessica stated, "I agreed to it because… with my exes I never felt like they were the person that I was gonna have a kid with… and then he comes along and everything is just completely different. I am no longer the angry person I used to be… I've never felt more secure of someone that I know will never harm me."

The third and fourth categories of factors that affect pregnancy intention and/or the pathway between intention and outcome were **Reproductive Coercion** (RC) and **Cultural Norms.** RC is defined as male partner coercive behaviors that restrict a woman's reproductive autonomous decision-making. Cultural norms of *machismo, marianismo* and *familismo* were identified as influencing male partners' RC behaviors. *Marianismo* also influenced women's desire and ability to use safety and harm reduction strategies. Findings on RC and cultural norms are reported in Chapter 3.

Developing a Conceptual Framework

Findings from this study will contribute to the development of a conceptual framework of the relationship between pregnancy intention and outcome and the impact of RC on this pathway. This framework builds off of an existing Theory of Planned Behavior for Fertility Decision-Making:[2]

Figure 3A-1 Theory of Planned Behavior for Fertility Decision-Making

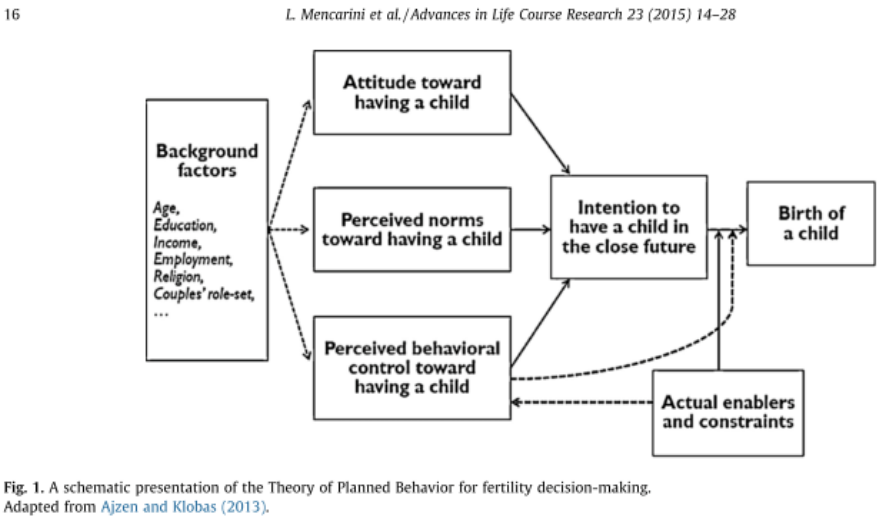


Fig. 1. A schematic presentation of the Theory of Planned Behavior for fertility decision-making. Adapted from Ajzen and Klobas (2013).

An initial draft of model components follows and will be further developed for publication. These include the three intention/outcome pathways described by women in this study.

Figure 3A-2 Model of Passive Non-Pregnant Intention to Pregnancy Outcome

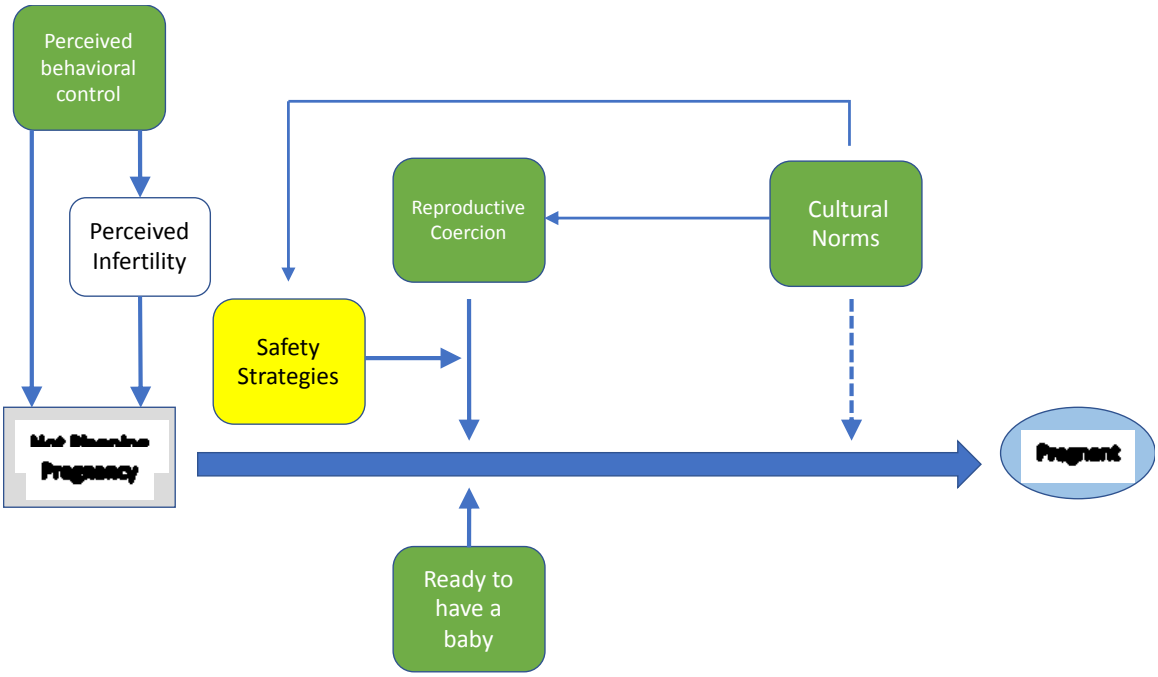


Figure 3A-3 Model of Active Non-Pregnant Intention to Pregnancy Outcome

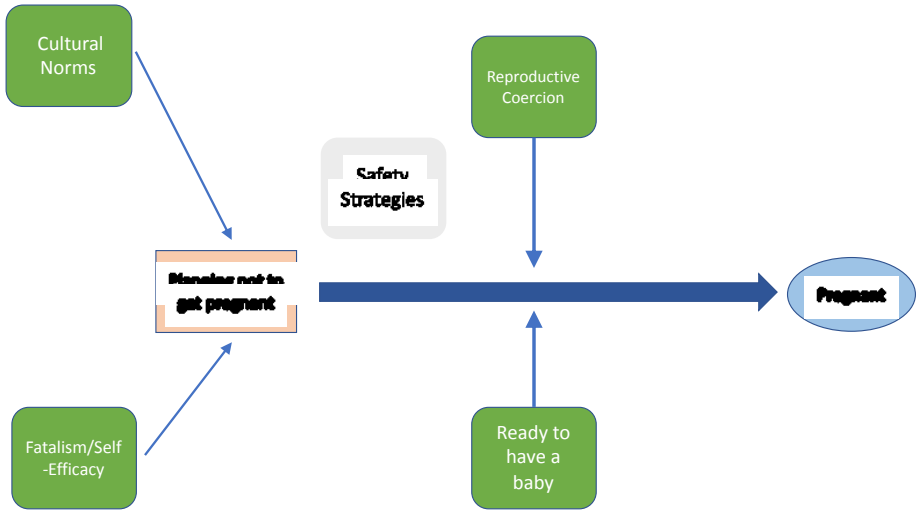
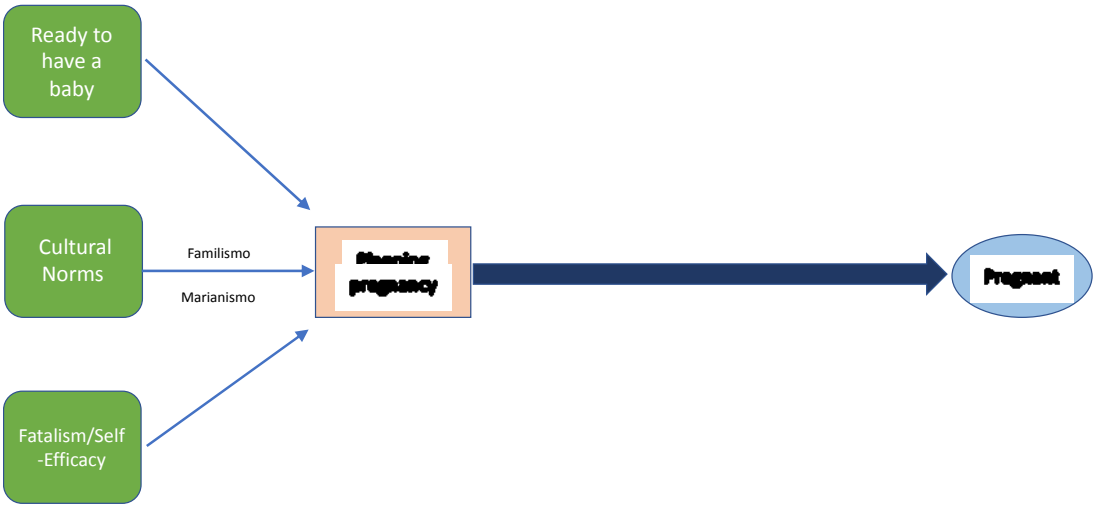


Figure 3A-4 Model of Active Pregnancy Intention to Pregnancy Outcome



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Chapter 4 : MANUSCRIPT THREE

Risk for Reproductive Coercion Among Latina Women and Strategies for Minimizing Harm

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Abstract

Reproductive coercion (RC) describes a set of male partner behaviors that restrict women's reproductive autonomy. Latina women have higher risk for RC and also unintended pregnancy, which is an established outcome of RC. This descriptive cross-sectional study examined risk factors for RC among Latina women, if there is a relationship between RC and unintended pregnancy among this population, and if this relationship is moderated by the use of safety and harm reduction strategies. A tablet survey was administered to 500 women between the ages of 15 and 45, self-identified as Latina, with a dating or sexual partner in the past year. Approximately 1 in 6 (16.4%) women experienced RC in the past year and risk factors included younger age, concurrent intimate partner violence (IPV), and having a partner who binge drinks. IPV carried the greatest risk. RC had an independent effect on unintended pregnancy, and this risk was not affected by the use of harm reduction strategies, which were used by 10.6 percent of participants. The study reinforces the risk of RC in abusive relationships and that health providers working with racially and ethnically diverse women have an important role in care and support for safety and harm reduction strategies that include informing women about less detectable methods of contraception.

Introduction

Reproductive coercion (RC) describes a set of male partner behaviors that restrict women's reproductive autonomy, including pregnancy pressure or coercion, sabotaging contraception, and controlling the outcome of a pregnancy. It is a critical area of research in women's health because of its overlap with intimate partner violence (IPV) (Clark, Allen, Goyal, Raker, & Gottlieb, 2014) and its association with health outcomes such as unintended pregnancy (Decker et al., 2017; Holliday et al., 2017; McCauley et al., 2017; E. Miller et al., 2014; Paterno, Draughon Moret, Paskausky, & Campbell, 2018), which itself has associated negative health

outcomes (Abajobir, Maravilla, Alati, & Najman, 2016; Dibaba, Fantahun, & Hindin, 2013; Jennifer A Hall, Benton, Copas, & Stephenson, 2017; Jennifer Anne Hall et al., 2018). Women resist RC and preserve their autonomous reproductive decision-making using a variety of safety and harm reduction strategies (Allsworth, Secura, Zhao, Madden, & Peipert, 2013; McCauley, Bonomi, Maas, Bogen, & O'Malley, 2018; Paterno, Hayat, Wenzel, & Campbell, 2017). Guidelines for providers who encounter women experiencing RC include recommending less detectable methods of contraception and abortion and social services referral (American College of Obstetricians & Gynecologists, 2013; Chamberlain & Levenson, 2012).

Risk factors for RC in current literature include younger age (Center for Impact Research, 2000; Rosenfeld et al., 2017), greater age discrepancy with partner (Center for Impact Research, 2000; Rosenbaum, Zenilman, Rose, Wingood, & DiClemente, 2016), not being married (Clark et al., 2014; E. Miller et al., 2014; Rosenfeld et al., 2017), less education (E. Miller et al., 2010, 2014; Upadhyay, Dworkin, Weitz, & Foster, 2014), higher religious activity (Wright, Fawson, Siegel, Jones, & Stone, 2018), non-Hispanic Black, multiracial or Latina women, or women born in the United States when compared to those born elsewhere (Clark et al., 2014; Hess & Del Rosario, 2018; Holliday et al., 2017; E. Miller et al., 2010, 2014; Rosenfeld et al., 2017; Sutherland, Fantasia, & Fontenot, 2015; Upadhyay et al., 2014), and multiple sex/dating partners (Fasula et al., 2018; Katz, Poleshuck, Beach, & Olin, 2017; Paterno et al., 2018).

In addition to unintended pregnancy, RC behaviors are associated with numerous health outcomes including PTSD and depression (Anderson, Grace, & Miller, 2017; Fasula et al., 2018), abortion (Cha, Chapman, et al., 2016), sexually transmitted infection (Fasula et al., 2018; Jones et al., 2016; Northridge, Silver, Talib, & Coupey, 2017), preterm birth (Liu et al., 2016), and decreased breastfeeding (Wallenborn, Chambers, Lowery, & Masho, 2018).

RC has been studied in diverse populations of women, but not in Latina women specifically, despite evidence that Latina women have higher risk for RC (Clark et al., 2014; E. Miller et al., 2014; Sutherland et al., 2015) as well as for unintended pregnancy (Finer & Zolna,

2016; Kim, Dagher, & Chen, 2016). Prevalence of RC in community samples of Latina women ranges from 14 (Clark et al., 2014) to 17 percent (E. Miller et al., 2010; Sutherland et al., 2015). Latina women are noted in some studies to be less likely to seek help or report IPV to police due to concerns about legal status (Pitts, 2014; Reina, Lohman, & Maldonado, 2014), and it may be that help-seeking for RC is similarly limited.

The purpose of this study was to explore risk factors for RC, association with pregnancy intention and IPV, and the use of RC safety and harm reduction strategies among Latina women attending an urban clinic.

Methods

Study Design

This research was part of a larger mixed-methods study on RC and pregnancy intention in Latina women. This component of the study was a descriptive cross-sectional design consisting of a tablet survey that was developed using findings from the first phase, qualitative interviews with Latina women seeking health services.

Sample and Sample Size

Data was collected at 3 locations of a Federally Qualified Health Center (FQHC) serving low-income, primarily immigrant residents in a mid-Atlantic metropolitan area, between January and August 2018. The study survey was field-tested with 11 Latina women, including cognitive interviewing to identify unexpected issues with wording and interpretation. Eligible women were between the ages of 15 and 45, self-identified as Latina, Hispanic or Spanish, and had a dating or sexual partner in the past year. Research assistants who were fluent in Spanish and English distributed flyers in clinic waiting rooms and interested women were screened for eligibility and completed the survey in Spanish or English on a tablet computer with audio-assistance capability. The survey was also available to complete from home using a web link, for anyone interested in that mode (6 women (1.2%) chose this option). Eligibility screening was completed 771 times,

123 women were ineligible (16.0%; no dating/sexual partner in past year, under age of 15 years or over age of 45 years, did not identify as Latina/Hispanic/Spanish) and 148 women (19.2%) started the survey but did not complete it either due to inadequate time or loss of interest, with a final sample of 500 women (Figure 4-1). Based on power analysis, a sample size of 500 was necessary to detect differences in key outcomes.

Measures

Measures included demographics such as age, education, race, nativity, employment, parity, relationship status, years in the United States and demographics and characteristics of the partner such as age and length of relationship. Other measures included previously validated measures with adaptation based on qualitative findings in the first phase of the study. The measures were translated and back-translated and tested with cognitive interviewing.

Reproductive coercion: RC was measured with 13 yes/no questions (Figure 4-2) derived from adaptations of the Reproductive Coercion Scale questions which were validated in observational and intervention RC research (Clark et al., 2014; Dick et al., 2014; Kazmerski et al., 2015; McCauley et al., 2014, 2015, E. Miller et al., 2010, 2011, 2014; Sutherland et al., 2015). Additional questions on abortion coercion were added, and questions were adapted to isolate pregnancy-promoting intent from coercive behaviors, based on recent literature (Katz et al., 2017; Katz & Sutherland, 2017). Five questions assessed pregnancy coercion, four questions assessed birth control sabotage, and four questions assessed controlling the outcome of a pregnancy (Figure 4-1). Positive responses to questions 2 or 6-9 were followed with the question, "Is this person trying to get you pregnant?" RC was defined as a positive response to any item, including 2 and 6-9, regardless of response to the question about partner's intent.

Unintended pregnancy: The London Measure of Unplanned Pregnancy (LMUP) (Aiken, Westhoff, Trussell, & Castaño, 2016) is similar to timing-based measures (e.g., the NSFG) but splits unplanned into unplanned and ambivalent. It assesses planning, wantedness and timing as advised by Santelli (Santelli, Lindberg, Orr, Finer, & Speizer, 2009). Cronbach's alpha scores on

these measures are 0.78 (US English) and 0.84 (Spanish translation) (Morof et al., 2012). To the existing 7 questions we added an answer option that looks at whether the woman did not plan her pregnancy because she thought she was unable to get pregnant. This is based on qualitative data from the first phase of the study and current literature (Borrero et al., 2015; Harris, 2013; Polis & Zabin, 2012). Responses were scored from zero to two, resulting in a pregnancy planning score ranging from zero to twelve, with a higher score indicating greater planning, and interpretation categories of "planned" (10-12), "ambivalent" (4-9), and "unplanned" (0-3) (Cronbach alpha .70).

Partner substance abuse: Substance abuse was measured with the Alcohol Use Disorder Identification Test (AUDIT) and Drug Abuse Screening Tool (DAST-10) measures, which were re-worded to assess partner substance use. Alcohol use was measured with five questions with responses indicating frequency of alcohol use behaviors (Cronbach alpha .80). Binge drinking, considered 5 or more drinks in 2 hours (Centers for Disease Control & Prevention (CDC), 2018), was scored as a response of anything greater than "3 or 4" in response to the question "How many drinks containing alcohol does your partner have on a typical day when they are drinking?", or a response of anything greater than "Never" in response to the question "How often does your partner have six or more drinks on one occasion?". Drug use was measured with six yes/no questions from the DAST-10 Scale (Yudko, Lozhkina, & Fouts, 2007) (Cronbach alpha .70). A "yes" response to any question was scored as "partner drug use".

IPV: The HARK scale (Sohal, Eldridge, & Feder, 2007) is made up of 4 yes/no questions that are broad in scope, assessing controlling behaviors in addition to physical and sexual violence. Using a cutoff score of ≥ 1 has 81% sensitivity and 95% specificity when compared to the 30 items of the Composite Abuse Scale (CAS) (Sohal et al., 2007). A positive response to any question was scored as IPV.

Acculturation: The Brief Acculturation Scale for Hispanics (BASH) was used, consisting of four items which assess what language the participant uses to speak at home, speak with friends, read and speak. (Cronbach alpha .89). Responses ranging from 1 for "Spanish only" to 5 for "English

only" were summed and divided by the number of completed items. A score of 3 or less was considered "low" acculturation and greater than 3 was considered "high" acculturation.

Safety and Harm Reduction Strategies: Actions taken by women to stay safe in coercive relationships or to maintain their autonomous reproductive decision-making when faced with coercive behaviors were labeled Safety and Harm Reduction Strategies. These were assessed with 6 investigator-developed yes/no questions based on qualitative data from the study and questions from current IPV (Glass et al., 2015) and RC studies (Tancredi et al., 2015). Examples of questions included "Did you change your method of birth control so your partner could not tamper with (mess with) it?" and "In the past year, have you hidden a method of birth control from your partner?". A "yes" response to any question was scored as "use of safety and harm reduction strategies".

Data Analysis

Descriptive statistics (means, standard deviations, and frequencies) were used to describe the characteristics of the sample, the prevalence of types of RC behaviors and the prevalence of safety and harm reduction strategies used. Chi square and t-tests were used to examine differences between those who had and had not experienced RC on risk factors and covariates. To account for possible multicollinearity, variables that were significantly related to RC in the bivariate analyses were entered into a logistic regression with RC as the outcome, to determine the independent effects of the predictor variables with RC. Multiple linear regression was used to examine the relationship between RC and unintended pregnancy. Age, marital status, health insurance, educational attainment, religious affiliation and being born in the US are known to be associated with unintended pregnancy (Finer & Zolna, 2016; Hughey et al., 2017; Kim et al., 2016), so we controlled for these factors when examining the association between RC and unintended pregnancy. Due to issues of collinearity we did not include IPV in the regression model, though it is also a risk factor for unintended pregnancy (Cha, Masho, & Heh, 2016). The

safety and harm reduction strategies, RC, and their interaction were included in a multiple linear regression model with safety and harm reduction strategies as a moderator. We also examined participants with and without missing data for any significant differences on key variables, and for any that were significant (importance of religion), they were included as a covariate in the regression analysis. All analyses were conducted in SPSS Statistics 25.0 (IBM Corp., 2017).

Ethics/IRB

The study was approved by the Johns Hopkins Medicine Institutional Review Board (IRB00129418). Research Assistants received standardized human subjects research ethics training as well as IPV advocacy training including safety assessment, technology safety, IPV resource referrals, and suicidality protocols. Participants reviewed tablet-based survey/questionnaire informed consent covering the nature of the questions, information about confidentiality, and the voluntary nature of the study including that they can refuse to answer any question. To thank them for their time, participants had the opportunity to enter a raffle for one of twenty $50 retail gift cards.

