## Title
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## Journal
Women's Health Issues, 25(3)

## ISSN
1049-3867

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## Publication Date
2015-05-01

## DOI
10.1016/j.whi.2014.12.004

Peer reviewed

HHS Public Access

Author manuscript

*Womens Health Issues*. Author manuscript; available in PMC 2016 May 01.

Published in final edited form as:

*Womens Health Issues*. 2015 ; 25(3): 216–223. doi:10.1016/j.whi.2014.12.004.

# Race and reproductive coercion: A qualitative assessment

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**Contributors:** The authors would like to thank Farrah Rahman and Hannah Roberts for their data analysis contributions.

**Prior presentations:** This paper has not yet been presented.

**Conflict of interest:** There are no conflicts of interest to report.

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## Abstract

**Background—**Unintended pregnancy is common and disproportionately occurs among low-income and African American (AA) women. Male partners may influence women's risk of unintended pregnancy through reproductive coercion, although studies have not assessed whether racial differences in reproductive coercion impact AA women's disparate risk for unintended pregnancy. We sought to describe women's experiences with pregnancy-promoting behaviors by male partners and explore differences in such experiences by race.

**Methods—**Semi-structured interviews were conducted with low-income, AA and white women aged 18–45 recruited from reproductive health clinics in Western Pennsylvania to explore contextual factors that shape women's contraceptive behaviors. Narratives were analyzed using content analysis and the constant comparison method.

**Findings—**Among the 66 participants (36 AA and 30 white), 25 (38%) described experiences with male partner reproductive coercion. Narratives provided accounts of contraceptive sabotage, verbal pressure to promote pregnancy and specific pregnancy outcomes, and potential motives behind these behaviors. AA women in the sample reported experiences of reproductive coercion more often than white women (53% and 20%, respectively). AA women were also more likely than white women to attribute a current or prior pregnancy to reproductive coercion. AA women identified relationship transiency and impending incarceration as potential motivations for men to secure a connection with a female partner via pregnancy.

**Conclusions—**Our findings suggest that reproductive coercion may be a factor contributing to disparities in unintended pregnancy. More research, including population-level studies, is needed to determine the impact of reproductive coercion on unintended pregnancy and to understand the social and structural factors associated with pregnancy-promoting behaviors.

### Keywords

Reproductive coercion; race; pregnancy; contraception

## INTRODUCTION and BACKGROUND

Unintended pregnancy, which disproportionately affects low-income and African American (AA) women (Finer & Zolna, 2014), is a substantial public health issue associated with numerous adverse health and social consequences for women, their families, and society

(Logan, Holcombe, Monlove, & Ryan, 2007; Sonfield, Kost, Gold, & Finer, 2011; Thomas & Monea, 2011). Nearly 70% of pregnancies among AA women are unintended compared to about 40% among white women (Finer & Zolna, 2014). Moreover, observed racial disparities persist across all income levels (Finer & Zolna, 2014), suggesting that broader socio-cultural and/or structural factors independently contribute to differential rates of unintended pregnancy.

Unintended pregnancy can be prevented by consistent and correct use of effective contraception (Foster et al., 2004; Rosenburg, Waugh, & Long, 1995). However, there are important racial differences in contraceptive use patterns that may impact women's risk of unintended pregnancy. AA women have higher rates of contraceptive non-use, incorrect use, and discontinuation than white women (Forrest & Frost, 1996; Frost & Darroch, 2008; Mosher, Martinez, Chandra, Abma, & Willson, 2004; Ranjit, Bankole, Darroch, & Singh, 2001; Trussell & Vaughan, 1999). The reasons underlying disparities in contraceptive use are not entirely understood but are likely multifactorial, including differences in access to and education about contraception; cultural and social attitudes related to sexuality, pregnancy and birth control; and experiences interfacing with the medical system (Armstrong, Ravenell, McMurphy, & Putt, 2007; Dehlendorf, Rodriguez, Levy, Borrero, & Steinauer, 2010; Gilliam, Davis, Neustadt, & Levey, 2009; Gilliam, Warden, Goldstein, & Tapia, 2004; Guendelman, Denny, Mauldon, & Chetkovich, 2000; Sangi-Haghpeykar, Ali, Posner, & Poindexter, 2006; Schwarz, Lohr, Gold, & Gerbert, 2007; Smedley, Stith, & Nelson, 2003). A growing body of literature has pointed to another factor that may influence women's use of contraception and may impact AA women differentially – male partner reproductive coercion (American College of Obstetricians and Gynecologists, 2013; Gee, Mitra, Wan, Chavkin, & Long, 2009; Miller et al., 2010; Miller et al., 2007b; Moore, Frohwirth, & Miller, 2010; Silverman et al., 2010; Silverman et al., 2011).

