Collaboration or Coercion

CHALLENGES IN PRIORITIZING YOUTHS’ AGENCY AND AUTONOMY IN CONTRACEPTIVE COUNSELING AND PROVISION
Facilitators

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Dr. Aletha Akers has the following commercial relationshipS to disclose:

• Bayer Healthcare, Investigator initiated grant
• Templeton Foundation, research grant
• Merck Inc., HPV Advisory Board
• Association of Reproductive Health Professionals, HPV Advisory Board
Objectives

1. Identify historical legacies that contribute to persistent structural realities affecting whether, when and how youth present for reproductive health services. (10 min)

2. Apply principles of reproductive justice when developing contraceptive counseling approaches for youth presenting with diverse needs and lived experiences. (10 min)

3. Distinguish between reproductive coercion when exercised by intimate partners and peers, parents/caregivers, institutions or health care providers. (10 min)

4. Summarize youth engagement and counseling skills used to maximize patient autonomy and to minimize discrepancies between youth reproductive goal-setting and actions. (50 min)
The Growing Diversity of the Adolescent Population

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<th>Ethnicity</th>
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<th>2050</th>
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<td>11.8</td>
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<tr>
<td>Hispanics</td>
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Socio-Cultural competency and adolescent health

❖ How does the “culture of adolescence” differ from commonly held notions of culture?

❖ How does the culture of adolescence interact and coexist with racial and ethnic cultures?

❖ How does understanding these identity, social and historical contexts impact application of cultural competency to provider interactions with young people?

What does it mean to provide culturally competent care to adolescents?
An Adolescent’s Identity Includes

- Race and Ethnicity
- Socioeconomic Status
- Ability
- Gender Identity
- Religion/Spirituality
- Sexual Orientation
- Genetics
- Geography
- Peer Group
- Stage of Development
- Family Structure
# Social Determinants of Health

**Image credit: the Kaiser Family Foundation**

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
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<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social integration</td>
<td>Health coverage</td>
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<td>Income</td>
<td>Transportation</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Support systems</td>
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<td>Vocational training</td>
<td>Discrimination</td>
<td>Health status</td>
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<td>Playgrounds</td>
<td>Higher education</td>
<td>equity options</td>
<td>Functional Limitations</td>
<td>Community engagement</td>
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<td>Support</td>
<td>Walkability</td>
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**Health Outcomes**

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations
Influences on Health

Nefarious legacies that influence patient-provider encounters

- "Stratified reproduction" leading to historical injustices
- Coerced sterilization used as a means of controlling "undesirable" populations
  - Poor, people of color, immigrants, disabled, mentally ill, unmarried mothers
  - Federally-funded eugenics programs

Contemporary transgressions

- **Norplant 1990s**
  - State legislators in 13 states proposed $$ incentives for women on welfare who got the device
  - In 7 states proposed mandated use for women getting public assistance
    - Substance use, abortion history, ”family caps”
  - In 2 states proposed device use in exchange for reduced prison sentences

- **CA coerced sterilization of female inmates 2006-2010**
  - Tubal ligations performed after birth without following review protocol for approval and standard informed consent procedure

- **Redress**
  - Medicaid 30 day waiting period; no one under age of 21
  - Title X regulations
  - State-level laws banning forced sterilization
  - Eugenics Compensation Act, passed by senate in 2015
Three frameworks of reproductive decision-making

- Rights
- Health
- Justice

Dismantling systems of oppression that impact the other two

Service Delivery
Healthcare System
Reproductive justice framework

Reproductive Justice (Groundswell)
Reproductive justice framework

- Term coined by group of black women in Chicago in 1994 after attending International Conference on Population and Development (Cairo)
  - Women of African Descent for Reproductive Justice

- Amalgamation of BLACK FEMINIST THEORY + HUMAN RIGHTS + SOCIAL JUSTICE applied to reproductive politics

- Launched with full page statement with 800+ signatures in The Washington Post and Roll Call
  - Start of national movement to uplift needs of most marginalized

- Ultimately concerned with intersectionality conceived as oppressions NOT identities
  - Centered around access not choice
  - More than abortion
  - Must analyze power systems
Reproductive justice framework

Nutshell Definition:

The human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.
Continuum of disparities

- 2008: national unintended pregnancy rate 54/1000 women aged 15–44; dropped to 45/1000 in 2011
  - Rate in poorest group more than five times that of women with income at least 200% of federal poverty level (137 vs. 26 per 1,000 women aged 15–44)

- Between 2008 and 2011, rates of unintended pregnancy still twice as high in AA women 15-44 compared with reproductive age average and white women


http://www.guttmacher.org/media/nr/2013/12/19/index.html
Reproductive coercion’s relationship to disparity and vulnerability

- 2008-09 cross-sectional data in aged 16-29 cohort drawn from family planning clinics in San Francisco
- Reproductive coercion significantly associated with race/ethnicity
  - Prevalence greatest in Black and multiracial young women 16-29
- Unintended pregnancy more prevalent among Black and multiracial women and significantly associated with reproductive coercion
Reproductive coercion

Behavior intended to maintain power and control in a relationship related to reproductive health by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent.
Reproductive coercion

Explicit attempts to:

• Impregnate a partner against her will
• control outcomes of a pregnancy
• coerce a partner to have unprotected sex
• interfere with contraceptive methods.
Case # 1: LARC and tiered counseling
Case # 1

Example of counseling about LARC
What is the goal?