Results

The mean age of the study sample was 30.44 (SD 6.83; Table 4-1). Equal proportions of the sample had achieved a high school diploma/GED/completed some college (42.8%) as had not completed a high school diploma/GED (40.0%). Most participants were from the Central American countries of El Salvador (47.6%), Guatemala (13%) and Honduras (10.8%); only 9.3% of the sample was born in the United States (US). The majority of participants who were not born in the US had lived there for 11 or more years (49.8%), and the majority of participants had low levels of acculturation (90%) The majority were married, either legally or common-law (68%). Thirty-two percent (31.6%) of the full sample were missing at least one item of data on key variables (Addendum Table 4A-3). The majority of key variables were missing data from fewer than 5 percent of the sample, with the exception of length of time lived in the US (5.2%) in which

most missing data (4.8%) was due to participants indicating "don't know" or "refuse to answer" as a response, ever had an abortion (missing 7.8%) and partner age (missing 6.8%).

Reproductive coercion

Approximately 1 in 6 (16.4%; n=82) women in the sample experienced one or more forms of RC in the past year, and 9.8% (n=49) experienced IPV in the past year. 67.1% (n=55) of those who experienced RC did *not* also experience IPV (Figure 4-3). Types of RC behaviors experienced were grouped into three main categories according to current RC literature: pregnancy coercion, birth control sabotage, and controlling the outcome of a pregnancy (Table 4-2). The most commonly experienced RC behavior was telling a woman not to use birth control (43.9% of those who experienced RC), followed by taking off the condom while having sex (37.8% of those who experienced RC). Other more commonly reported RC behaviors were making a woman have sex without a condom (20.7% of those who experienced RC) and forcing or pressuring a woman to become pregnant (19.5% of those who experienced RC).

Risk factors for RC

The differences between participants who did and did not report RC in the past year are presented in Table 4-3. Participants who experienced RC were significantly younger than those who did not experience RC (27.68 vs. 30.98, $p<0.001$), but age difference with partner was not significantly associated with RC (3.34 years vs. 2.39 years, $p=0.295$). Women who experienced RC were significantly more likely to also experience IPV (32.1% vs. 5.7%, $p<0.001$). Participants who experienced RC were more likely to be born in the United States (18.5% vs. 7.4%, $p=0.002$). RC was significantly associated with having had one or more abortions (17.7% vs. 5.8%, $p<0.001$). Relationship status was associated with RC; participants who experienced RC were significantly less likely to be married (legally or common-law) (48.8% vs. 72.1%, $p<0.001$) and to have had more than one past-year partner (23.2% vs. 8.5%, $p<0.001$). RC was significantly associated with having a partner who binge drinks (48.8% vs. 24.6%, $p <0.001$). RC was not significantly associated with level of education, importance of religion in daily life, current

employment, having had a miscarriage or length of time lived in the United States. After adjusting for all variables in the logistic regression model, the factors that remained significant were IPV ($p<0.001$), partner binge drinking ($p=0.041$) and younger age ($p=0.018$).

RC and unintended pregnancy

One hundred ninety-one women (38.2% of full sample) reported a pregnancy in the past year, and of these, 44% (n=84) of pregnancies were planned, 44.5% (n=85) were ambivalent, and 11.5% (n=22) were unplanned. Of women with a past-year pregnancy, those who experienced RC were more likely to have an unplanned pregnancy (33.3% vs. 6.5%, $p<0.001$). The mean pregnancy planning score was lower for women who experienced RC (6.25 vs. 8.37, $p<0.001$), indicating less planning. In multivariable regression analysis RC significantly decreased the pregnancy planning score ($p=0.001$) when controlling for known risk factors for unintended pregnancy (Table 4-4). Younger age ($p=0.005$) and single relationship status ($p=0.047$) also had significant effects on unintended pregnancy, but the effect of RC was stronger.

Safety and harm reduction strategies, RC and unintended pregnancy

The most common safety strategy used by the full sample of women in the study was ending a relationship because it felt unhealthy, unsafe or abusive (6.0% of women; out of all those who ended relationships in the past year, this was the reason given by 45.5%), followed by use of a less detectable method of contraception so that a partner would not find out (3.6% of women; 11.2% of women who used specified methods did so for this reason) (Table 4-5). Other safety or harm reduction strategies that were used are presented in Table 4-5. In total, 10.6% (n=53) of participants used a safety or harm reduction strategy to prevent an RC behavior or minimize the risk of pregnancy from RC in the previous year. Over two-thirds (67.1%, n=55) of those who experienced RC used one of these strategies regardless of whether it was specifically used to prevent RC (for example, reported they used an IUD in the past year), and nearly one-quarter (24.4%, n=20) used one of these strategies specifically to prevent RC (for example, reported they used an IUD in the past year so that a partner would not find out they were using

contraception). In multiple regression analysis the use of safety and harm reduction strategies for RC did not moderate the relationship between RC and unintended pregnancy (p=0.344) (Table 4-6). Women who used a safety strategy were more likely to have an unintended pregnancy when they experienced RC (p=0.008).

Discussion and Implications

Findings on prevalence and correlates of RC among this sample of Latina women were aligned with existing literature in many areas. However, unlike other studies which found age discrepancy with partner to be a significant risk factor in RC (Center for Impact Research, 2000; Rosenbaum et al., 2016), our findings did not support this. Using violence or threats of violence to pressure a woman into not having an abortion was not experienced by any women in this study in contrast with qualitative research reports on behaviors to sabotage pregnancy termination including violence (Hathaway, Willis, Zimmer, & Silverman, 2005; Moore, Frohwirth, & Miller, 2010; Nikolajski et al., 2015; Thiel de Bocanegra, Rostovtseva, Khera, & Godhwani, 2010; Tsui et al., 2011). Ever having had an abortion was significantly associated with RC (p<0.001) which is consistent with other studies (Sutherland et al., 2015) and may be explained by the strong association between RC and unintended pregnancy (p<0.001). Women whose partners were binge drinkers were more likely to experience RC behaviors, which is consistent with existing research demonstrating the connection between sexual assault and binge drinking (Abbey, Wegner, Woerner, Pegram, & Pierce, 2014), as well as research on Latina women showing IPV to be associated with partner substance abuse (Hazen & Soriano, 2007), and also may reflect the strong association between IPV and RC (p<0.001). Overall, rates of alcohol use and abuse in Latino populations are noted to be lower than in non-Hispanic White populations (Chartier & Caetano, 2010; Lipsky & Caetano, 2009). Women who reported more than one sexual or romantic partner in the past year were also more likely to experience RC. This is consistent with other RC studies (Fasula et al., 2018; Katz & Sutherland, 2017), and additionally, multiple sexual partners may

reflect relationship instability, which has been found to increase risk for RC (Paterno et al., 2018). Qualitative evidence shows at least some perpetrators of RC using violence to control the outcome of a pregnancy by causing a miscarriage (Coggins & Bullock, 2003; Grace et al., n.d.; Moore et al., 2010), but this study did not find any significant association between RC and miscarriage, likely because a large number of pregnancies end in miscarriage irrespective of violence or coercion (American College of Obstetricians & Gynecologists (ACOG), 2018).

The strong association between RC and IPV was supported by this study and is strengthened by the fact that this study measured past year experiences of RC and IPV with the same partner. Despite this strong association, the majority of those who experienced RC did not also experience any other form of IPV, lending support to the proposition that RC and IPV are distinct phenomena, at least in this sample of primarily Central American women. Supporting the notion of the *healthy immigrant effect* (the idea that residents of a country who are foreign-born have improved health outcomes over their native-born counterparts) (L. S. Miller, Robinson, & Cibula, 2016; Urquia, O'Campo, & Heaman, 2012), this study found that participants who were born in the United States had higher rates of RC than those who immigrated to the US, however, time lived in the US was not associated with RC.

The association between RC and unintended pregnancy was also noted in our sample of Latina women. Some women did use the recommended less-detectable methods of contraception in order to maintain reproductive autonomy, but more women separated from their partners due to the relationship being unhealthy, unsafe or abusive. Qualitative literature offers caution that even less-detectable methods of birth control may be detected by a coercive partner (Dasari et al., 2015; Grace et al., n.d.), which may account for the low utilization of these methods among women experiencing RC. Providers should fully inform women of the limits of non-detectability of these methods, when following guidelines to offer them to women experiencing RC. Women with low levels of acculturation, like the women in this study, are found to less frequently use these less detectable methods as well (Roncancio, Ward, & Berenson, 2012).

Surprisingly, participants who used a safety or harm reduction strategy were *more* likely to have an unintended pregnancy when they experienced RC. This is most likely due to the cross-sectional nature of the data, making it difficult to discern a temporal relationship. It is possible that participants started using a safety strategy as a *result* of RC and an unintended pregnancy instead of as strategy to prevent it. The use of specific safety and harm reduction strategies (especially less-detectable methods of contraception, which are all highly effective at preventing pregnancy) in women who experience RC warrants further exploration in longitudinal as well as larger studies with the power to detect their moderating effect on unintended pregnancy.

Limitations and Strengths

There are several limitations to the study that should be considered in generalizing findings. In analysis of significant differences between women who did and did not complete the full survey, it was noted that women who were not married and women with greater than one past-year sexual partner were more likely to not complete the survey (Addendum Table 4A-4). As these factors are also significant risk factors for RC, it is possible that data were biased in favor of those with lower risk, and therefore RC may be underreported. Two key variables had large amounts of missing data: history of abortion, which women in this sample may have been reluctant to report, and partner age, which women in this sample may not have known. These are significant factors in other RC literature, and their absence may have biased the results, though they were controlled for in the final regression model. The sample was limited to Latina women receiving or accompanying someone receiving health services in an urban area, and the majority of these women were from four Central American countries. Findings may not be generalizable to women from other countries or living in rural areas. The use of retrospective data may have recall or social desirability bias. However, strengths include use of cognitive interviewing to field-test the survey prior to data collection, availability of survey audio-assistance for participants with limited or reduced literacy, and a large sample size to detect significant associations with key variables.

Conclusion

This study adds to the growing body of literature on RC by identifying risk factors and outcomes of RC specific to a population of Latina women. Findings support the risk factors that have been identified in other studies as also being relevant in this population and highlight areas for providers to have heightened suspicion for RC, such as providers working with women presenting with unintended pregnancy or seeking abortion and any woman who is suspected or confirmed to be experiencing IPV. Any woman who discloses IPV should be assessed specifically for RC. Providers may also have increased vigilance for RC among Latina women who are younger, were born in the United States, who are single, whose report partners who binge drink, or who report more than one sexual partner in the prior year. In any woman who reports RC, especially those with other risk factors for unintended pregnancy such as younger age and being single, the use of existing provider guidelines for RC is supported in Latina women, with perhaps the greatest benefit to be gained from offering support services to plan for safety and harm reduction when making decisions about leaving unhealthy and unsafe relationships.

Tables and Figures

Table 4-1 Demographic Characteristics of the Study Population (N=500)

Characteristic	Prevalence N (%)
Age (mean, SD)	30.44, 6.83
Experienced RC in past year	
Yes	82 (16.4%)
No	411 (82.2%)
Experienced IPV in past year	
Yes	49 (9.8%)
No	438 (87.6%)
Education	
Less than high school diploma or GED	200 (40%)
High school diploma, GED or some college	214 (42.8%)
Associates degree or higher	83 (16.6%)
Country of Birth	
United States	46 (9.3%)
El Salvador	238 (47.6%)
Guatemala	65 (13%)
Honduras	54 (10.8%)
Mexico	48 (9.6%)
Other Caribbean or Central American country	20 (4%)
South America	17 (3.4%)
Other	11 (2.2%)
Acculturation level	
Low	450 (90%)
High	18 (3.6%)
Importance of religion in daily life	
Very important	351 (70.2%)
Somewhat or not important	144 (28.8%)
Currently employed	
Yes	211 (42.2%)
No	279 (55.8%)
Parity	
Never pregnant	66 (13.2%)
No live births	36 (7.2%)
1-3 live births	336 (67.2%)
4 or more live births	62 (12.4%)
Ever had an abortion	
Yes	37 (7.4%)
No	424 (84.8%)
Current relationship with partner	
Dating but also dating other people	14 (2.8%)
Dating this person only	90 (18.0%)
Married	192 (38.4%)

Characteristic	Prevalence N (%)
Married but not legally	148 (29.6%)
None	49 (9.8%)
Other	5 (1.0%)
Number of sexual partners in past year	
1	445 (89.0%)
More than 1	55 (11.0%)
Years living in the US	
5 or less	140 (28.0%)
6-10	85 (17.0)
11 or more	249 (49.8%)
Not sure	10 (2.0%)
Partner substance abuse	
Any binge drinking	
Yes	137 (27.4%)
No	347 (69.4%)
Drug use	
Yes	27 (5.4%)
No	462 (92.4%)

*Percentages may not sum 100% due to missing data

Table 4-2 Types of RC Experienced (N=82)

Behavior	Prevalence N (%)
Pregnancy Coercion	
Tried to force or pressure you to become pregnant	16 (3.2%)
Told you not to use any birth control	36 (7.2%)
Said they would leave you if you did not get pregnant	7 (1.4%)
Told you they would have a baby with someone else if you did not get pregnant	7 (1.4%)
Hurt you physically because you did not agree to get pregnant	3 (0.6%)
Birth Control Sabotage	
Taken off the condom while having sex	31 (6.2%)
Put holes in condom or broken condom on purpose while having sex	1 (0.2%)
Taken your birth control away or kept you from going to clinic to get birth control	5 (1.0%)
Made you have sex without a condom	17 (3.4%)
Controlling the Outcome of Pregnancy	
Tried to MAKE you get an abortion	7 (1.4%)
Violence or threats to try to MAKE you get an abortion	4 (0.8%)
Tried to STOP you from getting an abortion	5 (1.0%)

Behavior	Prevalence N (%)
Violence or threats of violence to try to STOP you from getting an abortion	0 (0%)

Note: Women can experience more than one type of RC

Table 4-3 Risk Factors for RC

Characteristic	Experienced RC N=82	Did not experience RC N=411	P value[1]
Age (mean, SD)	**27.68, 7.07**	**30.98, 6.67**	**<0.001**
Age discrepancy with partner (mean, SD)	3.34, 6.23	2.39, 5.69	0.295
Experienced IPV in past year			**<0.001**
Yes	**26 (32.1%)**	**23 (5.7%)**	
No	**55 (67.9%)**	**378 (94.3%)**	
Education			0.857
Less than high school diploma or GED	31 (37.8%)	165 (40.4%)	
High school diploma, GED or some college	36 (43.9%)	177 (43.4%)	
Associates degree or higher	15 (18.3%)	66 (16.2%)	
Born in the US			**0.002**
Yes	**15 (18.5%)**	**30 (7.4%)**	
No	**66 (81.5%)**	**375 (92.6%)**	
Importance of religion in daily life			0.092
Very important	52 (63.4%)	295 (72.7%%)	
Somewhat or not important	30 (36.6%)	111 (27.3%)	
Currently employed			0.783
Yes	36 (44.4%)	172 (42.8%)	
No	45 (55.6%)	230 (57.2%)	
Ever had a miscarriage			0.892
Yes	19 (23.2%)	95 (23.9%)	
No	63 (76.8%)	303 (76.1%)	
Ever had an abortion			**<0.001**
Yes	**14 (17.7%)**	**22 (5.8%)**	
No	**65 (82.3%)**	**355 (94.2%)**	
Currently married to partner (includes common-law marriage)			**<0.001**
Yes	**40 (48.8%)**	**295 (72.1%)**	
No	**42 (51.2%)**	**114 (27.9%%)**	
Number of sexual partners in past year			**<0.001**
1	**63 (76.8%)**	**376 (91.5%)**	
More than 1	**19 (23.2%)**	**35 (8.5%)**	
Length of time lived in the US			0.536
5 years or less	21 (26.9%)	119 (30.4%)	
More than 5 years	57 (73.1%)	272 (69.6%)	

Characteristic	Experienced RC N=82	Did not experience RC N=411	P value[1]
Partner binge drinking			
Yes	**39 (48.8%)**	**98 (24.6%)**	**<0.001**
No	**41 (51.2%)**	**300 (75.4%)**	

[1]Based on t-test or chi-square test.

Table 4-4 Effect of RC on Unintended Pregnancy Score –Multiple Regression Results (N=182)

	Standardized Regression Coefficient (ß)	95% Confidence Interval	p-value
RC (yes/no)	**-0.228**	**-0.373- -0.083**	**0.001**
Age	**0.205**	**0.060 - 0.350**	**0.005**
Relationship status	**-0.138**	**-0.283 - 0.007**	**0.047**
Health insurance (yes/no)	-0.070	-0.215 - 0.075	0.329
Highest level of education	0.082	-0.063 - 0.227	0.232
Importance of religion	-0.061	-0.206 - 0.084	0.397
Born in the US	-0.131	-0.276 - 0.014	0.081

Table 4-5 Use of Safety/Harm Reduction Strategies (N=500)

	Full sample N	% of Full Sample	% of Subgroup (when noted)
Used less detectable method of contraception in past year (IUD, implant, injectable) so partner would not find out about use	18	3.6%	11.2% of people who used these methods
Had an abortion in past year in order to keep partner from controlling you	1	0.2%	8.3% of people who had abortions
Did not tell partner about abortion you had in the past year due to fear of partner or thinking partner would be upset/angry	2	0.4%	16.7% of people who had abortions
Changed method of contraception in past year	5	1.0%	

	Full sample N	% of Full Sample	% of Subgroup (when noted)
so that partner would not tamper with it			8.3% of those who changed method
Hidden a method of contraception from partner in past year	7	1.4%	
Hidden a method of contraception from partner in past year due to fear partner would be upset with you for using it	3	0.6%	37.5% of those who hid a method
Ended a relationship in the past year because it felt unhealthy, unsafe or abusive	30	6.0%	45.5% of those who ended relationships
Used any safety strategy in past year, specifically to prevent RC behaviors Yes No	 53 (10.6%) 428 (85.6%)		
Experienced RC and used any safety strategy for any reason (eg, used an IUD)	55	11.0%	67.0% of those who experienced RC
Experienced RC and used any safety strategy specifically for RC (eg, used an IUD so partner would not find out)	20	4.0%	24.4% of those who experienced RC

Table 4-6 Effect of RC Safety Strategies on Unintended Pregnancy Score – Multiple Regression Results (N=182)

	Standardized Regression Coefficient (ß)	95% Confidence Interval	p-value
RC (yes/no)	**-0.223**	**(-0.368,-0.078)**	**0.008**
Used any RC safety strategy	0.072	(-0.073, 0.217)	0.495
Interaction term	-0.110	(-0.255,0.035)	0.344

Figure 4-1 Breakdown of Screening and Participation

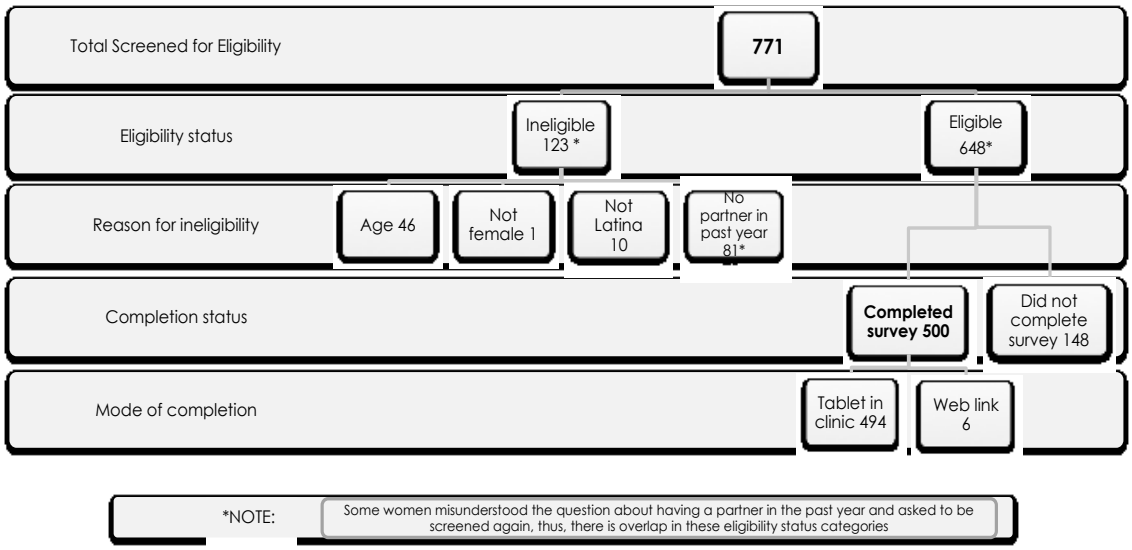
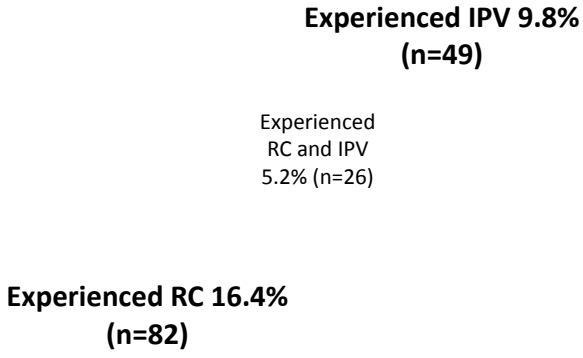


Figure 4-2 Reproductive Coercion Measures

1. In the past year, has this person tried to force or pressure you to become pregnant? 2. In the past year, has this person told you not to use any birth control (such as pills, shot, ring, etc.)? 3. In the past year, has this person said they would leave you if you did not get pregnant? 4. In the past year, has this person told you they would have a baby with someone else if you did not get pregnant? 5. In the past year, has this person hurt you physically because you did not agree to get pregnant? 6. In the past year, has this person taken off the condom while you were having sex? 7. In the past year, has this person put holes in a condom or broken a condom on purpose while you were having sex? 8. In the past year, has this person taken your birth control (such as pills) away from you or kept you from going to the clinic to get birth control? 9. In the past year, has this person made you have sex without a condom? 10. In the past year, has this person tried to make you get an abortion when you wanted to keep the pregnancy? 11. In the past year, did this person use violence or threats of violence to try to make you get an abortion when you wanted to keep the pregnancy? 12. In the past year, has this person tried to stop you from getting an abortion when you wanted to get an abortion? 13. In the past year, did this person use violence or threats of violence to try to keep you from getting an abortion when you wanted to get an abortion?

