CSIRO PUBLISHING

LETTER
https://doi.org/10.1071/SH21116

SEXUAL HEALTH

Reproductive coercion and abuse in Australia: what do we need to know?

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Handling Editor:
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ABSTRACT

Reproductive coercion and abuse refers to patterns of controlling and manipulative behaviours used to interfere with a person's reproductive health and decision-making. Unintended pregnancy, forced abortion or continuation of a pregnancy, and sexually transmissible infections all may result from reproductive coercion, which is closely associated with intimate partner and sexual violence. Clinicians providing sexual and reproductive healthcare are in a key position to identify and support those affected. Yet, reproductive coercion and abuse is not currently screened for in most settings and addressing disclosures poses many challenges. This article discusses what reproductive coercion and abuse is, who it affects, how it impacts, and potential strategies to improve identification and response.

Keywords: contraception, domestic violence, family planning, health systems, partner violence, pregnancy, reproductive coercion and abuse, sexual and reproductive health.

> 'Like the first couple of times, the condom seems to break every time. You know what I mean, and it was just kind of funny, like, the first six times the condom broke. Six condoms, that's kind of rare. I could understand one but six times, and then after that when I got on the birth control, he was just like always saying, like you should have my baby, you should have my daughter, you should have my kid.' Female, age 17[1]

What is reproductive coercion and abuse?

All people have a right to make decisions that govern their bodies in relation to their sexuality and reproduction, free of stigma, discrimination, coercion, exploitation and violence.[2] Reproductive coercion and abuse violate this right and are recognised by researchers and advocates as forms of violence, but they are often invisible and unknown by society.[1,3] Definitions of what is (and could be) considered reproductive coercion and abuse vary among disciplines,[4] although it is commonly characterised by deliberate attempts to exert power and control over a person's reproductive autonomy.[5–9] These include pressuring a person into becoming pregnant, interfering with a person's contraceptive methods with intent to promote pregnancy, forcing a person to continue a pregnancy or to have an abortion against their wishes, and forcing or coercing sterilisation and contraception without explicit consent from the individual. It is often achieved through emotional manipulation or subtle forms of control but can involve physical and sexual violence as well, and cause fear for personal safety.[4] Most studies on this topic have focused on young heterosexual women as victims and male intimate, dating, or ex-partners as perpetrators – and rightly so, given the inherently gendered nature of violence and reproduction. However, the notion that reproductive coercion and abuse can be enacted by women,[10–12] same-sex partners,[13] family members[14–16] and State actors (e.g. governments, healthcare providers)[17,18] is either unnoticed or heavily debated. In addition, there is debate as to whether menstrual suppression and denial of maternity, parenting and parental rights should be included within definitions of reproductive coercion and abuse,[6] or whether these practices are distinct though important phenomena that disproportionately affect women experiencing intersecting forms of oppression.[18,19] There is also debate as to whether the non-consensual

Received: 24 June 2021
Accepted: 11 August 2021
Published: 4 November 2021

Cite this:
Carter A *et al.* (2021)
Sexual Health
doi:10.1071/SH21116

removal of a condom during sex, or stealthing, should be considered a form of reproductive coercion and abuse. However, it is not always clear that the intent of stealthing is reproductive, or whether it is behaviour to privilege men's sexual pleasure and control and better understood as a form of sexual violence.[20,21]

Who reproductive coercion affects and how it impacts

There is an urgent need for population-based research on reproductive coercion and abuse in Australia so we can determine who is at greatest risk and how it impacts. Convenience sampling in health settings provides the first available data. One study involving Victorian general practices found that 21 of 230 women (almost 10%) reported having ever experienced pregnancy coercion or contraceptive sabotage.[22] More recent studies in Queensland[23] and New South Wales[24] put lifetime prevalence estimates of reproductive coercion and abuse at 5.9% and 2.3%, respectively; both studies measured three domains: (1) pregnancy coercion; (2) contraceptive sabotage; or (3) pregnancy outcome control, noting higher prevalence in those with multiple consultations. While this kind of violence can affect anyone, research in Australia suggests that women who are young, have a disability, are in financial hardship, or are in abusive relationships are at higher risk of reproductive coercion and abuse.[23,24] Further analysis for why this might be the case is needed, along with additional research across the population, and in communities impacted by family violence and intimate partner violence, to identify the full range of risk and protective factors that may guide prevention and intervention strategies. The clinical implications are significant and include higher rates of unintended pregnancy,[25,26] rapid repeat pregnancies,[27] sexually transmissible infections,[28,29] as well as anxiety, depression and distress in pregnancy,[14,23,30,31] which can have substantial risks for infant and child health.[32] However, most studies in Australia and internationally are not with samples representative of the population. Echoing calls for more research to better understand the prevalence and impact of this issue,[6,33,34] including from the 2017–2019 NSW Domestic Violence Death Review Team that identified reproductive coercion and abuse in several domestic and family violence-related deaths,[35] we advocate for increased research utilising both qualitative and quantitative methodologies to understand this phenomenon among diverse groups of people.