While men's influence on women's contraceptive use and pregnancy planning can be positive (Kraft et al., 2010; Shattuck et al., 2011), emerging studies indicate that reproductive coercion is common. Reproductive coercion includes direct interference with a woman's contraceptive efforts (birth control sabotage), pressuring a female sexual partner to become pregnant when she does not want to be (pregnancy pressure), and using pressure or threats to coerce women to either continue or terminate a pregnancy (control of pregnancy outcomes) (Chamberlain & Levenson, 2012; Miller et al., 2010; Moore et al., 2010). Although these behaviors have been previously described particularly within the context of abusive relationships (American College of Obstetricians and Gynecologists, 2013; Center for Impact Research, 2000; Clark, Allen, Goyal, Raker, & Gottlieb, 2013; Gee et al., 2009; Miller et al., 2010; Miller et al., 2007b; Moore et al., 2010; Silverman et al., 2010), they are not exclusive to abusive relationships (Miller et al., 2010).

Several qualitative and quantitative studies have begun to illuminate associations between reproductive coercion and contraceptive use, unintended pregnancy, and abortion (Grady, Klepinger, Billy, & Cubbins, 2010; Jacoby, Gorenflo, Black, Wunderlich, & Eyler, 1999; Miller et al., 2007a; Miller et al., 2010; Miller et al., 2014; Moore et al., 2010; Silverman et al., 2010). These studies provide evidence that women who experience male partner reproductive coercion may be less able to engage in consistent and effective contraceptive

use. Qualitative studies provide women's narratives about male partners removing their vaginal rings and throwing away birth control and also describe their attempts to surreptitiously continue using contraception to avoid pregnancy (Moore et al., 2010; Thiel de Bocanegra, Rostovtseva, Khera, & Godhwani, 2010). In one quantitative study by Miller at al. among young women aged 16–29 seeking care in five family planning clinics in Northern CA, 19% of women reported experiencing pregnancy pressure and 15% reported experiencing birth control sabotage, both of which were significantly associated with unintended pregnancy (Miller et al., 2010). Other studies have described women's experiences with partners' attempts to either force abortion or interfere with women's plans for abortion, such as threatening to hurt a woman if she tries to terminate a pregnancy (or force her to continue a pregnancy that she does not want), refusing transportation or funds for the procedure, and sabotaging appointments (Miller et al., 2007a; Moore et al., 2010).

There appear to be racial differences in prevalence of reproductive coercion. In the 2010 study by Miller et al., 26% of AA women versus 13% of white women had experienced pregnancy coercion, and 27% of AAs versus 7% of whites had ever experienced birth control sabotage (Miller et al., 2010; Miller et al., 2014). These findings suggest that reproductive coercion may play a role in the observed racial disparities in unintended pregnancy and contraceptive use. However, studies have not assessed *how* and *why* AA women may be at greater risk for reproductive coercion, which limits current studies from further elucidating whether reproductive coercion is a mechanism contributing to disparate rates in unintended pregnancy.

In this qualitative study examining contextual factors that shape low-income AA and white women's contraceptive behaviors, numerous reports of reproductive coercion spontaneously emerged in early interviews. We subsequently probed about the role that male partners may have in shaping women's pregnancy-related attitudes and behaviors. Thus, the analysis presented in this manuscript explores the research question, "What are women's experiences with contraceptive sabotage and pregnancy-promoting behaviors by male partners and how may these experiences vary by race?"

