PERSONAL OPINION

Interference with and abuses of sexual and reproductive health and rights: a new proposal for classification and terminology

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Abstract
There has been overuse of the term ‘reproductive coercion’, with a potential for confusion and weakening of messaging. This opinion paper ~~suggests~~ proposes a classification for the many and varied types of interference with, and abuse of, sexual and reproductive health and rights. It also stresses the need for accurate portrayal of behaviours, however uncomfortable this may be for survivors or perpetrators. There are a range of abuses including denial of access to services, control, pressure, threats, coercion and violence. Violence may consist of neglect, mistreatment, exploitation or sexual assault. Abuses are categorised sociologically, according to micro, meso and macro levels of influence. Many types of behaviour at meso and macro level contain elements of racism. It is concluded that the term reproductive coercion and abuse should refer only to micro level behaviour. Healthcare professionals should ascertain that no practices that could be considered abusive are taking place in their workplace.

Introduction

The term ‘reproductive coercion’ is being used in multiple senses, not just at the level of individual relationships [1-5]. The aim of this article is to propose a logical classification of the different ‘levels’ in society that abuses of sexual and reproductive health and rights (SRHR) arise at and to situate abusive behaviour and actions within this. The article does not cover in any detail the nature and extent of SRHR which have been described elsewhere [6]. In addition, others have suggested how SRHR can be respected, fulfilled and protected [7] .

Abuse is behaviour used to intimidate, harm, isolate, dominate or control another person; it does not solely consist of violence [8]. It is mainly heterosexual, cisgender women who suffer as a result of abuse of their SRHR but it is acknowledged that those who are gay, cisgender men, transgender people, non-binary people and others in the LGBTQIA community suffer too. This article focuses on heterosexual, cisgender women survivors of reproductive age, abused predominantly by male perpetrators. Although the end result is generally harm to women, there are important distinctions to be made between abuse mediated through domestic relationships (micro level), abuse mediated through community services (meso level) and abuse inflicted under the banner of national guidelines/standards/laws/policies (macro level) [9] – see Figure 1. These three sociological levels of analysis provide a general guide only; there is considerable overlap between them. This article gives examples of the range of abuses reported and suggests how these can be classified; it does not claim to be exhaustive. Terminology will be addressed in this paper too; it needs to be accurate and forthright so that the extent of abuse is not masked.

Gender-based violence is a wider phenomenon largely occuring at the micro and meso levels.

[Editors: Figure 1 about here]

Micro level

Domestic abuse is a term used to describe patterns of behaviour within personal relationships, be they one-to-one with an intimate partner or within the extended family. Another example of behaviour at micro level is that between human traffickers and the women they exploit [10]. Some of the behaviours under this micro heading take place within the context of strong cultural influence. It must always be remembered that behaviour at micro level, when taken to extremes, can result in femicide [11].

Coercive control

Coercive control (CC) is the basic mechanism underlying all domestic abuse – it was described in detail by Stark [12] and further elaborated on by others since [13]. Coercive control is when a perpetrator repeatedly behaves in a way that makes a person feel controlled, dependent, isolated or afraid. Behaviours are wide-ranging, include lovebombing (initially), gaslighting, isolating women from family and friends and micromanagement. Unfortunately, the word 'control' does not adequately convey the extremes of behaviour that are all too common.

Reproductive coercion and abuse

Reproductive control and abuse (RCA) consists of any *deliberate* attempt to dictate a woman's reproductive choices or interfere with her reproductive autonomy. RCA comprises a range of behaviours, from psychological pressure through to threats of, and actual, physical and sexual violence. RCA is mediated through decisions around whether or not to start, continue or terminate a pregnancy, including use of contraception, and may be exercised at various stages in relation to intercourse, conception, gestation and delivery [10]. RCA may encompass behaviours that operate either to promote or prevent pregnancy [14]. A common behaviour that promotes pregnancy is contraceptive sabotage: confiscating; tampering with; forcibly removing or denying access to contraception. Or a woman can be pressurised into continuing a pregnancy she does not want, for instance by sabotaging her access to abortion [15]. Much of this behaviour is insidious, hidden and not presented in a straightforward way to health and social care professionals.