Current practice and challenges in identifying reproductive coercion and abuse

Clinicians managing sexual and reproductive health consultations have a vital role to play in asking about and responding to reproductive coercion and abuse. Yet, this is not part of current practice in most health settings in Australia and, unless a patient alerts a clinician to the problem, may go unnoticed by a service. Until there is robust national data collection showing all the different ways that reproductive coercion and abuse presents and how to best identify it, sensitive enquiry and individual case-finding in clinical practice may be the best approach and is advocated by leading scholars in this field.[34] This means asking people about reproductive coercion and abuse if they show signs of high risk (e.g. intimate partner violence, family violence or sexual violence) or limited reproductive agency. When physical and/or sexual violence occurs alongside reproductive coercion, the need for risk assessment and early intervention is clear. However, when an incident of reproductive coercion does not involve overt violence, intimidation or force, what should the response be? Overall awareness of reproductive coercion and abuse remains low in Australia, according to the few researchers doing pioneering work in this area.[36–38] Few clinicians have received training about intimate partner and/or sexual violence,[39] and so it is not surprising that many health practitioners would not feel adequately prepared to approach the topic of reproductive coercion and abuse with their patients.[36–38] Clinicians are also challenged by significant time pressure in clinical visits and a lack of clarity around available health care, advocacy support and referral services for disclosures.[36] In fact, there is some evidence to suggest that clinicians may not always respond appropriately and can create barriers to women enacting reproductive agency and accessing care.[40] Disclosure of reproductive coercion and abuse requires that a woman trusts her healthcare provider and the service as a whole.[41] Structural racism and past breaches of trust, resulting in harms such as removal of children, may mean women from some cultural and community groups, such as Aboriginal and Torres Strait Islander peoples, may be less likely to disclose experiences of violence, including reproductive coercion and abuse. People with disability and migrant and refugee persons, who may have difficulties navigating access to reproductive health information and services or differences in their understanding of reproductive coercion, may also have feelings of distrust. Thus, anti-racist, anti-ableist and anti-oppressive health care is critical to supporting reproductive health and rights for all, especially those communities who are most impacted by social and health inequalities.

Implications for health professionals working in the area of sexual and reproductive health

Although there is a pressing need for more research on effective health system responses in the Australian context,[34,40,41] studies to date reveal some important insights about how healthcare providers can best care for affected families. Most

importantly, patients need a confidential and safe environment for disclosure and support.[38] Clinicians can promote a sense of safety by having a basic understanding of the issue, providing non-judgemental and empathetic care, and ensuring appropriate services and referrals are available.[38] Having printed resources on reproductive coercion and who patients can talk to about their concerns can also open conversations with physicians.[9,42–44] While screening programmes are subject to debate,[34] primarily because of a lack of evidence regarding the magnitude and nature of the benefits and harms, brief screening questions do exist, both in Australia[42,45] and overseas;[8,44,46] these range from asking broad questions about the patient's own fertility intentions and contraceptive practices to asking directly about reproductive coercion and abuse when the patient is alone to assure privacy and confidentiality.[3,9,38,47,48] When reproductive coercion is disclosed or identified, the appropriate response depends on the type of coercion, level of intensity, whether other forms of violence are present, who the perpetrator is, and of course, the individual patient and their preferences. Elements of a best practice response include recognising the patient as the expert in their own reproductive health and providing person-centred, trauma-informed, holistic care.[20,21,38,41] Women want healthcare providers to focus on what they came in for, but also to reinforce that reproductive coercion is wrong, ask about other forms of violence and abuse, and provide patients with options to safeguard their sexual and reproductive health.[40,41] This may include concealment of pregnancies and their termination, information on female-led and hidden forms of birth control (e.g. injectable contraceptives), testing for sexually transmissible infections, referrals to sexual assault support services, safety planning in the immediate and long-term, and provision of educational resources.[3,8,21,23,25,27,38,41,49] Clinicians should be aware that disagreements about contraceptive and pregnancy-related decisions are common and that women's decision making may be shaped by practical or material factors, or a desire to maintain the relationship, even in contexts of coercion. In the absence of physical or sexual violence, the role of the clinician may be primarily awareness raising. While medical needs are easiest to address in health settings, future studies would also be served by examining the wider range of patients' needs and developing response strategies that address the often interwoven medical, psychosocial, cultural, and economic factors shaping people's experiences.

Conclusion

Reproductive coercion and abuse are serious health and human rights issues. It is imperative that all clinicians managing sexual and reproductive health consultations are sensitive to signs of coercion, and are equipped with the knowledge and skills to support patients' agency in reproductive health. It is also important that health and social care providers appreciate and can advocate for change in the broader social context of inequality in which reproductive coercion and abuse occurs.

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Data availability. Data sharing is not applicable as no new data were generated or analysed during this study.

Conflicts of interest. The authors have no conflicts of interest to declare.

Declaration of funding. The authors have received no funding for this commentary.

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