## METHODS

### Recruitment

Data were drawn from a qualitative study exploring factors that shape pregnancy intention and contraceptive decision making in low-income populations, which have particularly high rates of unintended pregnancy. As the intersection between race and socioeconomic status (SES) is difficult to disentangle, we focused on low-income women to better isolate race-based over SES-based influences while simultaneously advancing understanding of contraceptive decision making in low-income populations, who are particularly vulnerable to unintended pregnancy.

Flyers advertising the study were posted in 7 reproductive health clinics that serve low-income populations in Western Pennsylvania. Women responding to advertisements were screened for eligibility over the phone and were considered eligible if they were between the ages of 18–45; self-identified as either AA or white; and were either currently pregnant, had

an abortion within the prior 2 weeks, or were not pregnant but had been sexually active with a man in the previous 12 months. We excluded women who were not fluent in English and who had a household income above 200% of the federal poverty level.

In qualitative studies, sample size is driven by thematic saturation, and many researchers suggest that thematic saturation will be reached by 12–15 interviews per group (Crabtree & Miller, 1999). Therefore, we conducted interviews with at least 15 women from each racial group and from each pregnancy category (pregnant and non-pregnant). We used a sampling matrix to ensure that we heard the perspectives of participants from each race who varied with respect to age, parity, and among pregnant women, whether they planned to continue or terminate their pregnancy.

## Interview procedures

Semi-structured interviews were conducted between June 2010 and January 2013 with study participants to explore the cultural, structural, and relationship factors that shape pregnancy intention and contraceptive behaviors. As reproductive coercion was not the focus of the parent study, our initial interview guide did not cover this topic specifically, although we asked about partnership dynamics. However, reports about male partners' pregnancy-promoting behaviors spontaneously emerged within the first 20 interviews. Fifteen of these initial interviews were conducted with AA women and 5 with white women with 6 AA and 1 white woman describing experiences with reproductive coercion. Following these initial interviews, we added additional questions to the interview guide to more fully explore the impact (both positive and negative) of male partners on contraceptive use and pregnancy intention. These questions included "What were your partner's thoughts about contraception?", "What were your partner's thoughts about potential pregnancy?", and "Did your partner ever ask you not to use birth control or refuse to use a condom during intercourse?" with additional probes as needed to obtain more detailed information about a participant's specific experiences and her thoughts about her partner's motivations. The process of refining the interview guide to systematically explore emerging themes is a standard approach to qualitative analysis (Crabtree & Miller, 1999).

All sessions were audio-recorded and transcribed verbatim except that participants' names were omitted for confidentiality. Each participant was asked to complete a brief paper-based, socio-demographic questionnaire and received $50 as compensation for her time. This study was approved by the University of Pittsburgh Institutional Review Board.

## Data analysis

Study transcripts were analyzed using content analysis. This method involves the breakdown of interview text into "units" which are formulated into thematic categories. These categories represent both an exploration of pre-defined areas of study inquiry, as well as new themes that emerged during participant interviews (Hsieh & Shannon, 2005). A codebook, reflecting primary thematic categories and subcategories, was developed and refined as new themes emerged. Two coders independently coded the first 50% of the transcripts using Atlas.ti, qualitative software (GmbH, Germany). The coders then compared their coding to determine whether there were any inconsistencies, which were typically resolved through

discussion. The principal investigator (S.B.) was available to adjudicate any differences in interpretation between the coders and reviewed the final coding scheme. Coding reliability was assessed by determining the percentage of overall coding agreement for the first 50% of transcripts which was over 80%. After ensuring congruence of codes, the primary coder (C.N.) then coded the remaining half of the transcripts. Double-coding only a portion of transcripts is common practice to save costs and reduce duplicative work once adequate reliability is achieved (Campbell, Quincy, Osserman, & Pedersen, 2013; Hruschka et al., 2004).

To capture narratives surrounding reproductive coercion, a code entitled “partner influence”, was generated with subcodes identifying whether the influence was positive or negative (i.e. coercion). Each experience with reproductive coercion was coded separately, and some women described multiple experiences with varying types of coercive behaviors. We also searched for meaningful patterns by race (e.g., frequency and severity of coercive experiences) using the constant comparison method, a central analytical approach in which codes are compared across participant types thus leading to relational discovery. For this manuscript, all codes related to reproductive coercion were reviewed and categorized *post hoc* based on a framework described by Miller and Silverman, as representing: birth control sabotage, pregnancy pressure, or control of pregnancy outcomes (Miller & Silverman, 2010). Representative quotations were selected from the transcripts to illustrate the spectrum of coercive behaviors.