Figure 4-3 RC with and without IPV in the sample



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Chapter 4: ADDENDUM

This addendum contains additional tables that were not included in Manuscript 3 due to space limitations but may be of interest to the dissertation reader.

Table 4A-1 Survey completion status

Completion Status	N	Percent (%)
Completed Survey	500	64.9
Did not complete survey	148	19.2
Ineligible	123	16.0
Total	**771**	**100.0**

Table 4A-2 Reasons for ineligibility

Reason for Being Ineligible	N	Percent (%)
Age <15	2	1.6
Age >45	34	27.5
Age <18 and NOT at clinic for confidential services	10	8.1
Not female	1	0.8
Not Latina/Hispanic/Spanish	10	8.1
No sexual/romantic/dating partner in past year	81	65.9
Total	**138**	**112.0**

NOTE: Totals are greater than the 123 participants who were ineligible (and greater than 100%) because some people were ineligible for more than one reason.

Table 4A-3 Differences between those with and without missing data on key variables in the study

Variable	Not missing any data N (%)	Missing any data N (%)	Significance p=
Total sample	342 (68.4%)	158 (31.6%)	
Age – mean (SD) (missing=0)	**29.97 (6.83)**	**31.46 (6.75)**	**0.023**
Age discrepancy with partner - mean (SD) (missing =34; 6.8%)	2.66 (5.83)	2.34 (5.68)	0.592
Experienced IPV in past year (missing =13; 2.6%) Yes No	 37 (10.8%) 305(89.2%)	 12 (8.3%) 133 (91.7%)	0.394
Education (missing =3; 0.6%)			0.414

Variable	Not missing any data N (%)	Missing any data N (%)	Significance p=
Less than HS/GED	131 (38.3%)	69 (44.5%)	
HS/GED or some college	158 (46.2%)	56 (36.1%)	
Associates or higher	53 (15.5%)	30 (19.4%)	
Born in the US (missing =9; 1.8%)			**0.045**
Yes	**38 (11.1%)**	**8 (5.4%)**	
No	**304 (88.9%)**	**141 (94.6%)**	
Importance of religion (missing =5; 1%)			**0.042**
Very	**233 (68.1%)**	**118 (77.1%)**	
Somewhat or not	**109 (31.9%)**	**35 (22.9%)**	
Employed (missing =10; 2%)			0.053
Yes	157 (45.9%)	54 (36.5%)	
No	185 (54.1%)	94 (63.5%)	
Ever had a miscarriage (missing = 14; 2.8%)			0.105
Yes	74 (21.6%)	41 (28.5%)	
No	268 (78.4%)	103 (71.5%)	
Ever had an abortion (missing = 39; 7.8%)			0.543
Yes	29 (8.5%)	8 (6.7%)	
No	313 (91.5%)	111 (93.3%)	
Currently married to partner (includes common-law marriage) (missing =2; 0.4%)			**0.049**
Yes	**224 (65.5%)**	**116 (74.4%)**	
No	**118 (34.5%)**	**40 (25.6%)**	
Number of sexual partners in past year (missing =0)			0.178
1	300 (87.7%)	145 (83.9%)	
More than 1	42 (12.3%)	13 (8.2%)	
Length of time lived in the US (missing 26; 5.2%)			0.367
5 years or less	97 (28.4%)	43 (32.6%)	
More than 5 years	245 (71.6%)	89 (67.4%)	
Partner binge drinking (missing 16; 3.2%)			**<0.001**
No	**223 (65.2%)**	**137 (86.7%)**	
Yes	**119 (34.8%)**	**21 (13.3%)**	
Used any RC Safety Strategy (missing =19; 3.8%)			0.467
No	294 (88.3%)	134 (90.5%)	
Yes	39 (11.7%)	14 (9.5%)	

Variable	Not missing any data N (%)	Missing any data N (%)	Significance p=
Experienced any RC behavior (missing = 7; 1.4%)			0.414
No	282 (82.5%)	129 (85.4%)	
Yes	60 (17.5%)	22 (14.6%)	

Table 4A-4 Differences between survey completers and non-completers on key variables in the study

Variable	Completers N (%)	Non-Completers N (%)	Significance p=
Total sample	500 (77.2%)	148 (22.8%)	
Age – mean (SD)	30.44 (6.83)	30.33 (6.68)	0.688
Age discrepancy with partner - mean (SD)	2.58 (5.78)	2.67 (4.65)	0.212
IPV			0.422
Yes	49 (10.1%)	6 (14.0%)	
No	438 (89.9%)	37 (86.0%)	
Education			0.083
Less than HS/GED	200 (40.2%)	54 (50.5%)	
HS/GED or some college	214 (43.1%)	34 (31.8%)	
Associates or higher	83 (16.7%)	19 (17.8%)	
Born in the US			0.983
Yes	46 (9.4%)	10 (9.4%)	
No	445 (90.6%)	96 (90.6%)	
Importance of religion			0.827
Very	351 (70.9%)	77 (72.0%)	
Somewhat or not	144 (29.1%)	30 (28.0%)	
Employed			0.785
Yes	211 (43.1%)	42 (41.6%)	
No	279 (56.9%)	59 (58.4%)	
Ever had a miscarriage			0.324
Yes	115 (23.7%)	27 (28.4%)	
No	371 (76.3%)	68 (71.6%)	
Ever had an abortion			**0.047**
No	**424 (92.0%)**	**89 (97.8%)**	
Yes	**37 (8.0%)**	**2 (2.2%)**	
Currently married to partner (includes common-law marriage)			**<0.001**
Yes	**340 (68.3%)**	**40 (41.2%)**	
No	**158 (31.7%)**	**57 (58.8%)**	
Number of sexual partners in past year			**0.004**

Variable	Completers N (%)	Non-Completers N (%)	Significance p=
1	**445 (89.0%)**	**76 (78.4%)**	
More than 1	**55 (11.0%)**	**21 (21.6%)**	
Length of time lived in the US			0.780
5 years or less	140 (29.5%)	29 (28.2%)	
More than 5 years	334 (70.5%)	74 (71.8%)	
Partner binge drinking			0.687
No	347 (71.7%)	24 (75.0%)	
Yes	137 (28.3%)	8 (25.0%)	
Used any RC Safety Strategy			0.376
No	428 (89.0%)	3 (75.0%)	
Yes	53 (11.0%)	1 (25.0%)	
Experienced any RC behavior			0.528
No	411 (83.4%)	44 (80.0%)	
Yes	82 (16.6%)	11 (20.0%)	

Table 4A-5 Past Year Pregnancy Intention Bivariate Association with RC (N=191)

Pregnancy planning category	Total sample N (%)	Experienced RC	Did not experience RC	P value[1]
The pregnancy was:				**<.001**
Planned	84 (44.0%)	12 (33.3%)	72 (46.5%)	
Ambivalent	85 (44.5%)	12 (33.3%)	73 (47.1%)	
Unplanned	22 (11.5%)	12 (33.3%)	10 (6.5%)	
Pregnancy planning score (mean, SD)		**6.25 (3.79)**	**8.37 (2.85)**	**<0.001**

[1]Based on t-test or chi-square test.

Chapter 5 : SYNTHESIS/DISCUSSION

Introduction

The purpose of this study was to explore the experience of, risk factors for, and strategies used to resist RC, and the relationship with unintended pregnancy, among Latina women, in order to inform healthcare practice guidelines and interventions. Overall, we found similar RC behaviors and risk factors to studies of other races and ethnicities as well as diverse samples, with some important nuances. This study has critical implications for healthcare providers who care for women as well as researchers in the area of RC and IPV.

Summary of Findings

Aim 1

Describe the experience of RC, the use of safety and harm reduction strategies for reproductive coercion, and pregnancy intention among low-income Latina women seeking IPV services at an urban clinic.

In Phase 1 of the study, 13 Latina women described the experience of RC in ways that were largely consistent with existing literature describing this phenomenon among other racial and ethnic groups (Pregnancy Pressure and Manipulation, Birth Control Sabotage, and Controlling Pregnancy Outcome), but some new behaviors emerged, including threats to break an implant contraceptive device, physically locking women up to prevent attendance at contraceptive appointments, and pressuring a woman not to place a baby for adoption. These behaviors are not necessarily specific to Latino populations or motivated by cultural norms that are unique to Latino culture, but these new behaviors add to a broader and more inclusive description of RC.

Immigration status was used against some women as a method of coercive control. Cultural norms of *machismo*, *familismo*, and *marianismo* were suggested as potential sources of increased vulnerability for Latina women. Pressure to have an abortion was perpetrated by partners, as well

as pressure not to have an abortion, and abortion was cited by some women as a strategy for separating from a coercive partner.

Some women used strategies to resist RC that are also recommended by professional guidelines,[1,2] including less detectable methods of contraception, but it is important to note the caveats these women provide, that IUDs and implants can sometimes be detected, and a determined partner can prevent a woman from leaving the house to receive other methods such as injectables. Some women sought assistance from community services, as is also recommended by experts, but others had to resort to deception and stalling as the only tools available to them. The strength and bravery associated with *marianismo* emerged as powerful sources of resilience and endurance that many women called upon to survive their difficult or dangerous situations, inspiring them to leave or to employ the use of a safety strategy.

Women in the study described pregnancy intentions of planning to get pregnant, planning not to get pregnant, and not planning to get pregnant (ambivalence). Factors that affected these intentions and the outcomes of pregnant or not pregnant included Perceived Behavioral Control (with themes of "birth control didn't work for me", "perceived infertility", "it just happens" and "high behavioral control"), Ready to Have a Baby (internal and external readiness factors), Reproductive Coercion and Cultural Norms.

The current definition of RC is clearly applicable to Latina women, and findings emerged that will inform practice as well as research. Aim 1 was the primary aim of the qualitative phase of the study, and an additional purpose of this phase was to inform the development of the quantitative survey for Phase 2 of the study. Measures were added to and adapted for the survey, as outlined in Table 5-1.

Aim 2

Examine multi-level risk factors (e.g. male partner factors, acculturation, poverty, trauma/violence history, time in United States, country of origin, employment) for RC among low-income Latina women, ages 15-45, seeking services at an urban clinic.

500 Latina women were enrolled in the study and completed the tablet-based survey. Participants who experienced RC were significantly younger than those who did not experience RC, but age discrepancy with partner was not significantly associated with RC. Women who experienced RC were significantly more likely to also experience IPV. Participants who experienced RC were more likely to have been born in the US. RC was significantly associated with having had one or more abortions. Relationship status was associated with RC; participants who experienced RC were significantly less likely to be married (legally or common-law) and to have had more than one past-year partner. RC was significantly associated with having a partner who binge drinks. RC was not significantly associated with level of education, importance of religion in daily life, current employment, having had a miscarriage or length of time lived in the US. After adjusting for all variables in the logistic regression model, the factors that remained significant were IPV, partner binge drinking and younger age.

Findings on prevalence and correlates of RC among this sample of Latina women were aligned with existing literature. Unlike other studies which found age discrepancy with partner to be a significant risk factor in RC,[3,4] our findings did not support this. Using violence or threats of violence to pressure a woman into not having an abortion was not experienced by any women in this study; qualitative literature reports on behaviors to sabotage pregnancy termination including violence.[5–9] Ever having had an abortion was significantly associated with RC which may be explained by the strong association between abortion and unintended pregnancy. Qualitative evidence describes perpetrators of RC using violence to control the outcome of a pregnancy by causing a miscarriage,[9–11] but this study did not find any significant association between RC and miscarriage, likely because a large number of pregnancies end in miscarriage irrespective of violence or coercion.[12]

The strong association between RC and IPV was supported by this study and is strengthened by the fact that this study measured past year experiences of RC and IPV with the same partner. Despite this strong association, the majority of those who experienced RC did not

also experience any other form of IPV, lending support to the proposition that RC and IPV are distinct phenomena. Supporting the notion of the *healthy immigrant effect* (the idea that those who are foreign-born have improved health outcomes over their native-born counterparts),[13,14] this study found that participants who were born in the US had higher rates of RC than those who immigrated to the US, however, time lived in the US was not associated with RC.

Aim 3

Determine the relationship between RC and unintended pregnancy in low-income Latina women, ages 15-45, seeking health or social services at an urban clinic.

One hundred ninety-one women (38.2% of full sample) reported a pregnancy in the past year, and of these, 44% (n=84) of pregnancies were planned, 44.5% (n=85) were ambivalent, and 11.5% (n=22) were unplanned. Of women with a past-year pregnancy, those who experienced RC were more likely to have an unplanned pregnancy. The mean pregnancy planning score was lower for women who experienced RC, indicating less planning. In multivariable regression analysis RC significantly decreased the pregnancy planning score when controlling for unintended pregnancy risk factors. Younger age and single relationship status also had significant effects on unintended pregnancy, but the effect of RC was stronger. The association between RC and unintended pregnancy was confirmed in our sample of Latina women.

Aim 4

Explore whether the use of specific safety strategies moderates the relationship between reproductive coercion and unintended pregnancy, in order to inform the adaptation of existing guidelines and interventions for RC for Latina women.

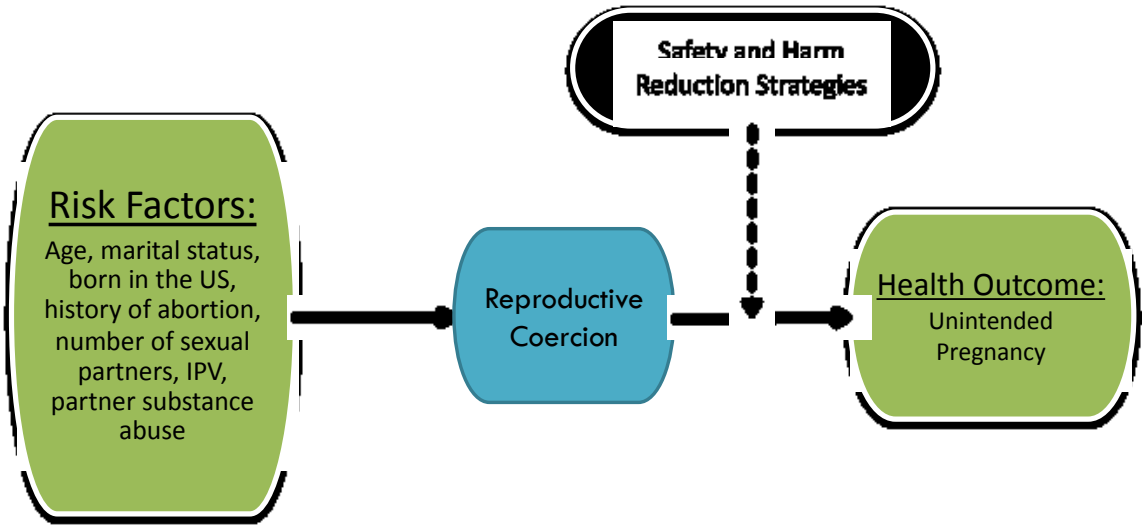
The most common safety strategy used by the full sample of women in the study was ending a relationship that felt unhealthy, unsafe or abusive, followed by use of a less detectable method of contraception so that a partner would not find out. In total, 10.6% (n=53) of participants used a safety or harm reduction strategy to prevent an RC behavior or minimize the risk of pregnancy from RC in the previous year. Over two-thirds (67.1%, n=55) of those who

experienced RC used one of these strategies regardless of whether it was specifically used to prevent RC (for example, reported they used an IUD in the past year), and nearly one-quarter (24.4%, n=20) used one of these strategies specifically to prevent RC (for example, reported they used an IUD in the past year so that a partner would not find out she was using contraception). In multiple regression analysis the use of safety and harm reduction strategies for RC did not moderate the relationship between RC and unintended pregnancy. Paradoxically, women who used a safety strategy were more likely to have an unintended pregnancy when they experienced RC. This is most likely due to the cross-sectional nature of the data, making it difficult to discern a temporal relationship. It is possible that participants started using a safety strategy after experiencing RC and an unintended pregnancy, not in order to prevent them.

Final conceptual model

As a result of qualitative and quantitative analysis the adapted conceptual model of the relationship between RC and unintended pregnancy was further refined (Figure 5-1).

Figure 5-1 Refined conceptual framework – RC and Unintended Pregnancy in Latina Women



This model reflects the RC risk factors that were identified in this study and the confirmed relationship between RC and unintended pregnancy. Safety and harm reduction strategies did not

have a moderating effect on this relationship in this study, but the cross-sectional nature of the data precludes definitively ruling this out. Thus, these have been retained in this model in transparent effect to indicate need for further study in future research.

Strengths and Limitations

Phase 1

Findings should be considered within the context of several limitations. First, the purposive sampling strategy used in Phase 1 recruited Latina women from a clinic serving predominantly low-income communities, living in an urban environment, who reported experiencing RC. Thus, their experiences may differ from Latinas living in rural settings or with higher socioeconomic status. The sampling strategy of recruiting participants from a population of women who were already seeking social or health services may be biased toward the experience of women in this situation – the experience of women still enduring IPV or RC, without the ability or the resources to seek help, may not be reflected here. It may also be biased toward women experiencing severe enough coercion and abuse that they have ultimately had to or been motivated to seek help. The researchers were non-Latina, which may have influenced aspects of data collection or interpretation of findings. The sample was small but yielded rich data for analysis, and while only women of Central American birth or descent were interviewed, this reflects the experience of the majority of immigrant women in the study locale. Finally, participants were referred to the study by clinic staff, which was subject to their workload, attitudes, and commitment to the study goals. Despite these limitations, this diverse sample and the powerful voices of the women who participated make a significant contribution to the understanding of RC as experienced by Latina women in the United States.

Phase 2

There are also limitations to Phase 2 of the study that should be considered in generalizing findings. In analysis of significant differences between women who did and did not complete the full survey, it was noted that women who were not married and women with greater

than one past-year sexual partner were more likely not to complete the survey. As these factors are also significant risk factors for RC, it is possible that data was biased in favor of those with lower risk, and therefore RC may be underreported. Two key variables had large amounts of missing data: history of abortion, which women in this sample may have been reluctant to report, and partner age, which women in this sample may not have known. These are significant factors in other RC literature, and their absence may have biased the results, though they were controlled for in the final regression model. The sample was limited to Latina women receiving or accompanying someone receiving health services at a clinic serving predominantly low-income communities in an urban area, and the majority of these women were from four Central American countries. Findings may not be generalizable to women from other countries or living in rural areas. The use of retrospective data may have recall or social desirability bias. However, strengths include use of cognitive interviewing to field-test the survey prior to data collection, availability of survey audio-assistance for participants with limited or reduced literacy, and a large sample size to detect significant associations with key variables.

Implications

Implications for Nursing Practice

Our findings have important implications for clinical practice. Health care settings and medical providers are important sources of assistance and refuge for women experiencing RC and IPV and this study suggests that there are concrete steps that clinics and medical providers can take to aid these women. The importance of translation services in all places non-English speaking women may seek help is clear. What also emerged is the importance of clearly stating what the legal risk of seeking help is and is not, as some women reported that they feared seeking help due to their undocumented status. Trauma-informed social support services that are integrated into health services and provided to all clients are a benefit for women who may not be comfortable asking for help, or who may not be sure if their partner's behaviors are coercive. As part of trauma-informed care, all women should receive information about IPV and RC and be

assessed for both. It is clear from these findings that a report of or suspicion for IPV or RC should trigger screening for the other. Despite their flaws, less detectable methods of contraception remain useful strategies of harm reduction for some women experiencing RC, and this study highlights the importance of ensuring access to the full range of contraceptive options for all women, including women without insurance or legal status. Providers should be mindful of the importance of honoring the request when women ask to change methods, particularly when removing a method early is perceived as inconvenient or not cost effective. While some women may want to remove an implant early due to unrealistic expectations about benign side effects, for example, others may have a partner who is threatening to break it.

Deception, lying and stalling may appear to be less-than-ideal safety strategies that a provider may be reluctant to suggest to women, but our findings suggest that these may be the only tools available to women with limited resources, power, and ability to seek help. As relationships are dynamic and situations change, women may need to use multiple harm reduction strategies, and some may not be ideal but are effective in the short-term as they make decisions for long-term safety. Women, including abused women without the language or the legal status to seek help, have tremendous resources and strength to mobilize when their options are limited. Healthcare providers who work with women, especially Latina and immigrant women, can honor this strength and resilience by listening and providing support and resources based on women's needs and priorities. Cultural norms of women's strength and resilience (*marianismo*) emerged as a vital source of power and endurance for Latina women in this study. Providers must consider how to support this, capitalize on it, and help women to access it.

