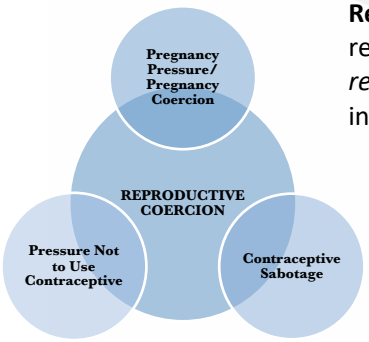
ADDRESSING IPV AND UNINTENDED PREGNANCY IN HEALTHCARE SETTINGS AMONG ADOLESCENTS IN MEXICO

Background

Violence from male partners is consistently associated with poor reproductive outcomes for women and girls.

- Women experiencing intimate partner violence (IPV) are twice as likely to have a male partner refuse to use contraception,[1,2] to report unintended pregnancy,[2-6] have five or more births[1] and to have had an induced abortion, and three times as likely to have had experienced multiple abortions. [1,3,4,7]
- Despite the World Health Organization (WHO) recommendations that identification and support of gender-based violence (GBV) survivors be integrated into reproductive health services, few effective models have been identified in low to middle income countries.[8]



Reproductive Coercion: A construct suggested by recent research to be a mechanism underlying associations of IPV and poor reproductive health is *reproductive coercion*, [6,9] defined as behavior that interferes with contraception use and pregnancy in ways that reduce female reproductive autonomy.[6,9,10] Examples include:

- Pregnancy Coercion: Threats or actual violence against a female partner to force her to comply with demands that she become pregnant (e.g., blocking access to family planning services) or that she continue or terminate a pregnancy (e.g., blocking access to abortion services)
- Contraceptive Sabotage: Hiding, withholding, destroying or removing female-controlled contraception in an attempt to promote pregnancy despite a female partner's wishes to contracept.

Women and girls who report IPV are significantly more likely to also experience reproductive coercion (RC) from male partners, [6,11] and RC predicts unintended pregnancy independent of the effects of IPV, as well as interacting with IPV to heighten risk for unintended pregnancy beyond that seen for IPV alone.[6]

Addressing Reproductive Coercion in Healthcare Settings

ARCHES (Addressing Reproductive Coercion in Healthcare Settings)[11,12] is a brief clinic-based behavioral intervention delivered within routine family planning (FP) counseling, and demonstrated to reduce IPV, RC and increase reproductive autonomy among women and girls (see Figure 1), based on evidence from tow U.S. randomized control trials involving >4000 female FP clients. A binational group of researchers from UCSD in San Diego, CA, the U.S.-Mexico Border Health Commission, El Colegio de la Frontera Norte (COLEF) in Tijuana, BC and local partners are now adapting and evaluating this intervention (renamed *Jovenes Sanos*) in Tijuana, Mexico.

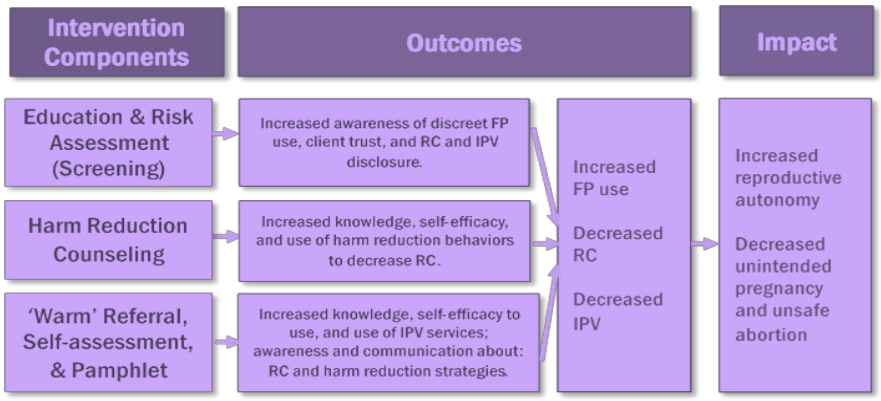


Figure 1. ARCHES Model

Jóvenes Sanos Pilot

Jóvenes Sanos is the first clinic-based behavioral intervention (adapted from ARCHES[11,12] and the findings from this study) focused on addressing IPV (including RC) and unintended pregnancy among adolescent girls conducted in a Latin American country. This project has entailed completing formative research, participatory adaptation, a 3-month pilot (ongoing) with 100 adolescent girls ages 16-20 accessing family planning (FP) services in two publicly funded community health centers in Tijuana, Mexico to demonstrate the acceptability and feasibility this intervention. Results from this pilot will inform a larger randomized control to the National Institutes of Health (NIH) in late 2019 after this formative work and pilot study are completed. Finalization of the *Jóvenes Sanos* toolkit will guide adaptation of the model in other Latin American countries.