1. To decrease rates of unintended pregnancy?
2. To help patients prevent unintended pregnancy?
3. To increase LARC use?

To help clients clarify what they want and help them get it.
Need to assess attitudes:

- Effectiveness
- Hormones
- Menstrual cycle and bleeding
- Return to fertility
- Non-contraceptive benefits
- Side effects

- Duration of use
- Need to conceal
  - No supplies
  - Maintain normal bleeding pattern
- Control over removal/taking
- Object in body
Pearl 1

Examine and tailor communication

Specific case of LARC

- Shift from goal of increasing availability and access to overt promotion/preference

- Risks of this approach
  - Can undermine reproductive autonomy
  - Contraception as a panacea
  - False “magic bullet” when other social determinants of pregnancy intention not considered
Examine and tailor communication

Pearl 1

Long-Acting Reversible Contraception Statement of Principles
Listen to the patient's perception of the problem
Explain your perceptions of the problem and your strategy for treatment
Acknowledge and discuss the differences and similarities between these perceptions
Recommend treatment while remembering the patient's cultural parameters
Negotiate agreement. Understand the patient's explanatory model so medical treatment fits in cultural framework
Pearl 1

Shared decision-making

“A collaborative process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient’s values and preferences.”

– Informed Medical Decisions Foundation

http://www.informedmedicaldecisions.org/
Case # 2: Building skills for decision-making
Case # 2

Janelle is an AA 16 year old sexually active women who presents with her mother. You have never met Janelle before but she presents 5 months after having a Nexplanon placed complaining of irregular bleeding. She wants to have it removed. She has not seen a provider since placement.

What do you do?
Case # 2

- Medical history: noncontributory

- Contraceptive history
  - Tried the pill but had worsening mood symptoms
  - Used depo but gained 30 pounds
  - Tried the patch, but it didn’t stick
  - Doesn’t want an IUD, doesn’t like the idea of something in “there”

- Sexual history
  - Currently having sex, does not want to be pregnant
  - Does not use condoms regularly

What do you do?
As you talk with the patient to try to help her think through her options and next steps, her mother keeps interjecting and stating:

“She should be able to have it removed if she wants. I don’t understand why you just won’t take it out?”

What do you do?
Pearl 2

On one hand…

Goal

Behavior

On the other hand…
Pearl 2

Find the obstacle

Goal

Obstacle
“So it sounds like on one hand you are saying that it’s very important to you to wait until you are ready, and yet on the other hand, a part of you would like to have a baby now? Do I have that right?

“On one hand you would really like to finish school before you become a parent yet on the other hand it’s hard to be consistent with your chosen method…”

Pause and wait for response
Case # 3: Accomplice to coercion
Case # 3

21yo new patient presents to have Mirena removed; inserted 6 months ago. She is a Caucasian female here with her male partner of 4 months and her 4yo mixed race son who appears to have apparent developmental disability. She moved from TX 4 months ago and met her partner soon after. They live together and she relies on him for money and necessities though she won’t say what kind of work he does. She says they are ready to have a baby together and she wants her IUD removed today. She says that her son is not yet set up with early intervention services in WA but he was getting services in TX. You observe that her partner is very easily frustrated with the little boy and keeps telling him to be quiet while standing over him.

You state that as you usually do, you’d like to have time to talk with the patient privately. She looks to her partner who hesitantly agrees and takes the little boy out of the room.

**What do you think is going on?**
Case # 3

With the partner and son out of the room, the young woman talks and answers your questions more readily but still seems to be holding something back. It also becomes apparent in the way she understands your questions and answers that she may have some cognitive disability but is competent to make medical decisions. She reports being kicked out of her sister’s house in TX but won’t say why. When asked about a history of trauma, she endorses being raped multiple times since age 15; she does not want to discuss further. You do a brief clothed exam and observe a freshly tattooed name on her wrist. It is her partner’s name and she says again how much she loves him and is ready to have a baby with him. She mentions that she tried going to another clinic to have the IUD removed but no one there had experience removing IUDs even though they placed them.

What do you do?
Pearl 3

Where is the justice?

A few reflections:

❖ Reproductive coercion is not about your intent but the individual’s perception.
❖ Be mindful of the role of your own worst fear in encounters.
❖ Okay to honestly reflect back to the patient what you are feeling/observing.

Justice doesn’t always settle at the same point in the same situation.
Case # 4: Risk is relative
Case # 4

• 16 year old homeless, female-to-male transgender street youth seeks gender-affirming testosterone therapy

• Excited to start testosterone, has been told by trusted peers that it will stop his periods

• He still sometimes has vaginal-penile sex for money or a place to crash, not using contraception. You talk to him about testosterone not being adequate contraception and recommend a progesterone-only method like the implant or hormonal IUD.