Among the guidelines for providers working with women who experience RC is to recommend a less detectable method of contraception. Qualitative literature offers caution that even these less-detectable methods may be detected by a coercive partner,[10,15] which may account for the low utilization of these methods among women in our study who experienced RC. Providers should fully inform women of the limits of non-detectability of these methods, when

following guidelines to offer them to women experiencing RC. Women with low levels of acculturation, like the women in this study, are found to less frequently use these less detectable methods as well.[16]

Implications and Recommendations for Nursing Science

Our findings also have implications for nursing research. We demonstrated that it remains difficult for women to draw a clear line where behaviors consistent with the definition of RC become coercive or harmful. This supports suggestions of some researchers that measures of RC should separate questions about behaviors from questions about intent.[17,18] While a woman may be able to accurately report a partner telling her not to use birth control or discarding her oral contraceptives, she may be unaware of whether his intent was to impregnate or some other reason, and this intent may be irrelevant in terms of harmful outcomes to the woman. Future research should examine outcomes associated with RC behaviors regardless of intent, to better inform counseling of RC survivors as well as future RC measures.

Future nursing research should continue to explore the perception of coercion among women experiencing RC behaviors, to further define this complex phenomenon. Research is needed on Latino cultural norms as sources of strength and positive outcomes. More research is needed to identify risk factors for RC as well as strategies for safety and harm reduction. Longitudinal research is especially needed to establish if harmful outcomes are associated with RC behaviors regardless of perception of intent, and to establish the relative benefits of the safety strategies recommended by providers and utilized by women. The use of specific safety and harm reduction strategies in women who experience RC warrants further exploration in longitudinal as well as larger studies with the power to detect their moderating effect on unintended pregnancy.

Work on pregnancy intention reported in Chapter 3 Addendum is ongoing. Nursing theory will be informed by the models developed in this chapter, which will lead to the development of a

novel theory of pregnancy intention that incorporates more culturally inclusive influencing factors than existing theories.

Summary

This study adds to the growing body of literature on RC by identifying risk factors and outcomes of RC specific to a population of Latina women. Findings support the risk factors that have been identified in other studies as also being relevant in this population and highlight areas for providers to have heightened suspicion for RC, such as providers working with women presenting with unintended pregnancy or seeking abortion and any woman who is suspected or confirmed to be experiencing IPV. Providers may also have increased vigilance for RC among Latina women who are younger, were born in the United States, who are single, who report partners who binge drink, or who report more than one sexual partner in the prior year. In any woman who reports RC, especially those with other risk factors for unintended pregnancy such as younger age and being single, the use of existing provider guidelines for RC is supported in Latina women, with perhaps the greatest benefit to be gained from offering support services to plan for safety and harm reduction when make decisions about leaving unhealthy and unsafe relationships.

Tables

Table 5-1 Measures and Adaptations

Variable	Description/Operational Definition and Rationale	Mapping to Specific Aims and Adapted Theory of Planned Behavior[19]	Cronbach's α Score	Adaptations	Available in Spanish?
Dependent					
Reproductive coercion	Uses the Reproductive Coercion Scale, 9 yes/no questions validated in observational and intervention RC research.[20–28] Added 4 questions about coerced abortion and prevention of wanted abortion based on interview data, questions from personal communication with Liz Miller.	Aims 2-4 TPB: Actual enablers/ constraints	α = 0.66-0.76[24,26–28]	After discussion with Liz Miller: Asked about past year RC Combined 2 condom questions Removed intent from all questions that used to say "so that you would get pregnant" because recent literature[17,18] suggests it may be the behavior that is harmful regardless of intent, and women don't always know what the partner's intent is. Some of these behaviors are broader than the strict definition of RC and so these questions may lose specificity, but also probably increase sensitivity. Also added one skip question asking about intent (Is this person trying to get you pregnant?) for anyone who answers Yes to the questions that previously asked about intent.	Yes
Unintended pregnancy	London Measure of Unplanned Pregnancy (LMUP).[29] Roughly concordant with timing-based measures (NSFG) but splits unplanned into unplanned and ambivalent.	Aim 3 and 4 TPB: Pregnancy intention	US English (α = 0.78) and Spanish translation (α = 0.84)[31]	Added an answer option that looks at whether the woman did not plan her pregnancy because she thought she was unable to get pregnant. This is based on interview data and existing literature.[32–34]	Yes

	Assesses planning, wantedness and timing as advised by Santelli[30] and personal communication with Liz Miller.				
Independent					
Demographics	Age Education Race/ethnicity Country of birth Employment Insurance status Parity Relationship status Cohabitation with partner Age discrepancy with partner	Aim 2 TPB: Background factors		Based on interviews and existing literature, added: Religiosity Generation in US Children in another country Length of relationship with partner Partner's country of birth (as proxy for measurement of cultural norms)	No
Years residing in the United States	≤5 years, 6-10 years, ≥11 years are used, as changes in health outcomes are shown to occur after 5 years living in the US.[35]	Aim 2 TPB: Background factors			No
Acculturation	Uses the Brief Acculturation Scale for Hispanics (BASH).	Aim 2 TPB: Background factors	$\alpha = 0.94$[36]		Yes
Planning a pregnancy in near future	Investigator-developed question This question will not be able to examine relationship between RC and UIP as described in Aim 3 specifically, but will address Aim 3 in looking at the relationship between RC and pregnancy intention [RC does not necessarily cause UIP but is likely to cause	Aim 3 TPB: Intention to have a child in close future			

	pregnancy which may or may not be intended]				
Partner substance use	Uses the Alcohol Use Disorder Identification Test (AUDIT) and Drug Abuse Screening Tool (DAST-10) measures, re-worded to assess partner substance use	Aim 2 TPB: Background factors	$\alpha = 0.97$[37] $\alpha = 0.97$[38] $\alpha = 0.97$ and 0.87[37]		Yes
IPV	HARK scale[39] – 4 questions.	Aim 2 TPB: Perceived behavioral control Enabler/ constraint	Using cutoff score of ≥ 1 has 81% sensitivity, 95% specificity.[39]	Formerly planned to use HITS scale.[40] This change was made due to seeking a scale that had broader questions and that assessed more controlling behaviors (in addition to physical and sexual violence), while still being brief. Has limited validation but has been used in Dr. Glass' research with good results.	No
Safety and Harm Reduction Strategies	Assessed with investigator-developed questions based on qualitative data from Phase 1 of the study, questions from the myPlan study, and added questions from intervention studies[41] which I adapted to be relevant to RC negative participants (for purposes of moderation analysis)	Aim 4 TPB: Perceived behavioral control Enabler/ constraint			No
Attitudes toward having child	2 investigator-developed questions about perception of positive and negative consequences	Aim 3 and 4 TPB: attitude toward having a child			
Perceived norms toward having a child	1 investigator-developed question about acceptance by family and friends	Aim 3 and 4 TPB: Perceived			

		norms toward having a child			
Perceived behavioral control toward having a child	3 investigator-developed questions about confidence in ability to use contraception, get partner to use contraception, and preventing pregnancy 2 investigator-developed questions about fatalistic attitudes toward pregnancy, adapted from predetermination dimension items from the Fatalism Scale[42]	Aim 3 and 4 TPB: Perceived behavioral control toward having a child			

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APPENDICES

Appendix A: Study Protocols

Exploring Correlates of Reproductive Coercion Among Low-Income Latina Women

Study Protocols

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[Removed to preserve formatting of dissertation TOC]

Welcome

Your willingness to conduct this important work is greatly appreciated and your role in this project is central to its success.

The purpose of this manual is to give you the tools and support you will need to conduct this work. You will be responsible for various facets of this data collection process including recruiting participants, answering participant questions, maintaining confidentiality, ensuring safety protocols are followed and reporting progress to the team.

IPV and reproductive coercion are well documented as having significant consequences for women's health. It is our hope that this project will strengthen the response to address the unique health needs of survivors and to promote prevention.

NONE of this can be done without you, so thank you for being a part of this dissertation research project.

RA Training Plan

Project Title: Exploring Correlates of Reproductive Coercion Among Low-Income Latina Women
Principal Investigator: Nancy Glass (Johns Hopkins University)
PhD Candidate: Karen Grace

Overview:
Our overall goal is to explore the experience of, risk factors for, and strategies used to resist reproductive coercion, and the relationship with unintended pregnancy, among low-income Latina women, in order to inform healthcare practice guidelines and interventions. Therefore, we are conducting an exploratory sequential mixed methods study to examine 4 study aims in two phases: In Phase 1, adult Latina women who report reproductive coercion will participate in in-depth interviews to describe experiences with reproductive coercion, risk factors and safety strategies, and pregnancy intention. Findings from Phase 1 will inform the quantitative phase (Phase 2), the administration of a linguistically appropriate survey on lifetime and past-year prevalence of IPV and reproductive coercion, risk factors, and unintended pregnancy with up to 500 Latina women seeking services at our partner urban health center.

Description of RA responsibilities may include:

- Phase 1: Contacting participants to arrange for interviews, conducting interviews.
- Phase 2: Recruiting participants at data collection sites, administering tablet-based survey.
- Following all study IRB approved protocols and procedures.
- Attending RA and team meetings.
- Communicating with PhD candidate about all schedule changes and study related issues.
- Other research related activities as assigned by PhD candidate and/or PI

Training/Reading to be done on your own

- ☐ All documents will be shared via email

HUMAN SUBJECTS:
- ☐ Complete per JHU IRB requirements

REPRODUCTIVE COERCION:
- ☐ Read
  - American College of Obstetricians & Gynecologists. (2013). Reproductive and sexual coercion. Committee opinion no. 554. *Obstetrics & Gynecology*, *121*(2), 411–415. http://doi.org/http://10.1097/01.AOG.0000426427.79586.3b
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PROJECT OVERVIEW:
- ☐ Review IRB Protocol

RECRUITMENT AND RETENTION in IPV Research:
- ☐ Read
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Important contact information

First Name	Last Name	Acad	Organization	Title	Email	Phone
Karen	**Grace**	PhD(c), MSN, CNM	Johns Hopkins University	PhD Candidate	Kgrace2@jhu.edu	347-742-8108 Public study phone #: 202-780-7057
Nancy	**Glass**	PhD, MPH, RN, FAAN	Johns Hopkins University School of Nursing	Professor (PI)	nglass1@jhu.edu	410-614-2849 off 443-257-9947 cell

Data Collection Sites

Site	Address, phone	Main Contact at Site	Site- Specific Notes
Mary's Center – Adelphi	8908 Riggs Road Adelphi, MD 20783 (301) 422-5900	**Eunice Espinal** – Director of Operations & Patient Support 301-422-5933 eespinal@maryscenter.org **Siomara Segovia** – Nurse Manager 240-485-3180 ssegovia@maryscenter.org	
Mary's Center – Flower Ave	8709 Flower Avenue Silver Spring, MD 20901 (240) 485-3160		
Mary's Center – Georgia Ave	3912 Georgia Ave, NW Washington, DC 20011 (202) 483-8196	**Juan C. Miranda** - Director of Operations Office: (202)545-2085 Cell: (202)697-0345 jmiranda@maryscenter.org	
Mary's Center – Ontario Rd	2333 Ontario Road, NW Washington, DC 20009 (202) 483-8196		
Mary's Center – Fort Totten	100 Gallatin St NE Washington, DC 20011 844-796-2797	**Megan Bailey, RN** – Nurse Manager 202-847-4258 mbailey@maryscenter.org **Anis Bajramovic** - Senior Director of Patient Services Director of Operations (202) 420-7190 (Direct) (412) 607-1678 (Cell) abajramovic@maryscenter.org	

Project Summary

What is this study about?

Reproductive coercion is abusive or controlling behavior that interferes with autonomous reproductive health decision-making by women. It is a type of intimate partner violence (IPV) that is strongly correlated with unintended pregnancy. Reproductive coercion disproportionally affects low-income Latina women, but little is known about the experience of reproductive coercion among Latina women, nor the factors that may increase their vulnerability, strategies used to increase safety, or the risk of negative health outcomes such as unintended pregnancy. Therefore, this exploratory sequential mixed-methods study aims to define reproductive coercion and to examine risk factors, safety and harm reduction strategies and the health outcome of unintended pregnancy among Latina women. This research will contribute substantially to filling identified gaps in the reproductive coercion literature. Further, this study is significant and innovative by: 1) exploring reproductive coercion with an underserved group that has not previously been studied; and 2) examining risk factors and safety strategies to prevent or respond to reproductive coercion and improve health outcomes. The findings will contribute to reducing disparities in Latina women's health by building the knowledge essential for advancing interventions to identify reproductive coercion and support women in developing safety and harm reduction strategies and reducing negative health outcomes.

Who is eligible to participate?

Phase 1 of this study will include approximately 20 participants, and Phase 2 will include up to 500 participants. Participants must meet the following inclusion criteria:

- Biological female
- Age 18-45
- Self-identify as Hispanic or Latina
- Able to speak and understand English or Spanish
- For Phase 1 only: self-report of lifetime experience of reproductive coercion
- For Phase 2 only: In a partnered relationship in your lifetime
- For Phase 2 only: Age 15-17 and currently receiving confidential services at clinical site
- Not experiencing an emergent need for medical care
- Able to provide informed consent

What will study participants be asked to do?

- Phase 1: Participate in an in-depth interview (about an hour)
- Phase 2: Complete a brief survey (10-15 min) on a tablet device in the clinic, or at home using a link to the survey
- Phase 1 participants will receive a $20 gift card for their time.
- Phase 2 participants can choose to enter a raffle for one of 20 $50 gift cards to thank them for their time.

Recruitment Procedures

INTRODUCING THE STUDY TO PATIENTS

Phase 1:
Family Support Workers and other staff who work with IPV survivors will introduce the study to potential participants who meet eligibility requirements (women aged 18-45 who self-identify as Hispanic or Latina) using a study script:

> A researcher (who speaks Spanish) is doing a study here at Mary's Center, and she is looking for survivors of domestic violence to interview about their health and their relationships. She is offering a $20 Target gift card to anyone who completes the interview, to thank them for their time. If you are interested in participating I will give her your safe contact information (phone number and/or email address) and she will contact you at a time you say is safe, to discuss the details and to see if you are eligible to participate. Are you interested in participating?
>
> *Una investigadora (que habla español) está haciendo un estudio aquí en Mary's Center, y está buscando sobrevivientes de violencia doméstica para entrevistar sobre su salud y sus relaciones. Ella está ofreciendo una tarjeta de regalo para Target de $20 a cualquier persona que complete la entrevista, para agradecerles por su tiempo. Si usted está interesada en participar le daré su información de contacto segura (número de teléfono y / o dirección de correo electrónico) y ella se comunicará con usted en un momento que diga que es seguro, para discutir los detalles y para ver si usted es elegible para participar. ¿Está interesada en participar?*

If the survivor is interested in participating but declines to provide any contact information, the FSW may provide her with the study phone number to call when she is able to.

Phase 2: In Clinic
An RA will sit in the clinic waiting room during agreed-upon hours. At ½ hour intervals (as appropriate) she will announce that she is conducting a women's health study, and ask if anyone is interested. If anyone is interested they will approach the RA to express interest, and accompany the RA to a private area in the clinic to be screened for eligibility using the following script:

> This is a research study about that is looking at women's health and relationships, how couples handle problems in their relationships, and how couples make decisions about having a baby. If you are interested you will answer the questions on this tablet to see if you are eligible to participate, and if you are you can complete the survey now on this iPad, which will take about 10 minutes. If you get called for your appointment you can finish the survey afterwards. After the survey you will have the opportunity to enter a raffle drawing for a chance to win a $50 gift card to Target, if you want to. Would you like to participate in the study?
> *Este es un estudio de investigación sobre la salud y las relaciones de las mujeres, cómo las parejas manejan problemas en sus relaciones y cómo las parejas toman decisiones sobre tener un bebé. Si está interesada responderá a las preguntas de esta tableta para ver si es elegible para participar, y si la*

es, puede completar la encuesta ahora en este iPad, lo que tomará unos 10 minutos. Si se le llama para su cita, puede terminar la encuesta después. Después de la encuesta tendrá la oportunidad de participar en un sorteo para tener la oportunidad de ganar una tarjeta de regalo de $50 a Target, si así lo desea. ¿Le gustaría participar en el estudio?

If no:

Ok thank you, would you mind telling my why you aren't interested?

Bueno, gracias, ¿le importaría decirme por qué no está interesada?

If they are interested but are not able to complete the survey on that day, the RA will offer a flyer with a link to complete the survey online from home, if the participant says it is safe to do so.

The PhD candidate will also conduct information sessions with providers and staff at each site, about the purpose of the study. There, she will provide copies of the pamphlet that providers and staff can distribute to potential participants on days when the data collectors are not in the clinic.

USE TRACKING SHEET TO DOCUMENT THOSE WHO DECLINED TO PARTICIPATE

Frequently Asked Questions At Recruitment

Q. What is the compensation/how do I get the compensation?

Phase 1: To thank you for your time, you will receive a $20 gift card to Target after the interview is over.

Phase 2: After the survey you will have the opportunity to enter a raffle drawing for a chance to win a $50 gift card to Target if you want to. 20 gift cards will be given away in total.

Q. How long will the surveys take to complete?

The interview is expected to take about an hour.

The total time to complete the survey is approximately 10 -15 minutes.

Q. Is this study confidential? Will I have to give my name?

Phase 1: Your participation and all the information you give in the surveys is completely confidential. None of your answers will be shared with any of the clinic staff. We will have to provide the researchers with your safe contact information in order to see if you are eligible and to set up the interview, but that information will not be linked to your interview in any way, and it will be thrown away after the study is over.

Conducting Data Collection

PHASE 1

When the PhD candidate receives safe contact information for a potential participant, she will contact the participant at the time and method requested, and will use the following script:

Hello, my name is _____ from Johns Hopkins School of Nursing.
Hola, me llamo _____ de la Escuela de Enfermería Johns Hopkins.

Mary's Center provided me with your name as possibly being interested in my research study – is this a safe time to talk?
Mary's Center me dió su nombre como alguien que podría estar interesada en mi estudio de investigación - ¿es un momento seguro para hablar?

If no: ---End call as quickly as possible.

If yes*: Thank you for your interest in this study. The study is about women's health and relationships, and how couples make decisions about having a baby, especially when there is violence in the relationship. If you would like to participate, I will ask you some questions to see if you are eligible, and if you are, we will set up a time and a place to meet to do the interview. Would you like to see if you are eligible?*

Gracias por su interés en este investigación. La investigación se trata de la salud y la relación con pareja, y cómo parejas deciden tener un bebé, especialmente cuando hay violencia o abuso en la relación. Si usted quisiera participar, le haré algunas preguntas para ver si usted es elegible, y si es, estableceremos un tiempo y un lugar para reunimos para hacer la entrevista. ¿Quiere ver si es elegible?

If no:

Okay thank you, would you mind telling me why you aren't interested?[thank the person for his/her time and politely end call]

Bueno, gracias, ¿le importaría decirme porqué no está interesada? [thank the person for his/her time and politely end call]

If yes:

We will be collecting information about you during this phone call. Your taking part in this phone call is completely voluntary.
Your information will only be seen by researchers at Johns Hopkins. No one from Mary's Center will see your information.
We try to make sure that the information we collect from you is kept private and used only for the research study we are discussing. If you do not agree to continue the phone call, it will not affect your care at Johns Hopkins or at Mary's Center.
If you do not want to enroll in the study, or if you are not eligible to participate, your personal information will not be kept.
Estaremos colecionando información sobre usted durante esta llamada telefónica. Su participación en esta llamada telefónica es completamente voluntaria.
Su información sólo será vista por los investigadores de Johns Hopkins. Nadie del Mary's Center verá su información..
Intentamos asegurarnos que la información que recopilamos de usted se mantiene privada y se utiliza sólo para la investigación que estamos hablando. Si no está de acuerdo continuar la llamada telefónica, no afectará su atención en Johns Hopkins o en el Mary's Center.
Si no desea inscribirse en la investigación , o si no es elegible para participar, su información personal no seria guardado.

Would you like to continue with the eligibility questions?

What is your sex? ¿Cuál es su sexo? If female, continue to next question.
How old are you? ¿Cuantos años tiene? If age 18-45, continue to next question
Is your ethnicity Latina, Hispanic, or Spanish? ¿Su origen étnico es Latina, hispana o española? If yes, continue to next question.
The next set of questions asks about your choices regarding your decision and your partner's involvement in your decision to have or not have children. El siguiente conjunto de preguntas le

preguntará acerca de sus decisiones con respecto a su decisión y la participación de su pareja en su decisión de tener o no tener hijos.