## FINDINGS

The study sample included 36 AA women and 30 white women, including the 20 women interviewed prior to the inclusion of the reproductive coercion questions. Participants’ demographic characteristics are shown in Table 1. Of the 66 study participants, 25 (38%) provided accounts of male partner reproductive coercion. Twenty-one of these 25 women reported one or more personal experiences with reproductive coercion while 4 did not endorse having experienced reproductive coercion themselves, but discussed the experiences of other women in their social networks.

Experiences with reproductive coercion were more common and of greater severity (i.e. overt contraceptive sabotage, pregnancy resulting from coercion) among AA participants compared to white participants. This was true among participants interviewed before and after reproductive coercion was systematically probed. Overall, 53% (19 of 36) of AA women and 20% (6 of 30) of white women described experiences with reproductive coercion. Accounts provided by white participants did not describe the same degree of overt contraceptive sabotage and pregnancy pressure that the AA women in our sample described. Furthermore, more AA women than white woman (n=8 and 1, respectively) reported their current or a past pregnancy resulted directly from birth control sabotage and/or pregnancy pressure by a male partner.

Narratives describing birth control sabotage, pregnancy pressure or control of pregnancy outcomes are discussed below with representative quotations. In addition, women’s accounts

provided new insight about potential reasons that might explain why men would desire a female partner to be pregnant.

### Birth control sabotage

Respondents described male partners' behaviors around contraceptive control across a spectrum, from condom refusal or purposeful misuse/deception (removing the condom mid-intercourse or saying one was used when it was not) to overt sabotage of women's contraceptive efforts. Some participants discussed their partner's general refusal to use a barrier method (most commonly to enhance sexual pleasure), while others described contraceptive interference in the context of men's expressed desires for a pregnancy. One young woman stated: *"He wants me to have his baby…He refused to use a condom"* (white woman, age 19). Another woman feared that if she did not yield to her partner's desire to forgo condom use, he would end the relationship: "*He said he didn't want to use them anymore…that he was tryin' to get me pregnant…I wanted to [use condoms] but I didn't want him to go to anybody else"* (AA woman, age 18).

A few participants reported that their male partners expressed displeasure or indignation when asked to use condoms - voicing that they did not feel trusted or that the women did not consider their relationship as serious enough to forgo condom use.

> *He was like, if you're my girlfriend then I don't understand why we have to use condoms. 'Cause I don't want to get pregnant…I don't want to have nobody's kids, period. And he was like, oh but I want children, yack, yack, yack... And, um, he refused to use a condom.* (AA woman, age 27)

Some respondents were led to believe that their partners were wearing condoms during intercourse only to find they had been deceived. A participant described one such experience that resulted in pregnancy:

> *"I was like, how did I get pregnant when I put a rubber on you every time? He was like, 'Oh I pulled it off three times.' And I'm like, when? I'm sittin' here thinking', when did he do that?"* (AA woman, age 32).

On the extreme end of the spectrum, one pregnant woman reported that her fiancé monitored her ovulatory cycles and sabotaged her contraceptive efforts prior to his incarceration:

> *"Before my fiancé got locked up he wanted a baby and I had birth control pills…he threw them away, yeah, he bought ovulation kits and a four-pack of pregnancy tests…he was serious…I didn't want no baby…I didn't want one but I was confused. But now he's not around and I don't want no baby."* (AA woman, age 19)

She continued on to describe repeated acts of contraceptive sabotage and her attempt to hide her oral contraceptive use:

> I had condoms, he threw them away. I had contraceptive stuff, the foam stuff, he threw it away…And I had a whole bag of stuff, the day after pills, he just threw the whole bag away…[Regarding birth control pills] I had 'em hidden for a minute…I

> told him they were vitamins and… I guess he researched on 'em and then I came home one day and [he said], 'these are not vitamins.'