Jóvenes Sanos

Formative Findings and Adaptation

Formative research included focus group discussions (n=3; 6-8 participants per group) with healthcare providers (e.g., clinicians, clinic managers, nurses, psychologists, social workers) and in-depth interviews (n=20) with adolescent family planning (FP) clients ages 16-20 from two community health centers in Tijuana.

- Findings from the focus group discussions with healthcare providers indicate a concern for the high levels of violence against women in the community; a lack of knowledge regarding the negative effects that GBV has on women and girl's health; and a lack of knowledge of reproductive coercion (RC). Further, the majority of the providers expressed their interest in more efficient screening tools for IPV/RC and a more efficient referral system for clients experiencing IPV.
- Findings from the in-depth interviews conducted with adolescent girls indicate high levels of GBV (e.g., IPV, RC) as well as normalization of these behaviors. Likewise, IPV and RC were common experiences reported by participants and posed a significant barrier to their reproductive autonomy. Further, majority of the adolescent girls that participated in this phase of the study were migrants (e.g., internal migration), had at least one child and reported their first pregnancy was average <15 years of age, and had dropped out of school as a consequence of the unintended pregnancy, thus the levels of literacy were very low.

FP Providers' Experiences

Community violence and violence against women are very high here… We dont have the proper screening tools or referals for women who have experienced violence… I look forward to training to have the skills to council better women" – male, ISESALUD provider, Tijuana, Mexico.

Image 1: One of the participating community health centers in Tijuana

Adolescent RC Experiences

"The first time I took the pill (ECP) because he (male partner) broke the condom, I think he did it on purpose. The second time (used ECP) was because he tricked me and didn't actually put on a condom, when he found out I took the pill he got very upset and hit me, so I stopped using it and ended up pregnant" -Marla, 16, FP client ISESALUD, Tijuana, Mexico.

Current Work

The Jovenes Sanos toolkit (e.g., slides and manuals for provider training, clinical protocols, provider job aids, and client education materials) was developed collaboratively with providers from the Ministry of Health based on the formative findings and the ARCHES intervention. Additionally, we also worked with a local Youth Advisory Board (YAB) from the *Grupos de Adolescentes Promotores de la Salud* (GAPS) from ISESALUD to ensure messaging was appropriate and appealing to this gender/age group. We also worked with local non-profit organizations (NGOs) and conducted a mapping of services for women who have experienced GBV that were incorporated to the client education materials. The pilot (provider training, baseline and 3-month follow-up data collection) began in December 2018. FP providers that work with adolescent girls in the participating community health centers received a 3-day intensive training in order to implement the *Jovenes Sanos* intervention with their adolescent clients. Following the training, adolescent girls (ages 16-20) receiving FP services in the two (one control and one intervention)

participating community health centers were invited to participate in the study (n=100) and completed a survey at baseline and 3-month follow up. Data collection is expected to end in mid-May 2019 and data analysis will begin.

Conclusions

Preliminary findings document a high prevalence of intimate partner violence and reproductive coercion among adolescent girls attending family planning clinics in Tijuana, Mexico.

The high prevalence of IPV found in this study is consistent with prior studies that have documented high rates of violence in intimate relationships among female clients presenting for SRH services.[11-13] Likely related to the reproductive health concerns associated with abuse and violence in intimate relationships, women and girls victimized by violence also have high rates of seeking SRH care at community and family planning clinics.[11,12]

Image 2: Members of the YAB /GAPS from ISESALUD that participated in the adaptation of the materials

The preliminary findings from the present study should be interpreted in light of several limitations. The cross-sectional nature of the investigation precludes conclusions concerning temporality regarding associations between RC and IPV with unintended pregnancy. Similarly, the qualitative design and small sample size due to saturation of themes limiting the generalizability to other regions. Longitudinal studies with a larger sample size are necessary to better understand the associations described here.