1. *In your lifetime, has someone you were dating or going out with tried to force or pressure you to become pregnant, or to end a pregnancy?*
   En su vida, ¿un pareja ha intentado forzarla o presionarla salir embarazada, o para terminar un embarazo?
   Yes – *Thank you, you are eligible to participate in this study. Gracias, usted es elegible para participar en este estudio.*
   No - continue to next question
2. *In your lifetime, has someone you were dating or going out with told you not to use any birth control (such as pills, shot, ring, etc.)?*
   En su vida, ¿un pareja le ha dicho que no use ningún método anticonceptivo (como píldoras, inyecciones, anillos, etc.)?
   Yes – *Thank you, you are eligible to participate in this study. Gracias, usted es elegible para participar en este estudio. yes*
   No - continue to next question
3. *In your lifetime, has someone you were dating or going out with said he would leave you if you did not get pregnant or did not end a pregnancy?*
   En su vida, ¿un pareja le ha dicho que la dejaría si no quedaba embarazada o no terminaba un embarazo?
   Yes – *Thank you, you are eligible to participate in this study. Gracias, usted es elegible para participar en este estudio.*
   No - continue to next question
4. *In your lifetime, has someone you were dating or going out with told you he would have a baby with someone else if you did not get pregnant?*
   En su vida, ¿un pareja le ha dicho que él tendría un bebé con otra persona si usted no quedaba embarazada?
   Yes – *Thank you, you are eligible to participate in this study. Gracias, usted es elegible para participar en este estudio.*
   No - continue to next question
5. *In your lifetime, has someone you were dating or going out with taken off the condom while you were having sex so that you would get pregnant?*
   En su vida, ¿un pareja se ha quitado el condón alguien con quien salía cuando estaban teniendo relaciónes sexuales para que usted quedaria embarazada?
   Yes – *Thank you, you are eligible to participate in this study. Gracias, usted es elegible para participar en este estudio*
   No - continue to next question
6. *In your lifetime, has someone you were dating or going out with put holes in the condom so you would get pregnant?*
   En su vida, ¿un pareja ha hecho agujeros en el condón para que usted quedaría embarazada?
   Yes – *Thank you, you are eligible to participate in this study. Gracias, usted es elegible para participar en este estudio.*
   No - continue to next question

7. *In your lifetime, has someone you were dating or going out with broken a condom on purpose while you were having sex so you would get pregnant?*
   En su vida, ¿un pareja ha roto a propósito el condón cuando estaban teniendo relaciónes sexuales para que usted quedaría embarazada?
   Yes – *Thank you, you are eligible to participate in this study. Gracias, usted es elegible para participar en este estudio.*
   No - continue to next question
8. *In your lifetime, has someone you were dating or going out with taken your birth control (such as pills) away from you or kept you from going to the clinic to get birth control?*
   En su vida, ¿un pareja le ha quitado su método anticonceptivo (como las píldoras) o le ha impedido ir a la clínica para obtener un método anticonceptivo?
   Yes – *Thank you, you are eligible to participate in this study. Gracias, usted es elegible para participar en este estudio.*
   No - continue to next question
9. *In your lifetime, has someone you were dating or going out with made you have sex without a condom so you would get pregnant?*
   En su vida, ¿un pareja la ha obligado a tener relaciones sexuales sin condón para que usted quedaira embarazada?
   Yes – *Thank you, you are eligible to participate in this study. Gracias, usted es elegible para participar en este estudio.*
   No - continue to next question
10. *In your lifetime, has someone you were dating or going out with hurt you physically because you did not agree to get pregnant or would not end a pregnancy?*
    En su vida, ¿un pareja le ha causado daño físico debido a que usted no aceptó quedar embarazada o no terminó un embarazo??
    Yes – *Thank you, you are eligible to participate in this study. Gracias, usted es elegible para participar en este estudio.*
    No – continue to next question

11. *In your lifetime, has a family member done any of the things I have asked about in the previous questions? ¿En su vida, un miembro de la familia ha hecho alguna de las cosas que he preguntado en las preguntas anteriores?*
    Yes – *Thank you, you are eligible to participate in this study. Gracias, usted es elegible para participar en este estudio.*
    No – *I'm sorry but unfortunately you are not eligible for the study, but I thank you for your interest. Lo siento pero desafortunadamente usted no es elegible para el estudio, pero le agradezco su interés.*

Once the interview has been scheduled, the RA conducting the interview will meet the participant at the time and location arranged. Care should be taken to ensure the location

selected is relatively private, so that the participant cannot be overheard while being interviewed. The RA will bring the following items to the interview:

- Digital voice recorders (2)
- Extra batteries
- Microphone
- Gift card
- Paper and pen to record observations
- Paper consent form
- Demographics collection form
- Interview guide (questions)
- Bottle of water
- Tissues

Conducting the interview:

1. The RA will review the informed consent form with the participant and answer any questions.

The consent includes the fact that the interview will be audio-recorded. If permission is denied, the RA will take notes with pen and paper.

2. Ask participant to develop pseudonym for herself
    - Cannot begin with the same letter of her own name
    - Should not be identifiable to her in any way (no nicknames or street names)

3. Complete demographic questions

Begin Study Interview

4. Remind client they agreed to have the interview recorded and ask again if that is ok.
    - Turn on both tape recorders

5. Begin by saying date, time, location, and ID number of participant into tape recorder

6. Introduce study to the participant – it is about relationships and how couples make decisions about pregnancy, specifically in Latina women.

7. Remind them that interview is meant to be a conversation

8. Ask participant to be as honest as possible

9. When referring to partners or anyone else, do not use names. Instead, ask participant to use initials or pseudonyms.

10. Remind participant of **mandated reporting** so ask that she not divulge ages or names of partners

Guidance for interviewer:

a. The interview will follow the interview guide, allowing for tangential discussion and spontaneous questions that arise during conversation.
b. Ensure that you allow participant to complete her thoughts and move in any direction she wants to give her maximum amount of space to tell her story how she wants
c. Ask all numbered question on the interview guide (though it is not necessary that they be asked in order)
d. Reminder of goals of study:
    i. Understand how Latina women experience RC, at what point does the behavior become coercive?
    ii. Learn about strategies women use to protect themselves when a partner perpetrates RC
    iii. Explore cultural gender norms that may influence RC
    iv. Explore the experience of unintended pregnancy with Latina women. Do they experience pregnancy as something that can be planned for or prevented? Or is it something that "just happens"?

Complete interview

After the interview is completed the RA will stop the recording, **provide the participant with the $20 gift card** to thank her for her time, and the interview will conclude. **Document** on the paper it is attached to, the participant ID number and date. Do not give paper it is attached to to participant.

The RA will then **download the audio file off of the digital recorder** onto the study server.

Post Interview

- Connect one recorder to computer
- Upload audio to designated folder on R drive
- Rename audio file with participant ID number, primary or backup, and date of interview (e.g. 05 primary 01-01-14)
- Upload audio to Box folder
- Make notes on back of demographic form. A few bullets about anything noteworthy:
    a. Setting
    b. Body language
    c. Significant events during interview
    d. etc

PHASE 2

Patients who are interested in participating either at the clinic site or from home, will see the following information when they are handed the iPad or enter the link to the study website:

- Eligibility screening questions
- Informed consent information
- Survey
- Option to enter the raffle and request for safe contact information

Participants who agree to participate will be informed on the study website that they can contact an RA if they have technical problems with the website, questions or concerns about the study, or need help finding someone safe to talk to.

Informed Consent

This study is conducting informed consent for survey electronically via the study website. Potential participants will read through the consent information on the study website and their consent is documented by their completion of the survey.

Asking for Contact Info

This study will only ask for contact information in two cases:

1. Referrals from Family Support Workers of potential participants for Phase 1 of the study.
2. Phase 2 participants who want to enter the raffle for a $50 gift card.

People are often hesitant to give out personal contact information, especially to someone they've never met before. This is particularly true for DV survivors who may be extremely concerned about anyone finding out that they are experiencing abuse, or concerned for their safety if an abusive partner discovered participation. Phase 1 contact information is necessary to arrange for the in-depth interview appointment. If the participant declines to provide any contact information, but is still interested in participating, Mary's Center FSWs will provide her with the study phone number to call when she is able to. Phase 2 participants may participate without providing any contact information; entering the raffle is completely voluntary, and will not affect study participation. They may be reassured that the contact information is never linked to their study responses, and will be destroyed after the study concludes.

Gift Card Procedures

In Phase 1, gift cards will be provided to participants in person, immediately following the interview. If the interview is conducted by phone at the request of the participant, the RA will ask if they prefer to receive the gift card by email or by mail, and will transmit the gift card via their preference.

In Phase 2, participants will be asked at the close of the survey, how they would like to receive their gift card if they are selected as a winner (email or mail). They will be asked to enter the address for their preferred method. Gift cards will be provided via this method.

All contact information will be kept separately from study data, and will be destroyed after the study is completed.

At JHUSON – Post Survey Administration

11. Turn off Airplane Mode on tablet and connect to Hopkins network.
12. Allow data to upload.
13. Complete Recruitment and Accrual Spreadsheet

Recruitment and Accrual Techniques

Rapport

As a community-based research assistant, it's important for you to remember the role that empathy, tone of voice, body language, and sensitivity to class and cultural differences plays in our ability to establish rapport with participants. It is also very important to be aware of nonverbal cues and how they may affect our interactions with people, even over the phone.

Establishing Rapport: The ability to establish rapport with the participant will be essential to this study. You must convey empathy and understanding, listen carefully to the participant, and be nonjudgmental in order for anyone to want to participate and continue to participate. Respecting the participants and showing them that their knowledge, experience, and feelings are important is essential to good recruitment and retention. Establishing rapport starts with the very first contact, thus it's essential that with the first contact you come across not only as caring, but also as representing a credible project, involving important research.

Establishing a good rapport and making the right impression with your participant can be one thing that makes the difference between a completed interview and a refusal. Good rapport can also help ensure that the study will be interesting and rewarding for both you and your participant.

Rapport is established through:

- A friendly, yet professional demeanor.
- Creating an atmosphere of trust and respect.
- A relaxed approach.

Good rapport begins with how you conduct yourself as an RA. You should always present yourself as pleasant, professional, open-minded, and non-judgmental. Additionally, you must always keep in mind that the participants we are interviewing are our greatest assets. Their participation is critical to the success of the study. Our job is to treat participants with respect. During your initial contact, you have just a few moments to convince the participant to participate in the study. To be effective in doing so, you must demonstrate that you are:

- A professional.
- Calling from a legitimate and reputable organization.

- Engaged in **important** and **worthwhile** research.

Additionally, you need to communicate that the participant's participation is ***vital*** to the success of the project. The first few minutes of contact can set the stage and may determine whether or not the participant is willing to continue participating in the study.

There are four critical pieces of information that should be communicated to the participant during the introduction.

- Who you are
- Where you are calling/emailing from
- The purpose of your call/email
- Did they receive the flyer or advertisement (where appropriate)?

Introductions should not be read verbatim, but need to be well practiced and said with confidence. Shaky introductions may lead the participant to believe you don't really know what you're doing. Practice your introductory calls before you begin.

Emotions can be felt over the phone. Showing such emotions such as impatience, bossiness, or irritation can have an adverse effect on an interview, just as expressing confidence and friendliness can have a positive effect. Be careful of not only what you say, but how you say it. Likewise, you may pick up an impression of the participant just by the expression of their emotion. Your success on the job will depend on you not taking what the participant says or the participant's emotions personally.

Maintaining Neutrality: As the research assistant, you must maintain neutrality throughout the interview. Establishing neutrality gives the participant the ability to say anything without you showing either favor or disfavor. You must also not show shock, anger, or embarrassment. Rather, you must accept whatever the participant says without judgment.

Voice Volume: Different cultures assign meaning to different types of voice inflections. In the U.S., we tend to equate loud speech with anger and hostility and ascribe traits such as shy or withdrawn to people who speak softly. Sometimes we reinforce racial or ethnic stereotypes based on voice volume.

Directness of Conversation: Directness or frankness of conversation is often culturally specific. American culture demands that people "get to the point" or "cut to the chase," but being too direct or frank may be offensive to some cultural groups. This point is important when conducting interviews because research participants may feel isolated and unimportant because they believe that the research assistant has interrupted their comments. With some participants, it may be important to make small talk, compliment children, etc., to put the participant at ease.

Gaining Cooperation

Many of the participants will be willing to complete the survey with little or no hesitation. The main issue with participants for this study will be finding a convenient time and safe place to do it. Our job is to be flexible and proactive in helping her find those things. Ask questions to

determine what sorts of time constraints the participant has, and then be flexible and creative in finding a time that will work for the participant to do the surveys.

Give the impression of confidence. Speak clearly and in a relaxed voice. When interacting with a person over the telephone, using a strong voice and speaking at a good pace will give the person that you're talking to an impression that you are confident.

Give the impression of competence. Before you begin calling, make sure that you can confidently answer all potential questions about the study. Be familiar with the purpose of the study so that you give an impression of competence. Be able to answer participant questions about the research project.

Be polite and respectful. In all interactions on the phone, with participants or others who might answer the phone, you should be extremely polite and respectful. Even if you don't agree with what a person says or feels, you should respect their opinion. If a person is rude to you when you call, you should never respond in the same manner.

Be positive and show enthusiasm about the study. If you convey that you believe the study is important and worthwhile, it will affect the way people respond to your request to participate.

Be reassuring. Convey to them that their opinions are important. If they have concerns about the length, tell them you understand their concerns and reassure them that you'll make the interview go as quickly as possible.

Call the participant by name.

Smile. A smile can be felt over the phone.

Refusal Prevention

Maintaining a high recruitment rate (and a low number of refusals) is critically important to the success of any study. Therefore, gaining participant participation will be our first step in collecting valid and reliable data.

The majority of the time, you will encounter participants who are more than willing and ready to participate. However, in a small number of cases, you will speak with a participant who says that he or she does not wish to participate in the study. ***Don't panic.*** Don't be caught off guard. This section summarizes some actions you should take in these situations, and gives you some suggested responses you can give a participant who is hesitant to participate in the study.

Maintaining Interaction.

Your success at getting a person to cooperate increases as the length of your conversation increases; the more you talk with a person the harder it becomes for them to dismiss you. Use your skills as an RA to keep the interaction going.

Use continuing statements. Rather than asking closed ended questions, ask open-ended questions that force the participant to continue and lengthen the interaction.

Ask questions to maintain the conversation. Be empathetic ("I understand that your time is limited") and then try to change their mind ("but it's really important that we talk with a variety of women so that we can learn more to help develop resources for other who have gone through similar experiences").

Always be confident. Even if you're having difficulty with a participant, don't lose your confidence. If you do, your temptation will be to give up and get off the phone. Obviously, if you give in to that, your chances of changing the participant's mind drop significantly. Keep your confidence, be creative, and be imaginative. The worst that can happen is that the participant ends up saying no.

Persuasion Techniques

Make personal appeals

Compliments can be effective persuasion. Most people react favorably to praise. By doing so, you make them feel good about themselves and they are more likely to want to spend time with you. Or take time to comment on something personal that they mentioned to you earlier. Here are some examples:

- ✓ "I'm looking forward to talking with you."
- ✓ "You sound like you are very committed to the work you do."
- ✓ "Wow you have 3 kids, you must be so busy and I appreciate you taking the time to talk to me"

Negotiate

- Respond to every objection and/or concern. Take them one at a time.
- Keep listening.
- Remember to use phrases like "I see" or "I understand" to help show that you are listening and to validate their concerns.
- Always treat the exchange as a conversation. Stay relaxed and conversational. Don't be too aggressive or passive.
- Use short and convincing responses. Don't overwhelm the participant. They may stop listening. They may think that you are not listening to them.
- Familiarize yourself with the project and use this information effectively.
- Think positively.

Use your personality

- Show your enthusiasm for the project. Let them hear that spark when you talk about the project and its importance.
- Show your willingness to help them work out a good time to do the interview.
- Make a joke. Laughter can be the best way to win a participant over.
- Validate their concerns. Don't act like their concerns aren't important. Listen to what they have to say.
- Ask them what would make the interview work for them.
- Stay flexible and creative. We are pretty open-minded when it comes to keeping someone in the study. Make a suggestion—we'll listen!
- Be genuine. If you can be genuine in your enthusiasm about the project and in your desire to help make this work for the participant, you will be effective in dealing with and preventing refusals.

Strike a balance

- Assume that the participant trusts you and is willing to be convinced. However, back off as you see appropriate.
- Be respectful of their situation, comments, and wishes.
- Always stop before you upset the participant.
- No matter what happens, always leave the door open for yourself or another person to call back.

Ask Why?

Some participants have very definite and strong reasons why they don't want to participate. It is difficult to address those concerns in a convincing manner if we don't understand what they are. The most important thing you can do for the project when you encounter a hesitant participant is ask why they don't wish to participate. It's easy. A participant says, "I don't want to do this!" You say:

- ✓ "Oh, I understand. May I ask the reason you don't want to participate?"

Offer Solutions

- Most of the time, participants will just need some understanding, reminders about how beneficial their participation is, and genuine encouragement.
- Familiarize yourself with possible objections and responses and use this information effectively. For example:

  - ✓ She doesn't have internet right now. Can she use the library or a friend's computer? Could you look up other places with public computers that she may be able to use?

  - ✓ Is the time commitment too long? You can do the interview in parts, the program will save your answers if you need to leave and come back to it.

Be Creative

If you understand the participant's concerns, then you can work with them to find solutions. If the participant has a difficult situation, and you think of a creative way to deal with it, let them know you want to help.

Know When to Back Off

A general rule for an adamant "NO!" is to stay calm yourself. Respond with a gentle, neutral question to get them talking and to get them to be more specific about why they don't want to participate. Staying calm and gentle yourself will communicate your tone for the conversation, and that you are willing to talk and listen with them, despite their very strong feelings. If they give a specific reason, this can at least give you some points to work with.

When you sense that things are going downhill fast, back off entirely. Be sure to do this *before going too far.* Tell them you understand, validate their concern and thank them for talking with you.

- ✓ "It sounds like I've caught you at a bad time. Let me call you back later in the week."
- ✓ "Okay, I understand your concerns."

Leave the door open for them to change their mind. Let them know they can call back if they think about it and decide they want to participate.

SAFETY

Measures to protect the study participant will follow the guidelines set forth by the Nursing Research Consortium on Violence and Abuse (NRCVA). We are extremely concerned about the safety of women in our study and will implement procedures to minimize risk for both study participants and research assistants.

Confidentiality

Confidentiality is extremely important for the safety of IPV research participants and is a primary element of all protocols. Implementing important safety procedures in communicating with survivors and handling all study material and data will serve to protect participants' confidentiality and reduce potential for harm. All research participants will receive informed consent information prior to enrolling in the study. These consent forms inform study participants of their right to refuse to participate in the study, to refuse to answer a question, or stop their participation at any time. Participants are also told that the interview is confidential and their identities will not be revealed or linked to their individual responses. The identity of participants in the study must remain strictly confidential, as well as all information given by the participant during the course of the study. No information will be given out to anyone outside the research team.

Email: This study will involve some email communication with participants as well as study staff. Follow the following precautions to protect participants:

- When communicating by email with study team members about specific participants, only refer to participants using their study ID #, not their name.
- When responding to a participant's email, delete all previous correspondence in that email.
- Never confirm a participant's contact info by sending an email listing the actual contact info: "Can you please send me your new address. Is your address the same as when we last talked" is acceptable, but do not write" can I confirm your address, is it 1224 Main St?".

Participant Distress

Asking questions and talking about partner violence is extremely sensitive and may cause distress for some participants. You may encounter participants who become upset while answering screening questions. Some participants may want to share their story or details of the violence they are experiencing with you either on the phone or by email. Participants may also be in

active crisis when they contact the study team to enroll in the study, or may go into crisis at any time during the study and need assistance to find resources immediately.

If Participant becomes upset during a discussion:

1. Listen

2. Use Empathy and Validation

"I know these questions are really hard to think about, I appreciate you being willing to answer"
"That sounds difficult"
"I'm so sorry that happened "
"I can't imagine what you are going through, anyone in your shoes would feel the same"

1. Offer Resources

"If you need to talk to someone I can give you a resource that may be able to help"

Only give study approved resource list:

Domestic Violence Hotline
Website: http://www.thehotline.org
Phone: 1-800-799-7233
Chat: http://www.thehotline.org

GLBT National Help Center:
Website: http://www.glbtnationalhelpcenter.org
Phone: 1-800-246-7743
Chat: http://www.glnh.org/talkline/

Suicide Hotline
Website: http://www.suicidepreventionlifeline.org
Phone: 1-800-273-TALK (8255)
Chat: http://www.suicidepreventionlifeline.org/GetHelp/LifelineChat.aspx

Do not share your own stories. Do not share other participant stories. Never tell a person that she should or shouldn't feel a certain way. Never tell a person that you are surprised about something she said or did.

It is likely painful and embarrassing for a participant to discuss abuse with you, showing you care can make a person more comfortable. Most people who become emotional actively choose to continue with the study. Many people find relief in sharing their stories and expressing these emotions.
However, need to determine if the distress is too great to continue if the study is causing her harm.

Role of a Clinician versus role of a Research Assistant
When a participant becomes distressed, the Research Assistant is to avoid taking on the role of a counselor or advocate. Remember that regardless of your background, your function while

conducting interviews is primarily that of a Research Assistant. Remember to: (1) Never give advice; (2) Do not ask for details beyond the study scope.

Safety mechanisms during telephone contacts

Research Assistants will not use their personal phone numbers to make contact with participants but will use a google voice # dedicated to the study.

When telephone contact is made, the Research Assistant will follow a prepared script identifying herself. When the woman answers, she will always be asked if it is safe time to talk ("Is this an ok and safe time to talk?") before proceeding with the discussion. The woman will also be given the study number and instructed that she can hang up at any time without explanation and can call back when it is safe to resume the interview. She will also be given the code phrase, "I'm sorry I have to go now" that she can use to terminate the interview if she wants. If that code is used or if the Research Assistant is concerned about safety (due to suspicious sounds or other cues), the Research Assistant is trained to assess for immediate safety as follows:

- Are you in danger right now?
- Is someone making you feel unsafe now?
- Is that person in the room?
- Does the person have a weapon?
- Do you want me to call the police to come to your house now?"