Regardless of participants' desire to avoid pregnancy and attempts to use contraception, women, especially AA women, described their partners' refusal to engage in and even thwart contraceptive efforts, which women perceived as attempts by their partners to get them pregnant (whether explicitly stated by the partner or not).

### Pregnancy pressure

Several participants described verbal and emotional pressure by a male partner to get pregnant. This was again most notable among AA participants. One participant described her partner's monitoring of her gynecology appointments:

> *I hated him. I think he was trying to get me pregnant 'cause he always asked me every time I got to the doctor's…he'll ask me like, 'Do they have you on birth control? Are you going to get birth control? You shouldn't get birth control, what if we just go natural…and if you get pregnant you just get pregnant and we don't need to use birth control.* (AA woman, age 21)

Another participant who had 7-year old twins said, *"I say their dad bullied me, and I still blame that on him. I felt like he bullied me into them"* (AA woman, age 32). She went on to explain that he is no longer an active presence in their lives. Another woman reported that her partner pressured her to stop using contraception so she would become pregnant, but he did not articulate why he desired pregnancy. She stated, *"I mean he would just talk about me getting off birth control, he wants me to get pregnant… nothing like what are we going to do in the future, nothing of a discussion like that – just he wants me to have his baby. That was it."* (white woman, age 19)

One young woman described the more subtle verbal and emotional pressure that her boyfriend exerted:

> *I mean, when I was on [Depo Provera] he didn't care. He knew I would take my shots, he would ask me about my shot because he knew I was still in high school… he wasn't as pressuring as he is now, he really wasn't pressuring. But he is kind of pressuring…He isn't aggressive about it at all… He wasn't like, 'get off of it'…He just want a baby so bad. [He talks about] how happy we would be, things we would do, how serious we would get, how more serious life would get at that point.* (AA woman, age 20)

This participant went on to say that she wanted to maintain a relationship with this partner and believed that, if she did not have a child with him now, he would leave her for someone else. She thus expressed ambivalence about her own pregnancy intentions, feeling on one hand that she is young and wants to achieve her educational and career goals, but on the other hand believes that her options for future partners are limited and wants to stay with her current partner whom she knows will be a good father. She stated, *"I just don't want to say no to him and my [future] baby's dad end up being some, you know, deadbeat."* In this case, pregnancy pressure from her partner was contributing to her own pregnancy ambivalence and contraceptive nonuse.

### Control of pregnancy outcomes

A few AA and white women described how male partners attempted to ensure a pregnancy outcome (both termination and pregnancy continuation) that was in opposition to the woman's desires. For example, the pregnant woman who described her experiences with overt birth control sabotage prior to her fiancé's imprisonment also disclosed that she was planning to terminate her current pregnancy, an option she believed would not be possible if her partner were not in jail.

> *He wouldn't let me have an abortion if he was out, uh uh. He wouldn't even let me come here [for the study interview]. If I was going to [neighborhood where interview being held], he'd think I was going to [the women's hospital] and he was comin' with me.* (AA woman, age 19)

She reported that after her abortion, she planned to have an intra-uterine device inserted, "so he won't know" about her contraception.

Another participant described the context of her goddaughter's birth in which the mother (her friend) had planned to terminate the pregnancy, but instead yielded to her partner's threats:

> *My goddaughter, she wouldn't be here if her dad didn't want her. 'Cause my friend, she wanted to keep going to school and stuff. Her dad wanted her [the child]. Her dad would be like, 'If you kill my baby I'm going to kill you.' And now he's acting all crazy, having all these other girls and, you know, doing whatever. Left her pregnant and putting her out, all type of stuff.* (AA woman, age 20)

Another woman described experiencing pressure from her partner to continue her pregnancy even though she did not think she was ready to have a baby:

> *At first I wanted [son's name] but then when I got pregnant I was like, 'Oh my god I'm scared, I don't know what to do.' And he influenced me to keep him. If it wasn't for [partner's name] pushing I probably wouldn't have kept him.…I was young and I wasn't ready for it.* (white woman, age 23)

Women's narratives describe circumstances in which women feel coerced to terminate or continue a pregnancy because of their male partner's consistent pressure or threatening behavior. Both white and AA women noted that, despite pressuring a woman to continue her pregnancy, it did not mean that a man would remain present in the life of his partner or his child.

