

Intimate partner violence and contraception: How family planning providers can help (Draft not published)

Addendum to: WHO, UNWomen, UNFPA. Health care for women subjected to intimate partner violence or sexual violence. A clinical handbook. Geneva, WHO, 2014. WHO/RHR/14.26.

Intimate partner violence often interferes with a woman’s sexual and reproductive well-being and self-determination.

If a client discloses violence to you, or you suspect violence, you can help. In general, follow the LIVES steps to give her first-line care and support (see pages 13–33 of Health care for women subjected to intimate partner violence or sexual violence. A clinical handbook).

You may suspect that a client visiting your family planning (FP) clinic is experiencing violence. There are a number of signs that may suggest that she is experiencing partner violence such as:

- Refusal of specific contraceptive methods or insistence on a particular type of method
- Resistance to contraceptive counselling
- History of repeated pregnancies and/or request for medical termination
- Insistence on tubal ligation
- Insistence on reversal of tubal ligation

What is reproductive coercion?

Behaviours that interfere with contraceptive use and/or pregnancy have been called "reproductive coercion".

These behaviours may come from someone who is, was, or wishes to be involved in an intimate or dating relationship. These behaviours may include:

- Attempts to make a woman pregnant against her wishes
- Controlling outcomes of a pregnancy: putting pressure on her to continue or to terminate her pregnancy
- Coercing a partner to have unprotected sex
- Interfering with contraceptive methods

A client who is seeking emergency contraception or abortion may be more likely to be experiencing intimate partner violence than your other clients. Be especially alert with these women for indications of violence.

To explore whether a client is experiencing partner violence and to support her to disclose violence, you may ask situation-specific questions as illustrated below.

Situation	Illustrative questions
Refusal of specific contraceptive methods or insistence on a particular type of method	Contraceptive methods are widely used and have been found to be beneficial to the health of women and their children. Is there any problem at home that makes you refuse this method?

Situation	Illustrative questions
Resistance to contraceptive counselling	We routinely offer all women counselling? FP procedures have important health benefits for women and their children. Is there any problem/Do you have any worry which is preventing you from being counseled?
Insistence on tubal ligation	Although tubal ligation is routinely offered as one contraceptive method, is there any particular reason for your insistence on undergoing this procedure? * Is there any problem at home which has made you take this decision? Is there anyone at home insisting on you getting this procedure done?
Looking anxious or depressed	You look very sad and I am very concerned about you. Can you tell me how I can help you?
Disclosure of insomnia or anxiety	We all need to have good sleep to lead a healthy life. Is there any particular reason for the state you are in? Is there something or someone at home that might be worrying you?

In particular, explore issues of violence when counselling about method choice. Your skills as a family planning provider can especially help a woman deal with this aspect of her situation.

To explore how violence affects her reproductive and sexual life, you can ask these four questions:

- Has your partner ever told you not to use contraception, blocked you from getting a method, or hid or taken away your contraception?
- Has your partner ever tried to force you or pressure you to become pregnant?
- Has your partner ever refused to use a condom?
- Has your partner ever made you have sex without using contraception so that you would become pregnant?

Discuss her answers and how she can make the best choices in these circumstances.

If your client wants a method that would be hard for her partner to interfere with, you can discuss:¹

- **Injectable contraceptives.** Intramuscular injectable contraceptives leave no signs on the skin. The 2- and 3-month injectables often stop menstrual periods after a time. This could be a concern if her partner monitors her periods. In contrast, monthly injectables usually make monthly cycles more regular. Let her know that injectables require regular follow up visits.

¹ Countries can adapt this section depending on what modern methods are commonly used.