If she says yes to the final question, the Research Assistant says "I will now call the police on another line and instruct them to go to your house. Once I have spoken with them I will get right back on the line with you and stay on the line with you until the police arrive."

If a woman says no (she does not want the police called), the Research Assistant says "Do you want me to stay on the line?"

If the woman says yes, the Research Assistant says, "You can hang up at any time. If you do, do you want me to call you back in 30 minutes to check to see if everything is ok?"

If the woman says yes, the Research Assistant calls back 30 minutes after the woman hangs up. When the Research Assistant calls back she opens the interview with the standard checking to see if this is a safe time to call, and asks again about calling the police if the woman says no. If the woman does not want to be called back but prefers to stay on the line, the Research Assistant will continue the conversation until the woman. If the woman hangs up then the Research Assistant will wait until the woman re-establishes contact.

These safety procedures were first developed by Dr. Holly Johnson and have been slightly modified and used successfully by Dr. Glass in previous telephone IPV studies. The investigators may be called at any time if a research staff is ever worried about how to proceed in an individual case.

Internet/Smartphone Safety

Abusers often misuse technology to locate, stalk, harass, monitor, scare, and control victims. It is common and easy to do.

- Participants given a choice of how to communicate with study, phone or email
- Safe device/email required at eligibility
- Internet/Smartphone safety info included in enrollment email about setting strong passwords, covering up tracks on web browsers, accessing private browsing, etc.
- RA's will learn about technology safety in order to assist participants:
    - http://www.womenslaw.org/laws_state_type.php?id=13404&state_code=PG&open_id=all
    - http://www.thehotline.org/2015/01/reducing-tech-footprints/
    - http://nnedv.org/projects/safetynet.html
- Study website password protected

Other Study Safety Protocols

RA's will document for every address, phone number, etc. if it is safe to use and under what conditions for each participant.

Adverse Events

If a research assistant learns of an unexpected or adverse event, the RA will immediately report it to the study coordinator or PI. If you are not sure if something qualifies as an adverse event, you must report it to the study coordinator or PI and the team will determine the next steps.

RA Safety

If at any time you encounter a situation in which you do not feel safe, do not hesitate to end your conversation immediately. Tell the participant that you would like to reschedule to talk with her another day or that you will be contacting her at a later time. This may become necessary if the participant responds in a hostile manner or is under the influence of alcohol or drugs or if someone comes and interrupts her. If you ever feel threatened, review the situation with the project coordinator/PI so the next step can be decided.

Vicarious Trauma and Self Care

Vicarious trauma is a result of the changes to your inner experience & world view linked to hearing about the trauma of others. Vicarious trauma is unavoidable when your work involves listening empathetically to traumatized people with the goal of helping. It's very important to assess for and manage the impact this work will have on you personally. Some ways to do that are:

- Avoid avoidance. Be aware of the changes that are occurring as a result of hearing traumatic stories and do not try to avoid that you are being affected.
- Avoid repeated invasion of trauma into your life (tv, movies, news…)
- Take care of your body (sleep, good food, exercise)

- Maintain a normal schedule
- Find meaning in your work and remind yourself of it
- Keep up support network inside and outside of work
- Use relaxation, meditation, etc.
- Find self care techniques that works for you and make it part of your lifestyle.

Study coordinator is available to call and debrief with after a difficult phone call or email exchange. Will discuss and support each other around this hard work in regular RA meetings.

Support

Many members of the research team are experts in the field of IPV and crisis intervention and can assist in an emergency or can consult on how to handle difficult situations. You are not alone!

If you need immediate assistance:

PhD Candidate: Karen Grace 347-742-8108 cell
PI: Nancy Glass 443-257-9947 cell

TABLE 1: Basic Safety Protocol When Conducting Research With Women Who Have Experienced Domestic Abuse

Borrowed from: Sullivan, Cris M, and Debra Cain. 2004. "Ethical and Safety Considerations When Obtaining Information from or about Battered Women for Research Purposes." *Journal of interpersonal violence* 19: 603–18.

1. Safety plan when first contacting potential research participants by telephone:

If a man answers:

• Ask for woman by first name.
• If he asks who you are:
• Give out very little information.
• Might say calling about a research survey.

If a woman answers:

• Don't assume it's the woman you're looking for.
• Ask for woman by first name.
• Assume the perp is either listening on an extension or is in the room with thewoman.
• When explaining the study, explain enough to gain her interest but not enough to endanger her if he is listening.
• Ask if this is a good time to talk.
• Listen for verbal cues that she might be unsafe or frightened.

By mail:

• Assume other people will read the mail.
• Do not mention that the study deals with domestic violence.
• Include a self-addressed stamped envelope so she can inform you not just if she's interested but if she does not want you contacting her again.

In person at courthouses, hospitals, social service agencies, and so forth:

• Make sure women are alone before approaching.

2. Safety plan when conducting in-person interviews:

Consider safety issues for women before, during, and after the interview.

If the interview does not occur at the woman's home:

• Provide safe transportation to and from interview site.
• If project staff transport her, make sure they know the route, watch for being followed, have a cell phone, and know where the local police station is in case they are followed.
• Conduct the interviewin a location that is well-lit and secure. Make sure a cell phone is available.

If the interview occurs at the woman's home:

• Stress that no other adults can be present during the interview for any reason.
• Have a "story" in place in case the perpetrator interrupts the interview (even if the woman insists he is at work, will not come home, etc.). You might carry cosmetic

products with you and pretend you are selling them door-to-door, or you might have a fake interview with you pertaining to women's health. You need to have your stories straight before being interrupted.

• Be prepared to stop the interview and continue at another time if safety is compromised.

• Every interviewer should carry a cell phone.

• Let the woman know that if the assailant comes to the home during the interview, it will be ended or postponed. Ask her if she has any concerns about his behavior and if she thinks hewould be upset if he sawthe interviewer. Ask her if shewants the police called if the assailant comes to the home and you leave. Ask if shewants to leave with you if he comes home.

3. Safety plan when contacting women over time:

• Have them sign Release of Information forms for family and friends to knowit is safe for them to tell you where she is over time. The form should simply say she is participating in a research study but should not give the topic of the study.

• Write downtimes and places it is safe to contact her as well as times and places it is unsafe
to contact her. (But do not assume these do not change over time.)

• Ask if it is safe to leave messages on her answering machine or voice mail, but even if it is,
never mention the nature of the study in the message.

• Consider using a code name (e.g., Bertha) so women relate that name to the project. The
name should be unusual enough that thewoman will remember the connection over time but not so unusual that it will raise other people's suspicions.

• Make surewomen have a safe and easyway to notify you if they change their minds about
participating for any reason (e.g., a business card with a toll-free number listed on it).

• Assume that some perpetrators will obtain your office telephone number and make sure
all project staff who might answer the phone are trained to deal with this safely. They should not share the true nature of the study with anyone who calls, and there should be a
generic study name that staff get used to using to refer to the study (e.g.,Women's Health
Study, Family Study). Perpetrators sometimes get women friends or relatives to find out information for them, and some perpetrators are female so do not let your guard downjust
because a woman is on the other end of the phone.

• If your research office has voice mail or an answering machine, the message should be vague and should not refer to violence or abuse.

In addition:

A. Do not assume a woman is no longer being abused simply because she is not in a
relationship any longer with the perpetrator.

B. Do not assume the woman is in the same situation she was in at a prior interview

(e.g., no longer living with the perpetrator).
C. Offer women written information about local domestic violence service programs
and community resources.
D. All research study staff who might have any contact with study participants should
be trained in basic safety planning.

Types of questions to ask participants if safety is an immediate concern:
- Are you safe right now?
- Do you want me to call the police for you?
- If we get disconnected, I'm going to call the police, okay?
- Do you have a personal protection order in place?
- Where can you go that you would feel safer?
- Can I give you the number of the local domestic violence shelter program?

Recruitment Materials and Consent Forms

Flyer for recruiting in clinic

Are you a Latina woman between the ages of 15-45?

If so, we need your help! Be part of a research study about women's health and relationships

WHAT YOU WOULD DO:

- Complete a short, confidential survey on a tablet computer while waiting for your appointment today
- The surveys will ask you questions about your health and relationships
- Your answers will be kept **PRIVATE**, and will not be shared with the clinic staff
- The total time will be 10-15 minutes

You may enter a raffle for a ***$50 gift card*** to thank you for your time – 20 chances to win!

Let the Research Assistant know if you are interested today

Flyer with study link

Are you a Latina woman between the ages of 18-45?

If so, we need your help! Be part of a research study about women's health and relationships

WHAT YOU WOULD DO:

- Complete a short, confidential survey on the internet
- The survey will ask you questions about your health and relationships
- Your answers will be kept **PRIVATE**, and will not be shared with anyone
- The total time will be 10-15 minutes

You may enter a raffle for a ***$50 gift card*** to thank you for your time – 20 chances to win!

If you are interested, go to this website to see if you are eligible!

www.xyz

Consent form

ORAL CONSENT SCRIPT (phase 1)

Protocol Title: Exploring Correlates of Reproductive Coercion in Low-Income Latina Women
Título del protocolo: Explorar los correlatos de la coerción reproductiva en las mujeres latinas de bajos ingresos

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You are being asked to take part in a research study. The purpose of this study is to learn about the risk factors for reproductive coercion, which is when men pressure women to get pregnant or to end a pregnancy. We expect a total of 20 women to participate in this part of the study, and 500 women to participate in the second part of the study (a survey).
Se le pide que participe en un estudio de investigación. El propósito de este estudio es conocer los factores de riesgo de la coerción reproductiva, que es cuando los hombres

presionan a las mujeres para quedar embarazadas o para terminar con un embarazo. Esperamos un total de 20 mujeres para participar en esta parte del estudio, y 500 mujeres para participar en la segunda parte del estudio (una encuesta).

You are being asked to participate in this research study because you are a woman between the ages of 18 and 45 who identifies as Latina or Hispanic, and who has had these sorts of experiences with a partner.
Se le pide que participe en este estudio de investigación porque usted es una mujer entre las edades de 18 y 45 que se identifica como latina o hispana, y que ha tenido este tipo de experiencias con un compañero.

If you agree to be in this study, you will be interviewed by a researcher in English or Spanish, which will take around one hour. The interview will be recorded on a digital recording device, and then transcribed (written down).
Si usted está de acuerdo en participar en este estudio, usted será entrevistado por un investigador en inglés o español, que tomará alrededor de una hora. La entrevista será grabada en un dispositivo de grabación digital, y luego transcrita (anotada).

The interview will ask questions about your relationship with your partner, your abuse experience, and questions about any past pregnancies.
La entrevista le hará preguntas sobre su relación con su pareja, su experiencia de abuso y preguntas sobre cualquier embarazo pasado.

Some of the questions you may be asked as part of the study may seem personal or embarrassing and may upset you. You may refuse to answer any of the questions that you do not wish to answer. If the questions make you very upset, we will help you to find someone safe to talk to or refer you to an appropriate service in your community. A research assistant will be available to answer any questions you may have during your study participation, and will also be able to provide you with information on personal safety and community resources during and at the end of your sessions. An additional risk of participating is that it is possible for an abusive partner to discover your participation and become angry. The information you share will be kept confidential.
Algunas de las preguntas que se le pueden hacer como parte del estudio pueden parecer personales o vergonzosas y pueden molestarle. Usted puede negarse a contestar cualquiera de las preguntas que no desea contestar. Si las preguntas la hacen muy molesto, le ayudaremos a encontrar a alguien seguro para hablar o a referirle a un servicio apropiado en su comunidad. Un asistente de investigación estará disponible para contestar cualquier pregunta que pueda tener durante su participación en el estudio y también podrá proporcionarle información sobre seguridad personal y recursos comunitarios durante y al final de sus sesiones. Un riesgo adicional de participar es que sea posible que un socio abusivo descubra su participación y se enoje. La información que usted comparta será mantenida confidencial.

You may not experience a direct benefit from participation in the study. However, the study will help to develop resources for women in the future. We value your time, so we will provide a $20 gift card after completing the interview. Further, your participation may provide you with an opportunity to learn about safety decisions and community resources available in relationship violence situations.
Quizás no tenga un beneficio directo de la participación en el estudio. Sin embargo, el estudio ayudará a desarrollar recursos para las mujeres en el futuro. Valoramos su tiempo, por lo que vamos a ofrecerle una tarjeta de regalo de $ 20 después de terminar

la entrevista. Además, su participación puede ofrecerle la oportunidad de aprender sobre las decisiones de seguridad y los recursos disponibles en la comunidad en situaciones de violencia en las relaciones.

You do not have to agree to be in this study. If you do not want to participate in the study, it will not affect your care at Mary's Center or Johns Hopkins.
No tiene que estar de acuerdo en participar en este estudio. Si no desea participar en el estudio, no afectará su cuidado en Mary's Center o Johns Hopkins.

If you have any questions about your rights as a research participant, or if you think you have not been treated fairly, you may call the Johns Hopkins Institutional Review Board (IRB) at 410-955-3008.
Si tiene alguna pregunta sobre sus derechos como participante en la investigación, o si cree que no ha recibido un trato justo, puede llamar a la Junta de Revisión Institucional de Johns Hopkins al 410-955-3008.

We will collect information about you in this study. Your privacy is important. Your interview will not be connected to your name or any identifying information. The transcribed interviews will be kept in password-protected files in the study office at JHU indefinitely. Your contact information, used to schedule this interview, will be destroyed. We will not use your identity for publication or publicity purposes.
Nosotros recogeremos información sobre usted en este estudio. Su privacidad es importante. Su entrevista no estará conectada a su nombre ni a ninguna información de identificación. Las entrevistas transcritas se guardarán en archivos protegidos por contraseña en la oficina del estudio en JHU indefinidamente. Su información de contacto, usada para programar esta entrevista, será destruida. No utilizaremos su identidad para propósitos de publicación o publicidad.

There are certain situations under which we would not be able to keep your information confidential. Under Maryland Law, suspected child abuse, elder abuse, or an imminent threat to others must be reported to the appropriate authorities. Additionally, if we learn that you are in danger of harming yourself, we will discuss it with you and assist you to seek help, and may be required to report to the appropriate authorities.
Hay ciertas situaciones bajo las cuales no pudiéremos mantener su información confidencial. Bajo la ley de Maryland, se debe reportar a las autoridades apropiadas sospechas de abuso infantil, abuso de ancianos o una amenaza inminente a otros. Además, si nos enteremos de que usted esté en peligro de hacerse daño, lo discutiremos con usted y le ayudaremos a buscar ayuda, y tal vez seamos obligados a informar a las autoridades pertinentes.

People at Johns Hopkins who are involved in the study or who need to make sure the study is being done correctly will see study information. People at Johns Hopkins may need to send your information to people outside of Johns Hopkins (for example the study sponsor) who are involved in the study or who need to make sure it is being done correctly. Johns Hopkins may also send your information to the sponsor.
La gente de Johns Hopkins que está involucrada en el estudio o que necesita asegurarse de que el estudio se está haciendo correctamente verá la información del estudio. Es posible que la gente de Johns Hopkins tenga que enviar su información a personas ajenas a Johns Hopkins (por ejemplo, el patrocinador del estudio) que están involucradas en el estudio o que necesitan asegurarse de que se está haciendo correctamente. Johns Hopkins también podría enviar su información al patrocinador.

These people will use your information for the purpose of the study.
Estas personas usarán su información para el propósito del estudio.

We will continue to collect information about you until the end of the study unless you tell us that you have changed your mind. If you change your mind and don't want your information used for the study anymore, you can call The Johns Hopkins Institutional Review Board at 410-955-3008. Just remember, if we have already used your information for the study, the use of that information cannot be cancelled.
Seguiremos recopilando información sobre usted hasta el final del estudio, a menos que nos diga que ha cambiado de opinión. Si cambia de opinión y no quiere que su información se utilice para el estudio, puede llamar a The Johns Hopkins Institutional Review Board al 410-955-3008. Sólo recuerde, si ya hemos utilizado su información para el estudio, el uso de esa información no se puede ser cancelado.

We try to make sure that everyone who needs to see your information uses it only for the study and keeps it confidential - but, we cannot guarantee this.

Intentamos asegurarnos de que todos los que necesiten ver su información lo utilicen sólo para el estudio y lo mantengan confidencial, pero no podemos garantizarlo.

Karen Grace, MSN, CNM, (202-780-7057) is available to answer any questions you may have about this study.
Karen Grace, MSN, CNM, (202-780-7057) está disponible para responder cualquier pregunta que pueda tener sobre este estudio.

Appendix B: Phase 1 Data Collection – Qualitative Interview Guide

1) *Ice breaker Questions:*
    a. Can you please tell me a little about yourself? ¿Puede decirme un poco sobre usted?
    b. Do you have children? ¿Tiene hijos?
        i. How many? ¿Cuántos?
        ii. Where do they live? ¿Dónde viven?
    c. What things do you like to do? ¿Qué cosas te gustan hacer?
    d. Tell me about your boyfriend or husband. How did you first meet? Cuéntame sobre su novio o esposo. ¿Cómo se conocieron?
        i. When did you get married? ¿Cuando se casó?
        ii. What does he do? ¿Que tipo de trabajo hace?

2) Can you tell me about a time you felt you needed to defer to your husband's decision about something even though you didn't agree with it? ¿Puede decirme acerca de una vez que sentía que necesitaba deferir a la decisión de su marido sobre algo a pesar de que no estaba de acuerdo con él?
3) What is the woman's role in the family, what should the woman's role be? What is the man's role in the family? ¿Cuál es el papel de la mujer en la familia, cuál debe ser el papel de la mujer? ¿Cuál es el papel del hombre en la familia?
4) Who is the center of the family? ¿Quién es el centro de la familia?
5) How does conflict get handled in your family? ¿Cómo se maneja el conflicto en su familia?
6) Who deserves the most respect in your family? ¿Quién merece más respeto en su familia?
7) Do you know the term "machismo"? ¿Conoce la palabra "machismo"?
    a. What does that term mean to you? ¿Qué significa para usted esa palabra?
    b. Can you give me an example of machismo in your life or your family? Or how it impacted an experience in your life? ¿Puede darme un ejemplo de machismo en su vida o en su familia? ¿O cómo afectó una experiencia en su vida?
    c. What do you think causes this kind of machismo behavior? Is it the influence of family? Friends? Religion?... ¿Qué crees que causa este tipo de comportamiento machista? ¿Es la influencia de la familia? ¿Amigos? ¿Religión?...

8) Do you know the term "marianismo"? ¿Conoces la palabra " marianismo "? [if needed, explain this usually means strongly feminine emphasizing submission and modesty, and can also mean strong mother who is central to the family - Esto suele significar fuertemente femenino enfatizando la sumisión y la modestia, y también puede significar una madre fuerte que es central para la familia]
    a. What does that term mean to you? ¿Qué significa para usted esa palabra?
    b. Can you give me an example of marianismo in your life or your family? Or how it impacted an experience in your life? ¿Puede darme un ejemplo de marianismo en su vida o en su familia? ¿O cómo afectó una experiencia en su vida?

9) *(If not currently pregnant)* If you were to find out you were pregnant right now, how would you feel about it? Si descubría que estaba embarazada en este momento, ¿cómo se sentiría?
    a. What do you think might be good about it? ¿Qué cree que podría ser bueno?
    b. What do you think might be bad or hard about it? ¿Qué cree que podría ser malo o difícil sobre ello?
10) If you did not want to be pregnant right now, would you be able to keep that from happening? How? Si usted no quería estar embarazada en este momento, ¿sería capaz de evitar que suceda? ¿Cómo?

11) If you were to find out you were pregnant right now, how would your family feel about it? How would your husband/partner feel about it? How would your friends react? Si usted descubriera que usted esté embarazada ahora, ¿cómo se sentiría su familia al respecto? ¿Cómo se sentiría su esposo / pareja? ¿Cómo reaccionarían sus amigos?
12) What does it mean to be "ready" to have a baby? How would someone know they are ready to have a baby, or how did you know you were ready? ¿Qué significa estar "listo" para tener un bebé? ¿Cómo alguien sabría que están listos para tener un bebé, o cómo sabía que estaba listo?