• His companion, 19yo friend further along in male-to-female transition, interrupts your counseling, shouting, “She’s not here to help you! She’s trying to give you female hormones!”

What do you think happens next?
Pearl 4

You are not the youth’s only expert

- Perception of risk is not always rational, often based on life experience
- Try NOT to disagree
- Seek alliances by “finding the yes”
  - Find a point of agreement in what the patient is saying...

  And then add your scientific/medical information

- “Yes!...and...” instead of “No” or “But”
- “Yes, progesterone is traditionally seen as a ‘female’ hormone, and we know from many years of studying the ways hormones work that taking doses of progesterone used for contraception should not interfere with his transition.”
Case # 5: Make agency apparent
Case # 5

15 yo who had an IUD placed 4 months ago for contraception who presents with her mother complaining of irregular bleeding. Her mother is aware that she is sexually active.

You acknowledge that the bleeding side effects can be annoying and try to engage the patient in a conversation about options for managing the bleeding. She seems uninterested in this. Several times she mentions that the idea of keeping the device gives her the “willies”.

Her mother keeps asking her why she won’t give the medicine to stop the bleeding a try.

What do you do?
Case # 5

What did I do?

Reflection

“Does it feel like your mother and I are trying to gang up on you to make you keep this IUD?”

Reflection

The idea of having a piece of plastic in your body all the time is really scary and you would just like to have it out.

Summary Statement

I have the feeling you have some ideas about what you might like to use next, but you can’t even bring yourself to think about them right now because you just need to have the IUD out so you have some piece of mind. Am I right?
Pearl 5

Listen for opportunities to gift agency

- The young person’s agency already exists
- Listen so you understand *what outcome she wants* at this moment in the journey
- Does she want:
  - To be reassured that she isn’t in danger?
  - To have the problem fixed?
  - To complain, be heard, be given compassion?
  - Get advice?
Case # 6: What just happened?!
Case # 6

Taniya is a 14 year old brought to your clinic by her mother for an exam and STD testing. Her mother recently found out that Taniya is sexually active. The mother is very upset and wants Taniya to have a pelvic exam, STD testing, a Pap smear and to be told that she should not have sex again.

What do you do?
Case # 6

FOR MOM, OPPORTUNITY TO...

• Educate about adolescent reproductive health care
• Educate about confidentiality
• Educate about when pelvic exams, pap smears, STD testing is needed
• Empower to collaborate with health providers and other youth serving adults in her adolescent’s life
• Empower to communicate and role model healthy decision making

FOR YOUTH, OPPORTUNITY TO...

• Educate about adolescent reproductive health care
• Educate about confidentiality
• Educate about when pelvic exams, pap smears, STD testing is needed
• Strengths-based HEADS assessment
• Promote abstinence and choice
• Assess and provide reproductive services
Case # 6

Outcome

- Mother pulled daughter out of clinic before the visit was completed. Mom yelled at daughter that she was angry that the daughter was willing to talk with a doctor she did not know, but not the mother. The daughter was dragged through the waiting room while pleading with the mother to let her get her condoms, STD testing and contraception.

- What happened here?
- How could this have been avoided?
Pearl 6

For you, opportunity to...

SELF-EVALUATE

- How do you react when confronted with a patient situation that doesn’t fit your expectations?

- Does the situation provoke feelings of anxiety and discomfort?

- Are you able to assess what is going on within yourself as well as within the patient?
Pearl 6

Health Care Providers’ Identities

- Race and Ethnicity
- Personal History
- Healthcare Specialty
- Marital Status
- Sexual Orientation
- Parental Status
- Gender Identity
- Age
- Religion/Spirituality
- Training Background

PHYSICIANS FOR REPRODUCTIVE HEALTH
Pearl 6

Socio-Cultural Humility

- Puts onus on provider to self-evaluate how personal biases may affect service delivery
- Redresses power imbalances in patient-provider dynamic

Tervalon and Murray-Garcia, 1998
Summary of Practice Pearls

1. More than one way to achieve a desired outcome
   - Shared decision-making
   - The desired outcome may change

2. Practice and demonstrate conflicting interests of decision-making
   - Acceptance theory, dialectical reasoning

3. It isn’t comfortable to interrupt patterns of injustice and coercion

4. Find the mutual “yes”
   - Let young people be and trust their own experts

5. Make the young person’s agency apparent to all, especially the young person

6. Take every opportunity to self-evaluate
Three frameworks of reproductive decision-making

- Rights
- Health
- Justice

Dismantling systems of oppression that impact the other two

Service Delivery
Healthcare System

Legal/Advocacy
Group Reflection

- How can we contribute to reproductive justice and avoid coercion during service provision?
  - Human rights foundation
  - Partnership
  - Locus of decision-making control
  - External factors that impact youth’s experience

By the end of the journey...

Who are we doing right by?
Resources

- www.sistersong.org
- ACOG Committee Opinion on Reproductive Coercion
  https://www.guttmacher.org/about/gpr/2014/09/guarding-against-coercion-while-ensuring-access-delicate-balance
- LARC Statement of Principles: www.tinyurl.com/LARCprinciples