- **Subcutaneously-administered depot medroxyprogesterone acetate (DMPA-SC, 104 mg/0.65 mL).** This is a new method added by WHO in its 2015 eligibility criteria for contraceptive methods². It is highly effective and follows the same profile as DMPA intra-muscular. It also requires regular follow up.
- **Implants.** Once inserted under the skin, implants work for several years. Sometimes they can be seen and felt under the skin, however, many women will experience a change in their bleeding pattern. This can include no bleeding, intermittent and/or frequent spotting and bleeding, and rarely heavy/prolonged bleeding. Usually implants do not require regular follow up.
- **Copper and hormonal (LNG) IUDs.** They remain out of sight in the uterus. Copper IUDs are associated with increase menstrual flow, while hormonal IUDs can make the periods lighter or cause periods to stop.

It is important to assess the risk of STIs before placing an IUD³. Since women subjected to

² For more information on this topic, see the World Health Organization 2015 *Medical eligibility criteria for contraceptive use. A WHO family planning cornerstone*. Fifth edition . Geneva, 2015
http://apps.who.int/iris/bitstream/10665/181468/1/9789241549158_eng.pdf?ua=1

³ IUDs cannot be initiated in women with current pelvic inflammatory disease (PID), current purulent cervicitis or Chlamydial infection, which are conditions that represent an "unacceptable health risk" for IUD initiation (MEC 4)(WHO. MEC, 2015). However if a woman has an IUD already in place, she can continue its use under mandatory appropriate treatment and close follow up. Women at increased risk of STI and HIV infections can

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intimate partner violence are at higher risk of STI and HIV infection, health care providers should take into account prevalence and individual risk to judiciously assess IUD insertion and continuation. Usually IUDs do not require regular follow up.

It is very important to make clear that the above contraceptive methods **DO NOT protect against STI or HIV infection**. Provide the woman with information and offer referral to support services for women's empowerment and skills building on condom use negotiation and safer sexual practices if available.

Emergency contraception (see section 2.2. page 49 of the Health care for women subjected to intimate partner violence or sexual violence. A clinical handbook)

Emergency contraceptive pills. The pills most commonly used for emergency contraception are levonorgestrel- only and combined estrogen-progestogen pills. In 2015, the WHO added the ulipristal acetate pills to the list of emergency contraceptive methods, although it is usually more expensive and has not been included yet in the WHO list of essential medicines. All these pills help prevent pregnancy if taken up to 5 days after unprotected intercourse. Clarify to the woman that emergency contraceptive pills are not designed to be

generally continue use of IUD under careful follow up (MEC 2). Regarding women with high HIV risk, and asymptomatic or mild HIV infection, WHO advises that the advantages of using the IUD generally outweigh the theoretical or proven risks (MEC 2). For women with severe or advanced HIV clinical disease (AIDS stages 3 or 4), IUD should not be initiated (MEC 3). However, in these cases, IUD can be continued under careful follow up (MEC 2). (For more information see: the 2015 WHO Medical eligibility criteria for contraceptive use).

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used as a regular contraceptive method, and that they do not protect from STIs and HIV infection and the current does not offer protection in case of new unprotected sexual intercourses.

- If you have the pills available, give her some to take straight away. If not, tell the woman where she can get the pills and how to use them correctly, and confirm that she has correctly understood all the information (see pages 49 – 51).
- **Copper and hormonal IUD** placed within 5 days after unprotected intercourse can be used as an emergency contraception method. In this case, IUD initiation should follow the same indications as when it is initiated as a regular contraceptive method. (See above as well as page 51).

DUAL PROTECTION

When a risk of HIV and other STI transmission exists, it is important that health-care providers offer information on safer sexual practices to prevent transmission and strongly recommend dual protection to all persons at significant risk, either through the simultaneous use of condoms with other methods or through the consistent and correct use of condoms alone for prevention of both pregnancy and STIs, including HIV. Women and men seeking contraceptive advice must always be reminded of the importance of condom use for preventing the transmission of STI/HIV and such use should be encouraged and facilitated where appropriate. When used correctly and consistently, condoms offer one of the most effective methods of protection against STIs, including HIV. Female condoms are effective and safe, but are not used as widely by national programs as male condoms.