13) Can you tell me about a time when someone you were dating or going out with or married to ever told you he wanted you to get pregnant or have a baby? ¿Puede decirme acerca de un momento en que alguien con quien estaba saliendo o andando con o casada le dijo alguna vez que quería que se quede embarazada o tener un bebé? [probe also to see if any of these have occurred with people other than the partner, such as a family member]
    a. *Probes*
        i. How did your partner let you know that he wanted you to have a baby? ¿Cómo su pareja le hizo saber que él quería que usted tuviera un bebé?
        ii. What did it mean to you, that your partner wanted to have a baby with you? ¿Qué significó para usted, que su pareja quería tener un bebé con usted?
        iii. If you weren't ready to get pregnant, did you talk to your partner about your feelings? Tell me about that discussion. If not, why not? Did you feel like you could have a conversation with your partner about not wanting to be pregnant? Si usted no estaba lista para quedar embarazada, ¿habló con su pareja acerca de sus sentimientos? Háblame de esa discusión. Si no, ¿por qué no? ¿Te sientes como si pudieras tener una conversación con tu pareja acerca de no querer estar embarazada?
        iv. At what point did your partner saying this to you change from being a positive thing to a negative thing? ¿En qué momento el hecho de su compañero diciéndole esto se convirtió de una cosa positiva a una cosa negativa?
        v. Did you do anything to keep from getting pregnant? Did your partner find out about it? ¿Hizo algo para evitar quedar embarazada? ¿Tu pareja se enteró?
        vi. If you got pregnant, how did you feel about the pregnancy? Did anything change in your relationship with your partner? Are you still together with that partner? Si quedó embarazada, ¿cómo se sintió con respecto al embarazo? ¿Cambió algo en su relación con su pareja? ¿Sigue con ese compañero?
        vii. If you got pregnant, did you consider terminating the pregnancy (having an abortion)? Did you tell your partner about this? Why or why not? If you had an abortion, did you try to keep your partner from finding out about it? How did you do that? Si quedó embarazada, ¿pensó en terminar el embarazo (tener un aborto)? ¿Le contó a su pareja sobre esto? ¿Por qué o por qué no? Si usted tuvo un aborto, ¿trató de evitar que su pareja se enterara? ¿Cómo hizó eso?
        viii. How did you keep yourself safe in this situation? ¿Cómo se mantuvo a salvo en esta situación?
14) Can you tell me about a time when someone you were dating or going out with or married to told you not to use birth control? Who would not let you use birth control or interfered

with your use of it? Who threw your birth control away? Who poked holes in a condom or told you he was using a condom and later you found out he wasn't? ¿Puede decirme acerca de un momento en que alguien con quien estaba saliendo o andando con o casada le dijo que no usara anticonceptivos? ¿Quién no le permitiría usar anticonceptivos o interferiría con su uso? ¿Quién arrojó su control de natalidad? ¿Quién metió agujeros en un condón o le dijo que estaba usando un condón y más tarde se enteró de que no lo estaba?

   a. *Probes:*
      i. What emotions did you have, when you realized you had had sex without a condom? ¿Qué emociones tuvo cuando se dio cuenta de que había tenido sexo sin condón? *(adapt to response participant provides)*
      ii. Did you talk to your partner about your feelings about what had happened? Why or why not? Tell me about that conversation. ¿Habló con su pareja acerca de sus sentimientos acerca de lo que había sucedido? ¿Por qué o por qué no? Háblame de esa conversación.
      iii. Have you ever tried to hide your birth control to keep your partner from finding out about it? How did you hide it, or how did you keep him from finding out about it? ¿Alguna vez ha tratado de ocultar su control de natalidad para evitar que su pareja se entere de ello? ¿Cómo lo disimulo, o cómo le impidió descubrirlo?

15) Have you ever used or heard of birth control that may be harder for men to know you are using, like an IUD or an implant? Has a doctor or midwife ever told you about these methods or asked if you might want one? Do you think these methods would be helpful to someone in your situation? Why or why not? ¿Alguna vez ha utilizado o escuchado hablar de control de la natalidad que puede ser más difícil para los hombres saber que está usando, como un DIU o un implante? ¿Alguna vez le ha dicho un médico o partera acerca de estos métodos o le ha preguntado si podría querer uno? ¿Cree que estos métodos ayudarían a alguien en su situación? ¿Por qué o por qué no?

   a. *Probes:*
      i. How did you keep yourself safe in this situation? ¿Cómo se mantuvo a salvo en esta situación?

16) Can you tell me about a time when someone you were dating or going out with or married to told you he wanted you to terminate (abort) a pregnancy ¿Puede decirme acerca de un momento en que alguien con quien estaba saliendo o andando con o casada le dijo que quería que terminara (abortar) un embarazo?

   a. *Probes:*
      i. What did it mean to you, that he wanted you to terminate the pregnancy? ¿Qué significaba para usted que quería que terminara el embarazo?
      ii. Did you terminate the pregnancy? How did your partner respond? ¿Terminó el embarazo? ¿Cómo respondió su pareja?
      iii. Did you talk to your partner about your feelings about the pregnancy? Why or why not? ¿Habló con su pareja acerca de sus sentimientos acerca del embarazo? ¿Por qué o por qué no?
      iv. How did you keep yourself safe in this situation? ¿Cómo se mantuvo a salvo en esta situación?

17) Has the partner we have been discussing ever been violent with you? Have you ever been afraid of him? Has he ever threatened you physically? ¿El compañero con el que hemos estado hablando ha sido violento consigo? ¿Alguna vez le ha tenido miedo? ¿Alguna vez le ha amenazado físicamente?

   a. *Probes:*

i. Can you tell me more about that experience? ¿Me puede contar más sobre esa experiencia?
ii. How has this violence affected your health? ¿Cómo afectó esta violencia a su salud?

18) Have you sought help from anyone about any of these things we have been discussing (pregnancy pressure, birth control sabotage, violence)? ¿Ha buscado ayuda de alguien acerca de cualquiera de estas cosas que hemos estado discutiendo (presión de embarazo, sabotaje de control de la natalidad, violencia)?
    a. *Probes:*
        i. Who? ¿Quién?
        ii. Why did you not feel like you could seek help from anyone about this? ¿Por qué no sentía que podría buscar ayuda de alguien acerca de esto?
19) What kinds of things have you done to stay safe or to keep your family safe when this was happening? ¿Qué tipo de cosas ha hecho para estar a salvo o para mantener a su familia segura cuando esto estaba ocurriendo?
20) Is there anything you wish a doctor or midwife or social worker or anyone else had said or done that could have helped you? ¿Haya algo que desee que un médico o partera o trabajador social o alguien más haya dicho o hecho que podría haberle ayudado?
21) Is there anything else important that you would like to share that I didn't ask about? ¿Hay algo más importante que le gustaría compartir que no le pregunté?

General Prompts: Tell me more about that… Give me an example of that… Describe a time when… What does that look like?
Cuénteme más sobre eso ... Déme un ejemplo de eso ... Describa una época en que ... ¿Cómo es eso?

Appendix C: Phase 2 Data Collection – Quantitative Measures

Thank you for completing the Latina Women's Health Study survey!

We are studying relationships, health and safety for Latina women.
Thank you for your help!
Everything here is confidential. You can always:

- Skip questions you don't want to answer
- Take a break whenever you need one, if you feel upset or anxious when answering these questions.
- Contact us if we can help you find someone safe to talk with.

Your partner/ex-partner may become angry if he/she finds out about this study.
Always use a safe device (one that an abusive partner/ex-partner hasn't had and will never have
access to) for the survey, especially if you suspect your partner monitors your online activities. Contact us if you need help finding a safe device.

Please read the directions carefully on each page.

Let's get started!

[new page]

If you complete the survey, you will be eligible to enter into a random drawing of a $50 gift card good at all Target stores. There are 20 chances to win (20 cards will be given away). The winner of the $50 Target gift card will be notified by email. Your email address will be used ONLY to notify you if you win the drawing.

Your completion of this survey or questionnaire will serve as your consent to be in this research study.

¡Gracias por completar la encuesta del Estudio de Salud de Mujeres Latinas!

Estamos estudiando relaciones, salud y seguridad para las mujeres latinas.
¡Gracias por su ayuda!

Todo aquí es confidencial. Siempre puede:

- *Omitir las preguntas que no desea responder*
- *Tómese un descanso cuando lo necesite, si se siente molesto o ansioso al responder estas preguntas.*
- *Póngase en contacto con nosotros si podemos ayudarlo a encontrar a alguien seguro con quien hablar.*

Su pareja / ex pareja puede enojarse si se entera de este estudio.
Siempre use un dispositivo seguro (uno que un pareja abusivo / ex pareja haya tenido y que nunca tendrá acceso a) para la encuesta, especialmente si sospecha que su pareja supervisa sus actividades en línea. Póngase en contacto con nosotros si necesita ayuda para encontrar un dispositivo seguro.

Lea atentamente las instrucciones en cada página.

¡Empecemos!

[new page]

Si completa la encuesta, será elegible para participar en un sorteo al azar de una tarjeta de regalo de $ 50 en todas las tiendas Target. Hay 20 oportunidades de ganar (20 cartas serán regaladas). El ganador de la tarjeta de regalo Target de $ 50 será notificado por correo electrónico. Su dirección de correo electrónico se utilizará SOLAMENTE para notificarle si gana el sorteo.

Su realización de esta encuesta o cuestionario servirá como su consentimiento para estar en este estudio de investigación.

	English	**Spanish**	**Instruction**
		Eligibility	
1	*[iPad version of survey, administered in clinic]* How old are you? _____ **If <15 or >45:** *not eligible*. We are sorry, but you are *not eligible for this study*. If you have questions, please contact the study staff at 202-780-7057	 Cuantos años tiene Ud.? _____ **If <15 or >45:** *not eligible*. Lo sentimos, pero no es elegible para este estudio. Si tiene preguntas, por favor comuníquese con el personal del estudio al 202-780-7057	

	If 15-17: Are you visiting the clinic today for any of the following reasons? (This information is completely confidential, and will not be shared with anyone. It is used to determine study eligibility only.) <u>Birth control, a sexually transmitted infection (STD), or prenatal care</u> **No**: We are sorry, but you are *not eligible for this study*. If you have questions, please contact the study staff at 202-780-7057 **Yes**: *continues to next question:* **If 15-45:** *continues to next question*	**If 15-17**: ¿Está visitando la clínica hoy por alguna de las siguientes razones? (Esta información es completamente confidencial y no será compartida con nadie.) Se utiliza para determinar la elegibilidad del estudio solamente.) <u>Control de la natalidad, una infección de transmisión sexual o atención prenatal</u> **No**: Lo sentimos, pero no es elegible para este estudio. Si tiene preguntas, por favor comuníquese con el personal del estudio al 202-780-7057 **Sí:** *continues to next question* **If 15-45:** *continues to next question*	
1.	*[web-link version of survey, accessed from home]* How old are you? _____ **If <18 or >45:** *not eligible*. We are sorry, but you are *not eligible for this study*. If you have questions, please contact the study staff at 202-780-7057 **18-45:** *continues to next question*	 Cuantos años tiene Ud.? _____ **If <18 or >45:** *not eligible*. Lo sentimos, pero no es elegible para este estudio. Si tiene preguntas, por favor comuníquese con el personal del estudio al 202-780-7057 **18-45:** *continues to next question*	
2.	What is your gender? **Female**: *continues to next question* **Male** or **Other** We are sorry, but you are *not eligible for this study*. If you have questions, please contact the study staff at 202-780-7057	¿Cuál es su género? Mujer Hombre u otro Lo sentimos, pero no es elegible para este estudio. Si tiene preguntas, por favor comuníquese con el personal del estudio al 202-780-7057	

3.	How do you identify yourself in terms of ethnic origin? **Hispanic, Latina or Spanish Origin**: *continues to next question* **Not Hispanic, Latino or Spanish Origin** We are sorry, but you are *not eligible for this study*. If you have questions, please contact the study staff at 202-780-7057	¿Cómo se identifica en términos de origen étnico? Hispana, Latina, or Origen Español: *continues to next question* No Hispana, Latina, or Origen Español Lo sentimos, pero no es elegible para este estudio. Si tiene preguntas, por favor comuníquese con el personal del estudio al 202-780-7057	
4.	Have you had a sexual or romantic or dating partner at any point in the past year? **Yes**: *continues to next question* **No** We are sorry, but you are *not eligible for this study*. If you have questions, please contact the study staff at 202-780-7057	¿Ha tenido una pareja sexual, romántica o de citas en cualquier momento del año pasado? **Sí**: *continues to next question* **No** Lo sentimos, pero no es elegible para este estudio. Si tiene preguntas, por favor comuníquese con el personal del estudio al 202-780-7057	
		Demographics	
5.	*Thank you for deciding to participate in this research study.* *First we'd like to collect a little more information about you.* What is the highest level of education that you have completed? 8th grade or less	*Gracias por decidir participar en este estudio de investigación.* *Primero queremos recoger un poco más de información sobre usted.* ¿Cuál es el nivel más alto de educación que usted ha completado? 8º grado o menos Alguna escuela secundaria, pero no se graduó o obtuvo GED Diploma de escuela secundaria o GED	

	Some high school, but did not graduate or get GED High school diploma or GED Some college Associate's degree or vocational graduate 4 year college degree/Bachelor's degree Post-Baccalaureate/Master's degree/Doctoral degree	Alguna educación superior Grado de asociado o graduado profesional título universitario de 4 años / licenciatura Post-Bachillerato / Maestría / Doctorado	
6.	How do you identify yourself in terms of race? American Indian or Alaska Native Asian Black or African American Native Hawaiian or Pacific Islander White/Caucasian Mixed Other None of the above Refuse to answer	¿Cómo se identifica a sí mismo en términos de raza? India Americana o Nativa de Alaska Asiática Negra o afroamericana Nativa de Hawaii o de las islas del Pacífico Blanca / caucásica Mezclada Otra Ninguna de las anteriores Negarse a responder	
7.	Were you born in the United States? No Yes Don't Know Refuse to Answer	¿Nació en los Estados Unidos? No Sí No lo sé Negarse a responder	*skip to 7.2* *skip to 7.1*
7.1	Which generation of your family came to the United States? Parents Grandparents Great-grandparents Don't Know Refuse to Answer	¿Qué generación de su familia vino a los Estados Unidos? Padres Abuelos Bisabuelos No lo sé Negarse a responder	*skip to 8*

7.2	In what country were you born? Belize Bolivia Colombia Costa Rica Dominican Republic El Salvador Ecuador Guatemala Honduras Mexico Nicaragua Panama Peru Puerto Rico Other _____ Don't know Refuse to answer	¿En qué país naciste? Belice Bolivia Colombia Costa Rica República Dominicana El Salvador Ecuador Guatemala Honduras México Nicaragua Panamá Perú Puerto Rico Otros _____ No lo sé Negarse a responder	
7.3	How long have you lived in the United States? 5 years or less 6-10 years 11 years or more Don't Know Refuse to Answer	¿Cuánto tiempo ha vivido en los Estados Unidos? 5 años o menos 6-10 años 11 años o más No lo sé Negarse a responder	
8	Currently, how important is religion in your daily life? Would you say it is: Very important Somewhat important Not important	Actualmente, ¿qué importancia tiene la religión en su vida? ¿Usted diría que es: Muy importante Algo importante No importante	
9	Do you currently have a paying job?	¿Actualmente tiene un trabajo pagado?	

	No Yes Refuse to Answer	No Sí Negarse a responder	
10	Do you currently have health insurance? No Yes Don't Know Refuse to Answer	¿Tiene seguro de salud actualmente? No Sí No lo sé Negarse a responder	*skip to 11*
10.1	What type of insurance do you have? Private (Kaiser, BlueCross) Public (Medicare, Medicaid, SSI) Don't Know Refuse to Answer	¿Qué tipo de seguro tiene? Privado (Kaiser, BlueCross) Pública (Medicare, Medicaid, SSI) No lo sé Negarse a responder	
11	Have you ever been pregnant? No Yes	¿Alguna vez ha estado embarazada? No Sí	*skip to 12*
11.1	How many times have you given birth? 0 1 2 3 4 5 or more	¿Cuántas veces ha dado a luz? 0 1 2 3 4 5 o más	*If 0 skip to 11.2* *If 1 or more go to 11.1.1*
11.1.1	How many of your children live with you? ___	¿Cuántos de sus hijos viven con usted? ___	
11.1.2	How many children, under age 18, do not live with you? ___	¿Cuántos niños menores de 18 años no viven con usted? ___	*If 0 skip to 11.2*
11.1.3	Where do they live? In another country In this country, with family members Other _____	¿Dónde viven? En otro país En este país, con miembros de la familia Otros _____	

11.2	How many times have you had a miscarriage? ____	¿Cuántas veces ha tenido un aborto involuntario? ____	
11.3	How many times have you had an abortion? ___	¿Cuántas veces ha tenido un aborto? _____	
11.4	Are you currently pregnant? No Yes	¿Está embarazada actualmente? No Sí	*If yes skip to 13*
12	Are you planning to get pregnant in the next year? No Yes	¿Está planeando quedar embarazada en el próximo año? No Sí	
13	*Thinking about your current or most recent [next most recent] sexual or romantic or dating partner from the past year:* What is your current relationship with this person? Dating, but also dating other people Dating this person only Married Married but not legally None Other _____ (specify)	*Pensando en su pareja sexual o romántica o de citas más reciente [próximo más reciente] del último año:* ¿Cuál es su relación actual con esta persona? Citas, pero también con otras personas Conociendo a esta persona solamente Casado Casado pero no legalmente Ninguna Otra (especifica) _____	
Reproductive Coercion			
14	*The next set of questions asks about your choices regarding your decision and your partner's involvement in your decision to have or not have children, even if you are currently having or recently had sex with a woman:* *Still thinking about your current or most recent [next most recent] sexual or romantic or dating partner from the past year*	*El siguiente grupo de preguntas trata de sus decisiones con respecto a su decisión y la participación de su pareja en su decisión de tener o no tener hijos, incluso si actualmente tiene o ha tenido recientemente relaciones sexuales con una mujer:* *Aún pensando en su actual o más reciente [próximo más reciente] pareja sexual o romántica o de citas del año pasado*	

	In the **past year**, has this person tried to force or pressure you to become pregnant? No Yes Refuse to Answer	En el último año, ¿esta persona ha intentado obligarle o presionarle a quedar embarazada? No Sí Negarse a responder	
15	In the **past year**, has this person told you not to use any birth control (such as pills, shot, ring, etc.)? No Yes Refuse to Answer	En el último año, ¿le ha dicho esta persona que no use ningún método anticonceptivo (como la píldora, la inyeccion, el anillo, etc.)? No Sí Negarse a responder	
16	In the **past year**, has this person said they would leave you if you did not get pregnant? No Yes Refuse to Answer	En el último año, esta persona ha dicho que le dejaría si no queda embarazada? No Sí Negarse a responder	
17	In the **past year**, has this person told you they would have a baby with someone else if you did not get pregnant? No Yes Refuse to Answer	En el último año, ¿esta persona le dijo que tendría un bebé con otra persona si no quedó embarazada? No Sí Negarse a responder	
18	In the **past year**, has this person hurt you physically because you did not agree to get pregnant? No Yes Refuse to Answer	En el último año, ¿ha esta persona le duele físicamente, porque no estaba de acuerdo para quedar embarazada? No Sí Negarse a responder	
19	In the **past year**, has this person taken off the condom while you were having sex? No Yes Refuse to Answer	En el último año, ¿esta persona ha sacado el condón mientras tenías sexo? No Sí Negarse a responder	

20	In the **past year**, has this person put holes in a condom or broken a condom on purpose while you were having sex? No Yes Refuse to Answer	En el último año, ¿esta persona ha puesto agujeros en un condón o ha roto un condón a propósito mientras estaba teniendo sexo? No Sí Negarse a responder	
21	In the **past year**, has this person taken your birth control (such as pills) away from you or kept you from going to the clinic to get birth control? No Yes Refuse to Answer	En el último año, ¿esta persona le quitó su anticonceptivo (como píldoras) o le impidió ir a la clínica para obtener control de la natalidad? No Sí Negarse a responder	
22	In the **past year**, has this person made you have sex without a condom? No Yes Refuse to Answer	En el último año, ¿esta persona te obligó a tener sexo sin condón? No Sí Negarse a responder	
23	Is this person trying to get you pregnant? No Yes Refuse to Answer	¿Esta persona está tratando de impregnarle usted? No Sí Negarse a responder	*IF YES to 15 or 19-22, ask question 23*
24	In the **past year**, has this person tried to make you get an abortion when you wanted to keep the pregnancy? No Yes Refuse to Answer	En el último año, ¿esta persona ha tratado de hacerle un aborto cuando quería mantener el embarazo? No Sí Negarse a responder	
25	In the **past year**, did this person use violence or threats of violence to try to make you get an abortion when you wanted to keep the pregnancy? No Yes	En el último año, ¿utilizó esta persona violencia o amenazas de violencia para intentar hacer que usted abortara cuando quería mantener el embarazo? No Sí	

	Refuse to Answer	Negarse a responder	
26	In the **past year,** has this person tried to stop you from getting an abortion when you wanted to get an abortion? No Yes Refuse to Answer	En el último año, ¿esta persona ha intentado evitar que usted haga un aborto cuando quisiera abortar? No Sí Negarse a responder	
27	In the **past year**, did this person use violence or threats of violence to try to keep you from getting an abortion when you wanted to get an abortion? No Yes Refuse to Answer	En el último año, ¿utilizó esta persona violencia o amenazas de violencia para tratar de evitar que usted haga un aborto cuando usted quiso abortar? No Sí Negarse a responder	*IF YES TO ANY QUESTION IN 14-27, CONTINUE TO 28* *IF NO TO ALL QUESTIONS 14-27, skip to 47*
28	How old is this partner? _____	¿Qué edad tiene esta pareja? _____	
29	Do you currently live in the same household with this partner? No Yes Refuse to Answer	¿En la actualidad vive en la misma casa con esta pareja? No Sí Negarse a responder	
30	How long have you been together with this partner? 0-6 months 6 months to 1 year More than 1 year	¿Cuánto tiempo llevas con este pareja? 0-6 meses De 6 meses a 1 año Más de 1 año	
31	In what country was this partner born? Belize Bolivia	¿En qué país nació esta pareja? Belice Bolivia	