Future recommendations

The present findings underscore the potential utility of community health centers to provide intervention programs to reduce harm related to IPV and RC, and to serve as a bridge to other services for the large numbers of adolescent girls who are affected by GBV. Comprehensive screening in clinical settings for the prevalent experiences of IPV and RC should be considered a priority, particularly in the context of family planning and related programmatic efforts to reduce unintended pregnancy among adolescent girls in Mexico. Such screening may facilitate the critical work of addressing barriers to contraception among affected adolescent girls and young women so as to reduce their elevated risk for unintended pregnancy.

Acknowledgments

We acknowledge with profound gratitude the patients and community health centers who have participated in this study and the support of the Ministry of Health (ISESALUD) in Baja California, Mexico. We gratefully acknowledge the staff of the Ministry of Health (ISESALUD), the multiple domestic violence and sexual assault victim advocates in Tijuana, Dr. Xóchitl Castañeda , and Caroline Dickinson for their continued support of this study. Project sponsored by the UC Berkeley Health Initiative of the Americas (PiMSA) and the National Institute and the Child Health and Human Development (5K23HD084756; PI:Servin).

References

1. Garcia-Moreno C, Jansen H, Ellsberg M, Heise L, Watts CH, the WHO Multi-country Study on Women's Health and Domestic Violence against Women Study Team (2005) *The WHO multi-country study on women's health and domestic violence*; World Health Organization: Geneva.
2. Fanslow J, Whitehead A, Silva M, Robinson E (2008) Contraceptive use and associations with intimate partner violence among a population-based sample of New Zealand women. *Aust N Z J Obstet Gynaecol*; 48:83-9.
3. Pallitto CC, García-Moreno C, Jansen H, Heise L, Ellsberg M, Watts C, the WHO Multi-Country Study on Women's Health and Domestic Violence (2013) Intimate partner violence, abortion, and unintended pregnancy: Results from the WHO Multi-country Study on Women's Health and Domestic Violence. *International Journal of Gynecology & Obstetrics*; 120:3-9.
4. Silverman JG, Gupta J, Decker MR, Kapur N, Raj A (2007) Intimate partner violence and unwanted pregnancy, miscarriage, induced abortion, and stillbirth among a national sample of Bangladeshi women. *BJOG: An International Journal of Obstetrics and Gynaecology*; 114:1246-1252.
5. Martin SL, Kilgallen B, Tsui AO, Maitra K, Singh KK, Kupper LL (1999) Sexual behaviors and reproductive health outcomes: Associations with wife abuse in India. *Journal of the American Medical Association;* 282:1967–1972.
6. Miller E, Decker MR, McCauley HL, Tancredi, D, Levenson, R, Waldman J, Shoenwald P, Silverman JG (2010) Pregnancy coercion, intimate partner violence, and unintended pregnancy. *Contraception*; 81:316-22.
7. Colombini M, Mayhew S, Watts C (2008) Health-sector responses to intimate partner violence in low- and middle-income settings: a review of current models, challenges and opportunities. *Bull World Health Organ*; 86: 635–642.
8. (8) Silverman JG, Decker MR, McCauley HL, Raj A, Reed E, Miller E (2011) Coercive and deceptive forms of sexual risk and associated violence perpetrated by male partners of female adolescents. *Perspectives on Sexual and Reproductive Health*; 43:60-5.
9. Miller E, Levenson R, Jordan B, Silverman JG (2010) Reproductive coercion: Connecting the dots between partner violence and unintended pregnancy. *Contraception*; 81:457-9.
10. Tsai AC, Subramanian SV (2012) Proximate context of gender-unequal norms and women's HIV risk in sub-Saharan Africa. *AIDS*; 26:381-386.
11. Miller E, Decker MR, McCauley HL, Tancredi DJ, Levenson RR, Waldman J, Schoenwald P, Silverman JG (2011) A family planning clinic partner violence intervention to reduce risk associated with reproductive coercion: results of a small-scale RCT. *Contraception*; 83:274-80.
12. Tancredi DJ, Silverman JG, Decker MR, McCauley HL, Anderson HA, Jones KA, Ciaravino S, Hicks A, Raible C, Zelazny S, James L, Miller E. (2015) Cluster randomized controlled trial protocol: addressing reproductive coercion in health settings (ARCHES). *BMC Womens Health*; Aug 6:15:57.
13. Silverman JG, McCauley HL, Decker MR, Miller E, Reed E, Raj A. (2011). Coercive forms of sexual risk and associated violence perpetrated by male partners of female adolescents. *Perspect Sex Reprod Health*. 2011 Mar;43(1):60-5.