### Potential reasons underlying men's pregnancy-promoting behaviors

Interviews also explored women's perceptions about reasons that men might want their female partners to get pregnant. While all women who reported experiences with male partner reproductive coercion were asked what they thought their partner's motives were, specific social and structural factors that might motivate men's pregnancy-promoting behaviors emerged only in AA women's narratives.

AA women commented that incarceration, lack of social support, and structural barriers to stable housing and employment seemed to motivate men to secure connections with their female partner via pregnancy. One participant used the phrase "catching a case" to describe a man's impending incarceration and his use of pregnancy as a pragmatic way of maintaining economic and emotional security. Her narrative also describes the cycle of incarceration and perpetual instability that she feels characterizes her community:

> *The dude catches a case, so he is going to go to jail two years down the road so he is going to knock you up so you can do your biz with him. You can take care of him while he is in jail and he has somewhere to land when he comes home. I definitely see that as a cycle…Oh yeah, knock her up, who cares? All you do is write her letters and make collect calls and you keep her for two years till you get out… They all become Muslim, they all find Jesus [while they're in jail]. Everybody is going to walk the straight and narrow and then what, like 70% of them go back to jail? Because you know it is set up to work against them. You are a convicted felon so you can't get a decent job. You don't have a decent job so you gotta hussle, you get caught husslin' on paper, you go back to jail!* (AA woman, age 43).

She further describes the destabilizing effects of repeated incarceration and high mortality rates among AA males on relationships, families, and communities:

> All the brothers are dead or in jail… And the family structure got broken down and it trickled down to that what the kids perceive as what was expected as them as men and women because there was no example in place…And the kids got lost as a result. That is why they are out there now, they are the angry ones with the guns and babies.

Another woman reported that her partner deceived her prior to serving his jail time by getting her pregnant to artfully secure a potential lifetime of social, economic, and housing support from the mother of his child.

> *I knew he had a case but I didn't know the details of the case. He didn't tell me until after he was actually incarcerated…I wish I knew that he was going to jail for three years before I actually conceived my son…That is not a conscious decision I would have made. I feel like he trapped me and I asked him several times and he laughed about it. A lot of these men try to have babies with people that they know are there for them. Because they are always in their corner. Just like my son's dad will always have me in his corner.* (AA woman, age 25)

In contrast to these narratives from AA women, white women mostly attributed pregnancy-promoting behaviors to love or maintenance of the relationship without identifying the social or structural factors that may contribute to men's pregnancy motivations: *"I guess he loved me, I honestly don't know why he wanted it"* (white woman, age 23), and *"I really honestly don't know…maybe to keep me around"* (white woman, age 19).

These narratives reveal potential emotional as well as utilitarian reasons why men might desire their female partners to get pregnant and shed light on how sociocultural contexts, including unstable employment and disproportionate incarceration among AA men, might contribute to reproductive coercion.

## CONCLUSIONS and DISCUSSION

In this qualitative study of low-income AA and white women of reproductive age, we found that nearly 40% of study participants described experiences with male partner reproductive coercion. These narratives describe a continuum of coercive behavior ranging from condom refusal to overt contraceptive sabotage for the explicit purpose of promoting pregnancy. These accounts add to the growing body of evidence that reproductive coercion may be commonly experienced by women and may contribute to the high rate of unintended pregnancy in this country.

Descriptions of reproductive coercion were much more prevalent among AA participants in our sample, which is consistent with existing data documenting higher rates of reproductive coercion among AA women (Miller et al., 2010). Significantly more AA participants also attributed pregnancy to reproductive coercion, suggesting that reproductive coercion may play a role in observed racial disparities in unintended pregnancy. Further study of the prevalence and impact of reproductive coercion on disparities in unintended pregnancy in large, population-based samples are warranted as this will have implications for pregnancy prevention programs which do not typically address male pregnancy-promoting behavior.