	Colombia Costa Rica Dominican Republic El Salvador Ecuador Guatemala Honduras Mexico Nicaragua Panama Peru Puerto Rico United States Other _____ Don't know Refuse to answer	Colombia Costa Rica República Dominicana El Salvador Ecuador Guatemala Honduras México Nicaragua Panamá Perú Puerto Rico Estados Unidos Otros _____ No lo sé Negarse a responder	
		IPV	
32	*In the next section I will be asking you questions about the different types of violence and threats of violence that women sometimes report experiencing in relationships. You may not have experienced these kinds of violence but many women have.* *Still thinking about your current or most recent [next most recent] sexual or romantic or dating partner from the past year:* Within the **last year**, have you been humiliated or emotionally abused in other ways by this partner? No Yes	En la próxima sección le haré preguntas sobre los diferentes tipos de violencia y amenazas de violencia que las mujeres a veces reportan experimentar en las relaciones. Puede que no haya experimentado este tipo de violencia, pero muchas mujeres lo han experimentado. Sigue pensando en su pareja sexual o romántica actual o más reciente [próximo más reciente] del último año: En el último año, ¿ha sido humillado o abusado emocionalmente de otras maneras por este pareja? No Sí No lo sé	

	Don't Know Refuse to Answer	Negarse a responder	
33	Within the **last year**, have you been afraid of this partner? No Yes Don't Know Refuse to Answer	En el último año, ¿ha tenido miedo de esta pareja? No Sí No lo sé Negarse a responder	
34	Within the **last year**, have you been raped or forced to have any kind of sexual activity by this partner? No Yes Don't Know Refuse to Answer	En el último año, ¿ha sido violada o forzada a tener cualquier tipo de actividad sexual por parte de este pareja? No Sí No lo sé Negarse a responder	
35	Within the **last year**, have you been kicked, hit, slapped or otherwise physically hurt by this partner? No Yes Don't Know Refuse to Answer	¿En el último año, le ha pateado, golpeado, abofeteado u otro daño físico por parte de este pareja? No Sí No lo sé Negarse a responder	
Substance Use			
36	*Now I am going to ask you some questions about your partner's use of alcoholic beverages during the past year (e.g., beer, wine, vodka, etc.). Still thinking about your current or most recent [next most recent] sexual or romantic or dating partner from the past year:* How often does your partner have a drink containing alcohol? Never Monthly or less 2-4 times a month	Ahora voy a hacerle algunas preguntas sobre el uso de bebidas alcohólicas por su pareja durante el año pasado (por ejemplo, cerveza, vino, vodka, etc.). Sigue pensando en su pareja sexual o romántica o pareja de citas más reciente [próximo más reciente] del último año: ¿Con qué frecuencia su pareja toma una bebida que contenga alcohol? Nunca Mensual o menos 2-4 veces al mes 2-3 veces a la semana	

	2-3 times a week 4 or more times a week	4 o más veces a la semana	
37	How many drinks containing alcohol does your partner have on a typical day when they are drinking? 1 or 2 3 or 4 5 or 6 7 to 9 10 or more	¿Cuántas bebidas que contiene alcohol tiene su pareja en un día típico cuando está bebiendo? 1 o 2 3 o 4 5 ó 6 7 a 9 10 o más	
38	How often does your partner have six or more drinks on one occasion? Never Less than monthly Monthly Weekly Daily or almost daily	¿Con qué frecuencia su pareja tiene seis o más bebidas en una ocasión? Nunca Menos de un mes Mensual Semanal Diario o casi diario	
39	How often during the last year has your partner been unable to remember what happened the night before because of their drinking? Never Less than monthly Monthly Weekly Daily or almost daily	¿Con qué frecuencia durante el último año su pareja ha sido incapaz de recordar lo que sucedió la noche anterior debido a su consumo de alcohol? Nunca Menos de un mes Mensual Semanal Diario o casi diario	
40	Has your partner or someone else been injured because of your partner's drinking? No Yes, but not in the last 6 months Yes, during the last 6 months	¿Ha sido su pareja o alguien más herido debido a la bebida de su pareja? No Sí, pero no en los últimos 6 meses Sí, durante los últimos 6 meses	

41	*The following questions concern information about your partner's possible involvement with drugs excluding alcohol and tobacco during the past year. When the words "drug abuse" are used, they mean:* *1. The use of prescribed or over-the-counter drugs in excess of the directions or* *2. Any non-medical use of drugs.* *The various types of drugs may include: cannabis (marijuana, hash), solvents, tranquilizers (Valium), barbiturates, cocaine, stimulants (speed), hallucinogens (LSD) or narcotics (heroin). Remember that the questions* ***do not*** *include alcohol or tobacco.* *Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right. Remember, everything in this interview is confidential.* *Still thinking about your current or most recent [next most recent] sexual or romantic or dating partner from the past year:* Has your partner used drugs other than those required for medical reasons? No Yes Refuse to answer	Las siguientes preguntas se refieren a la información sobre la posible participación de su pareja con drogas, excluyendo alcohol y tabaco durante el año pasado. Cuando se usan las palabras "abuso de drogas", significan: 1. El uso de medicamentos recetados o de venta libre que excedan las instrucciones o 2. Cualquier uso no médico de drogas. Los diferentes tipos de drogas pueden incluir: cannabis (marihuana, hash), disolventes, tranquilizantes (valium), barbitúricos, cocaína, estimulantes (velocidad), alucinógenos (LSD) o narcóticos (heroína). Recuerde que las preguntas no incluyen alcohol o tabaco. Por favor, responda todas las preguntas. Si tiene dificultad con una declaración, elija la respuesta que es mayormente correcta. Recuerde, todo en esta entrevista es confidencial. Sigue pensando en su pareja sexual o romántica o pareja de citas más reciente [próximo más reciente] del último año: ¿Ha usado su pareja drogas que no sean las requeridas por razones médicas? No Sí Negarse a responder	
42	Does your partner abuse more than one drug at a time? No Yes Refuse to answer	¿Su pareja abusa más de una droga a la vez? No Sí Negarse a responder	

43	Has your partner neglected their family because of their use of drugs? No Yes Refuse to answer	¿Su pareja ha descuidado a su familia por el uso de drogas? No Sí Negarse a responder	
44	Has your partner engaged in illegal activities in order to obtain drugs? No Yes Refuse to answer	¿Su pareja ha participado en actividades ilegales para obtener drogas? No Sí Negarse a responder	
45	Has your partner ever experienced withdrawal symptoms (felt sick) when they stopped taking drugs? No Yes Refuse to answer	¿Su pareja alguna vez ha experimentado síntomas de abstinencia (se sintió enfermo) cuando dejó de tomar drogas? No Sí Negarse a responder	
46	Has your partner had medical problems as a result of their drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)? No Yes Refuse to answer	¿Su pareja ha tenido problemas médicos como resultado de su uso de drogas (por ejemplo, pérdida de memoria, hepatitis, convulsiones, sangrado, etc.)? No Sí Negarse a responder	
47	Have you had any other sexual or romantic or dating partners in the past year? No Yes Refuse to Answer	¿Ha tenido otras parejas sexuales o románticas o de citas en el último año? No Sí Negarse a responder	*pattern needs to skip back to this question until answer is No* *skip to 49*
47.1	*Thinking about your last partner before the current one, or your next most recent partner*	*Pensando en su última pareja antes del actual, o su próxima pareja más reciente*	*go back to 14, changing*

			instructions to reference appropriate partner
Acculturation			
48	*These questions ask about what language you typically use in different situations.* What language do you speak at home? only Spanish Spanish more than English Spanish and English equally English more than Spanish only English Language other than English or Spanish	*Estas preguntas tratan del idioma que usa usted típicamente en diferentes situaciones.* Qué idioma habla usualmente en su hogar? Sólo Español Español más que Ingles Los Dos Por Igual English Más Que Español Sólo Inglés Idioma que no sea inglés o español	
49	What language do you speak with your friends? only Spanish Spanish more than English Spanish and English equally English more than Spanish only English Language other than English or Spanish	¿En qué idioma habla usualmente con sus amigos? Sólo Español Español más que Ingles Los Dos Por Igual English Más Que Español Sólo Inglés Idioma que no sea inglés o español	
50	What language do you read in? only Spanish Spanish more than English Spanish and English equally English more than Spanish only English	En general, ¿qué idioma Ud. lee? Sólo Español Español más que Ingles Los Dos Por Igual English Más Que Español Sólo Inglés Idioma que no sea inglés o español	

	language other than Spanish or English		
51	What language do you think in? only Spanish Spanish more than English Spanish and English equally English more than Spanish only English language other than Spanish or English	¿En qué idioma piensa usualmente? Sólo Español Español más que Ingles Los Dos Por Igual English Más Que Español Sólo Inglés Idioma que no sea inglés o español	
Unintended Pregnancy			
52	*The next set of questions ask about the times in your life when you have been pregnant* Have you been pregnant in the past year? No Yes Refuse to Answer	El siguiente conjunto de preguntas pregunta acerca de los tiempos en su vida cuando usted ha estado embarazada ¿Ha estado embarazada en el último año? No Sí Negarse a responder	skip to 0
53	***Please select the statement which <u>most</u> applies to you.*** *Thinking about this pregnancy that occurred in the past year:* **In the month that I became pregnant.....*:*** I/we were not using contraception I/we were using contraception, but not on every occasion I/we always used contraception, but knew that the method had failed (i.e. broke,	***Por favor seleccione la declaración que <u>más</u> corresponda para usted*** *Pensando en este embarazo que ocurrió en el último año:* En el mes en que quedé embarazada... No usé/usamos anticonceptivos Usé/usamos anticonceptivos, pero no en cada ocasión Siempre usé/usamos anticonceptivos, pero nos dimos cuenta de que fallaron por lo menos una vez (por ejemplo el anticonceptivo se rompió, se movió de su sitio, se desprendió, no funcionó, etc.) Siempre usé/usamos anticonceptivos	

	moved, came off, came out, not worked etc.) at least once I/we always used contraception		
54	**In terms of becoming a mother *(first time or again)*, I feel that my pregnancy happened at the.....** right time ok, but not quite right time wrong time	En lo que respecta a ser madre (por primera vez u otra vez), pienso que quedé embarazada… en el momento adecuado en un buen momento, pero no en el ideal en un mal momento	
55	**Just <u>before</u> I became pregnant.....** I intended to get pregnant my intentions kept changing I did not intend to get pregnant	Justo <u>antes</u> de quedar embarazada... planeaba quedar embarazada cambiaba de opinión constantemente al respecto no planeaba quedar embarazada	
56	**Just <u>before</u> I became pregnant....** I wanted to have a baby I had mixed feelings about having a baby I did not want to have a baby	Justo <u>antes</u> de quedar embarazada... quería tener un hijo tenía sentimientos contradictorios al respecto no quería tener un hijo	
57	<u>Before</u> I became pregnant.... My partner and I had agreed that we would like me to be pregnant My partner and I had discussed having children together, but hadn't agreed for me to get pregnant We never discussed having children together	<u>Antes</u> de quedar embarazada, Mi pareja y yo nos pusimos de acuerdo en que queríamos que quedara embarazada Mi pareja y yo habíamos hablado de tener hijos juntos, pero no llegamos a decidir que queríamos que quedara embarazada Nunca habíamos hablado de tener hijos juntos	
58	<u>Before</u> you became pregnant, did you do anything to improve your health <u>in preparation for pregnancy</u>?	<u>Antes</u> de quedar embarazada, ¿hizo algo para mejorar su salud <u>en anticipación para el embarazo</u>?	

	No Yes	No Si	*skip to 58.1* *skip to 58.2*
58.1	What was the main reason you did not do anything to improve your health in preparation for pregnancy? I was not trying to get pregnant I did not think I was able to get pregnant Other _____	¿Cuál fue la razón principal por la que no hizo nada para mejorar su salud en preparación para el embarazo? No estaba tratando de quedar embarazada No pensé que pude quedar embarazada Otros _____	*Skip to 59*
58.2	Which of the following things did you do to improve your health in preparation for pregnancy? took folic acid stopped or cut down smoking stopped or cut down drinking alcohol ate more healthily sought medical/health advice took some other action, please describe _____	¿Cuál de las siguientes cosas ha hecho usted para mejorar su salud en <u>anticipación</u> para el embarazo? tomé ácido fólico dejé de fumar cigarrillos o fumaba menos dejé de beber o bebía menos alcohol empecé a comer de una manera más saludable pedí consejo médico/de salud tomé otras medidas (explique) _____	
Safety Strategies			
59	*These questions ask about different things you may have done in the past year to keep from becoming pregnant* In the past year, have you used an injectable method of birth control (Depo Provera) or an implant method (like Nexplanon) or an IUD (like Paragard or Mirena)?	*Estas preguntas hacen sobre diferentes cosas que usted puede haber hecho en el último año para evitar quedar embarazada* En el último año, ¿ha utilizado un método inyectable de control de la natalidad (Depo Provera) o un método de implante (como Nexplanon) o un DIU (como Paragard o Mirena)?	*(if no) skip to 60*

	No Yes Refuse to Answer	No Sí Negarse a responder	
59.1	Did you choose this method so that your partner would not find out you were using birth control? No Yes Refuse to Answer	¿ Usted eligió este método para que su pareja no descubriera que usaba anticonceptivos? No Sí Negarse a responder	
60	In the past year, have you used the morning after pill or emergency contraception (Plan B, Ella, Take Action, My Way, etc.) to prevent a pregnancy? No Yes Refuse to Answer	En el último año, ¿ha utilizado la píldora del día siguiente o la anticoncepción de emergencia (Plan B, Ella, Take Action, My Way, etc.) para prevenir un embarazo? No Sí Negarse a responder	
61	In the past year have you terminated a pregnancy (gotten an abortion)? No Yes Refuse to Answer	¿En el último año ha terminado un embarazo (se le hizo un aborto)? No Sí Negarse a responder	*skip to 62*
61.1	Did you terminate the pregnancy (get an abortion) to keep your partner from being able to control you? No Yes Refuse to Answer	¿Terminó el embarazo (abortar) para evitar que su pareja pudiera controlarle? No Sí Negarse a responder	
61.2	Did you tell your partner you had terminated the pregnancy (had an abortion)? No Yes Refuse to Answer	¿Le dijo a su pareja que había terminado el embarazo (se le hizo un aborto)? No Sí Negarse a responder	*skip to 62*

61.3	What was the main reason you did not tell your partner you had terminated the pregnancy (had an abortion)? I was afraid of my partner I thought my partner would be upset or angry Other _____	¿Cuál fue la razón principal por la que no le dijo a su pareja que había terminado el embarazo (se le hizo un aborto)? Tenía miedo de mi pareja Pensé que mi compañero estaría molesto o enojado Otros _____	
62	In the past year, have you changed your method of birth control? No Yes Refuse to Answer	En el último año, ¿ha cambiado su método de control de la natalidad? No Sí Negarse a responder	*skip to 63*
62.1	Did you change your method of birth control so your partner could not tamper with (mess with) it? No Yes Don't know Refuse to Answer	¿Ha cambiado su método anticonceptivo para que su pareja no pueda manipularlo (meterse con él)? No Sí No lo sé Negarse a responder	
63	In the past year, have you hidden a method of birth control from your partner? No Yes Refuse to Answer	En el último año, ¿ha escondido un método anticonceptivo de su pareja? No Sí Negarse a responder	*skip to 64*
63.1	Did you hide a method of birth control because you were afraid your partner would get upset with you for using it? No Yes Refuse to Answer	¿Escondió un método anticonceptivo porque temía que su pareja se enojara con usted por usarlo? No Sí Negarse a responder	

64	Have you ended a relationship in the past year? No Yes Refuse to Answer	¿Ha terminado una relación en el último año? No Sí Negarse a responder	*skip to 65*
64.1	Did you end the relationship because it felt unhealthy, unsafe, or abusive? No Yes Refuse to Answer	¿Terminó la relación porque se sentía insalubre, inseguro o abusivo? No Sí Negarse a responder	
65	Has a partner ever accused you of getting pregnant or trying to get pregnant in order to "trap" them or to keep the relationship? No Yes Refuse to Answer	¿Alguna vez un pareja se acusó de quedarse embarazada o intentar quedar embarazada para "atraparlos" o mantener la relación? No Sí Negarse a responder	
66	*How much do you Agree or Disagree with the following statements:* If I was to get pregnant right now it would be extremely difficult for me to deal with Strongly agree Agree Undecided Disagree Strongly Disagree Don't Know Refuse to Answer Not Applicable	¿Hasta qué punto está de acuerdo o en desacuerdo con las siguientes afirmaciones: Si yo fuera a quedar embarazada en este momento sería muy difícil para mí tratar Totalmente de acuerdo De acuerdo Indeciso Discrepar Muy en desacuerdo No lo sé Negarse a responder No aplica	
67	If I was to get pregnant right now it would be a very positive thing in my life Strongly agree	Si yo fuera a quedar embarazada en este momento sería una cosa muy positiva en mi vida Totalmente de acuerdo	

	Agree Undecided Disagree Strongly Disagree Don't Know Refuse to Answer Not Applicable	De acuerdo Indeciso Discrepar Muy en desacuerdo No lo sé Negarse a responder No aplica	
68	Most people in my life (family and friends) would be happy if I got pregnant right now Strongly agree Agree Undecided Disagree Strongly Disagree Don't Know Refuse to Answer Not Applicable	La mayoría de la gente en mi vida (familia y amigas) estaría feliz si quedé embarazada ahora mismo Totalmente de acuerdo De acuerdo Indeciso Discrepar Muy en desacuerdo No lo sé Negarse a responder No aplica	
69	I am confident that I can keep from getting pregnant when I don't want to be Strongly agree Agree Undecided Disagree Strongly Disagree Don't Know Refuse to Answer	Estoy seguro de que puedo evitar quedarme embarazada cuando no quiero ser Totalmente de acuerdo De acuerdo Indeciso Discrepar Muy en desacuerdo No lo sé Negarse a responder	
70	Using contraception regularly is difficult for me Strongly agree Agree Undecided Disagree Strongly Disagree Don't Know	Usar anticonceptivos con regularidad es difícil para mí Totalmente de acuerdo De acuerdo Indeciso Discrepar Muy en desacuerdo No lo sé	

	Refuse to Answer	Negarse a responder	
71	Getting my partner to use contraception is difficult for me Strongly agree Agree Undecided Disagree Strongly Disagree Don't Know Refuse to Answer Not Applicable	Conseguir que mi pareja use la anticoncepción es difícil para mí Totalmente de acuerdo De acuerdo Indeciso Discrepar Muy en desacuerdo No lo sé Negarse a responder No aplica	
72	If someone is meant to get pregnant, it doesn't matter what they do to prevent it, they will get pregnant anyway Strongly agree Agree Undecided Disagree Strongly Disagree Refuse to Answer	Si alguien está destinado a quedar embarazada, no importa lo que hagan para prevenirlo, se quedarán embarazadas de todos modos Totalmente de acuerdo De acuerdo Indeciso Discrepar Muy en desacuerdo Negarse a responder	
73	The number of kids I will have is determined by fate. Strongly agree Agree Undecided Disagree Strongly Disagree Refuse to Answer	El número de niños que tendré está determinado por el destino. Totalmente de acuerdo De acuerdo Indeciso Discrepar Muy en desacuerdo Negarse a responder	
	Thank you for completing the survey! You are eligible to enter into a random drawing of a $50	**¡Gracias por completar la encuesta! Usted es elegible para participar en un sorteo al azar de una tarjeta de**	

	gift card to Target stores. There are 20 chances to win the gift card (20 cards will be given away). The winner of the $50 Target gift card will be notified by email. Your email address will be used ONLY to notify you if you win the drawing.	**regalo de $ 50 a las tiendas Target. Hay 20 oportunidades para ganar la tarjeta de regalo (20 cartas serán regaladas). El ganador de la tarjeta de regalo Target de $ 50 será notificado por correo electrónico. Su dirección de correo electrónico se utilizará SOLAMENTE para notificarle si gana el sorteo.**	

BIOGRAPHICAL SKETCH

Karen Trister Grace was born in 1969 in the USA. She received a Bachelor of Arts from Barnard College, a BSN and MSN from the University of Pennsylvania School of Nursing, and while completing her PhD at Johns Hopkins School of Nursing she also received a Certificate in Health Disparities & Health Inequality from the Bloomberg School of Public Health. She began her teaching career began as an Instructor in Clinical Nursing at Columbia University School of Nursing, and later became a clinical instructor at New York University College of Nursing and a Clinical Assistant Professor at SUNY Downstate's Midwifery Education Program. After relocating to Washington, DC, she joined the faculty at Georgetown University's Nurse-Midwifery/WHNP Program, where she ultimately became the Assistant Program Director and Interim Program Director, until beginning doctoral studies at Johns Hopkins. During her time at Hopkins she was a co-investigator on an Alliance for Healthier Worlds Planning Grant (Prioritizing gender equity in midwifery care: improving maternal and newborn health through nurse-midwifery leadership development in Tanzania), and a research assistant on the IPV Provider Network: Engaging the Health Care Provider Response to Interpersonal Violence Against Women grant (HHS, Office on Women's Health ASTWH150032-01-03), the Sexual Safety and Sexual Security: Explorations of Relationship Dynamics among Black Emerging Adult Heterosexual Men (BEAHM) project, and the Effectiveness of a Safety App to Respond to Dating Violence for College Women grant (NICHD R01HD076881). She was also a Pre-doctoral Trainee in the Predoctoral Clinical Research Training Program (NIH/NCATS TL1-TR001078) and in the Interdisciplinary Research Training on Violence in the Family (NICHD T32-HDO64428). She has first-authored three published articles, co-authored four published articles, and co-edited the textbook *Prenatal and Postnatal Care: A Woman-Centered Approach, 2nd ed.* (along with several textbook chapters). She has presented her research at multiple conferences in podium and poster presentations and participates in peer review for multiple journals.