Our study also sheds light on contextual and structural factors that might shape fertility behaviors, including the role of disproportionate incarceration of men and social instability in low-income, AA communities. According to recent reports, a staggeringly high rate of 1 in 15 black men, compared to 1 in 106 white men, are currently incarcerated (The Pew Charitable Trusts, 2008). This is one of the few studies that begins to link how experiences of incarceration may contribute to fertility behaviors and unintended pregnancy. Another study by Thomas and Torrone found an association between high prevalence of incarceration and teenage pregnancy in North Carolina. In line with our participant who opined, “all the brothers are dead or in jail,” these authors speculated that high incarceration rates can destabilize a community, disrupt relationships, and contribute to the inability of communities to maintain the dominant social norms around parenting and family formation. In addition, because the community ratio of men to women is lowered, this can impact power dynamics, giving men more power in sexual relationships (Thomas & Torrone, 2006) and may also make women more tolerant of pregnancy promoting behaviors due to a lack of available partners. Indeed, several of our participants voiced fears about losing their partners in the context of limited alternatives. More fully understanding the impact of the high prevalence of incarceration on unintended pregnancy and family formation will be important for intervention strategies, which may require a more focused effort to incorporate structural interventions as well as pregnancy prevention efforts that target men in these communities.

There are important limitations to consider in interpreting our findings. First, qualitative research is used to explore concepts and their meanings from participant’s perspectives. Thus, sample sizes are small and typically limited to the number of participant interactions necessary to reach thematic saturation thereby limiting our ability to generalize findings and make assumptions about population prevalence rates of the phenomena explored. However, it is important to recognize the utility of qualitative research for examining highly sensitive issues including sex and contraception in the context of race. Second, the parent study did

not seek *a priori* to explore coercive reproductive behaviors by male partners. Because this phenomenon emerged only after we had conducted initial interviews and additional questions thereafter added to the interview guide, not all women were probed for details about reproductive coercion. Our analytic approach, however, took this into account and we noted few differences, if any, in themes among the narratives of women who were or were not specifically asked about experiences with reproductive coercion. In addition, given the face-to-face nature of data collection, participants may have felt uncomfortable revealing their experiences with these behaviors. Thus, for these two reasons, women's experiences with reproductive coercion may have been underreported in our study. Third, it is important to note that male partners are not the only perpetrators of deceptive behaviors to promote pregnancy; a few participants also shared that they knew of women who had told their male partners they were using contraception when they were not. However, this paper seeks to illuminate contexts that may contribute to the high rates of *unintended* pregnancy observed among US women. Fourth, the white women in our sample had higher educational attainment, which may have confounded the relationship between race and reproductive coercion. Finally, these descriptions of men's coercive behaviors are from women's perspectives. Understanding men's perspectives around fertility-related behaviors and motivations can help inform efforts to empower women to negotiate with their partners, increase their reproductive autonomy, and achieve their reproductive goals.

## Implications for practice and/or policy

Our findings are clinically relevant in that they highlight the fact that male partner reproductive coercion may be one explanation for contraceptive nonadherence. While providers have primarily focused on women's behaviors, there is increasing recognition that providers should probe about male partner's reproductive intentions and consider the possibility of coercive behaviors. This may be particularly important when women's stated pregnancy intentions are incongruent with her contraceptive behavior, when she expresses ambivalence, or for women who make frequent visits for pregnancy testing or emergency contraception. Women experiencing reproductive coercion may not necessarily recognize such behaviors as unhealthy especially if they do not occur within the context of a physically violent relationship or if the woman believes the behavior is normative. As such, clinicians are in a unique position to ask a woman specifically about both her own and her partner's pregnancy intentions and to explore how a partner may influence the woman's own pregnancy intentions. Clinicians might then use discrepancies in pregnancy intentions within a couple to guide women in identifying strategies to help reduce her risk of unintended pregnancy, while respecting her relationship choices. As outlined in a report recently released by the American College of Obstetrics and Gynecology, such strategies may include use of "hidden" methods of contraception that cannot be detected by male partners such as an intrauterine device, contraceptive injection, or subdermal implant (American College of Obstetricians and Gynecologists, 2013; Chamberlain & Levenson, 2012; Miller et al., 2007b).

In summary, we found that nearly 40% of study participants described experiences with male partner reproductive coercion, and that reports of reproductive coercion emerged more often among AA women. This study adds to the growing body of literature on reproductive

coercion by providing explicit narratives of women's experiences with contraceptive sabotage, pregnancy pressure, and control of pregnancy outcomes as well as women's perceptions of men's motivations for these behaviors. Narratives underscored the structural context of disproportionate incarceration and social instability that may influence fertility behaviors, especially in low-income, AA communities. To better inform pregnancy prevention strategies, larger, population-based studies that examine the impact and contextual correlates of reproductive coercion are needed.

## ACKNOWLEDGEMENTS

**Funders:** This study was made possible by Dr. Borrero's grant (1 R21 HD068736-01) from the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), a component of the National Institutes of Health (NIH). Dr. Steinberg's effort on this project was funded by her K01 grant from NICHD (K01 D075834). The content of this publication is solely the responsibility of the authors and does not necessarily represent the official views of NICHD or NIH.

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## Table 1

Sample demographic characteristics

| Characteristic | African American Women (n=36) | White Women (n=30) |
|---|---|---|
| Accounts of reproductive coercion | | |
| Yes | 52.8% (n=19) | 20.0% (n=6) |
| No | 47.2% (n=17) | 80.0% (n=24) |
| Pregnancy status | | |
| Pregnant and continuing pregnancy | 19.4% (n=7) | 26.7% (n=8) |
| Recent abortion or planning abortion | 36.1% (n=13) | 23.3% (n=7) |
| Non-pregnant | 44.4% (n=16) | 50.0% (n=15) |
| Age | | |
| 18–24 | 63.9% (n=23) | 66.7% (n=20) |
| 25–45 | 36.1% (n=13) | 33.3% (n=10) |
| Education | | |
| <High School diploma | 11.1% (n=4) | 10.0% (n=3) |
| High School diploma/GED | 61.1% (n=22) | 23.3% (n=7) |
| Trade/technical school | 2.8% (n=1) | 3.3% (n=1) |
| Some college | 13.8% (n=5) | 30.0% (n=9) |
| College degree | 11.1% (n=4) | 33.3% (n=10) |
| Income | | |
| $0 – $9,999 | 47.2% (n=17) | 43.3% (n=13) |
| $10,000 – $19,999 | 33.3% (n=12) | 26.7% (n=8) |
| $20,000 – $29,999 | 5.6% (n=2) | 16.7% (n=5) |
| $30,000 – $49,999 | 13.9% (n=5) | 13.3% (n=4) |
| Marital Status | | |
| Single | 58.3% (n=21) | 33.3% (n=10) |
| Single, living with male partner | 30.6% (n=11) | 53.3% (n=16) |
| Married | 5.6% (n=2) | 6.7% (n=2) |
| Divorced/separated | 2.8% (n=1) | 6.7% (n=2) |
| Widowed | 2.8% (n=1) | 0.0% (n=0) |
| Parity | | |
| 0 | 41.7% (n=15) | 60.0% (n=18) |
| 1 | 19.4% (n=7) | 30.0% (n=9) |
| 2 | 22.2% (n=8) | 3.3% (n=1) |
| 3 | 8.3% (n=3) | 3.3% (n=1) |
| 4+ | 8.3% (n=3) | 3.3% (n=1) |
| Insurance | | |
| Private | 5.6% (n=2) | 30.0% (n=9) |

| Characteristic | African American Women (n=36) | White Women (n=30) |
|---|---|---|
| Public | 86.1% (n=31) | 40.0% (n=12) |
| None | 8.3% (n=3) | 30.0% (n=9) |
| Religion | | |
| None | 47.2% (n=17) | 36.7% (n=11) |
| Protestant | 5.6% (n=2) | 3.3% (n=1) |
| Catholic | 2.8% (n=1) | 43.3% (n=13) |
| Other Christian | 41.7% (n=15) | 3.3% (n=1) |
| Other | 2.8% (n=1) | 13.4% (n=4) |

NOTE: One participant took part in both the pregnant and not pregnant cohort interviews. Given the time lapse between interviews, she was no longer pregnant at the time of the second interview.