The term 'reproductive control' [10] arose out of the use of the word 'control' in CC, but this does not convey the extent of abusive behaviour by the perpetrator. Increasingly, the term 'reproductive coercion and abuse' (RCA) is being used to emphasise the harmful effect on the survivor [15]. It is important to appreciate that women generally perceive psychological

abuse as more hurtful than physical assaults and that non-physical abuse can be more frightening [16]. RCA has, rightly, been more fully covered in the media recently [17] and its nature is becoming better understood through research studies. RCA is a form of gender-based violence distinct from, but overlapping with, intimate partner abuse [15].

Some jurisdictions have controlling or coercive behaviour on the statute book as a civil offence but, more commonly, criminal legislation is being introduced. A detailed understanding of the motivation and thinking of perpetrators is largely absent so far.

Intimate partner abuse

Intimate partner abuse (IPA) is often termed 'intimate partner violence' but use of the word 'abuse' is more accurate. IPA is physical, verbal, emotional, economic or sexual violence against a current or former partner. It has long been known that the incidence of IPA increases during and following pregnancy. There is also a suggestion that IPA is more common in women with infertility [18]. Marital rape is now criminalised in a majority of countries; many countries now recognise in law that sex without consent is rape. Non-consensual condom removal (stealthing) probably sits better under the heading of IPA rather than RCA [19]. Sexual violence can be in the form of sexual harassment, sexual assault or rape.

Coercion to marry

Forced marriage

An arranged marriage is one organised by the family but where both partners consent. In a forced marriage, one or both of the partners do not consent. Forced marriage is quite common in South Asian cultures; the woman is regarded as chattel, first under the 'ownership' of the natal family and then of the marriage family [20].

Bride abduction

Bride abduction is a phenomenon seen in Central Asia, among other regions [21]. In Central Asia, it re-emerged as a tradition after the dissolution of the Soviet Union. In rural Kyrgyzstan, 1 in 3 marriages start with bride abduction.

Honour-based abuse

Honour-based abuse is often termed 'honour-based violence' and takes many forms. Most commonly, a young woman who has gone against family norms is abused or disowned by her family [22]. Non-conformance with these norms includes refusal to enter into a forced marriage, extra-marital sex or coming out as gay. Many types of abuse can come under this heading, including virginity testing, forced abortion, forced marriage and FGM – not to mention murder.

Female genital mutilation

Female genital mutilation (FGM) is an injury to the genitalia carried out mainly to girls under the age of 16 years which has serious physical and psychological effect on the person concerned [23]. Perpetrators of FGM are mostly female members of the girl's family/extended family [24]. FGM is a culturally based ritual which is still prevalent despite being criminalised.

Menstrual restriction

Menstruation has a history of being stigmatised and relatively recently this has been countered for example by use of the term 'period products' rather than euphemistic ones like 'women's hygiene products'. Around the world, many girls do not attend school during menstruation [25]. Restricting movement and activities of a menstruating woman is a widespread phenomenon in some countries. In the west of Nepal, women can be banished to small outbuildings during menstruation [26], despite this practice having been outlawed in 2005. 'Restriction' is too mild a word for these practices – terms such as 'isolation' and 'ostracism' would be more appropriate.

Sexual exploitation and abuse

Human trafficking is done for a number of reasons, one of which is for sexual exploitation and abuse (SEA); this comes under the heading of modern slavery. SEA often involves grooming women and girls and forcing them to engage in sex work, pornography or be sold as 'mail-order brides' [27].

Technology-facilitated abuse

This covers a wide range of abuse through phones, social media and GPS [28]. Perpetrators can spy on and monitor their subjects by tracking their whereabouts. There are many other activities such as cyberstalking, trolling, revenge porn and doxxing (revealing private information about someone on the internet). Digital, or cyber, sexual assault is the sharing of intimate and sexualised images of a person online without their consent. Again, use of terms such as online misogyny and harassment do not do justice to the violence and the devastating impact of this abuse.

Meso level

Meso (institutional) level abuses occur in communities and are mediated through official bodies/organisations, generally healthcare facilities and practitioners [29] [30] but also by police, prison and immigration services.

Coerced use of long-acting reversible contraception

This type of coercion may include a lack of fully informed consent when fitting long-acting reversible contraceptive (LARC) methods [31] and/or requests to remove LARC that are

resisted, undermined or even met with outright refusal [32-34]. There has been widespread promotion of LARC as first-line contraception rather than as part of a range of options. There have also been certain marginalised communities that have been targeted for LARC [31]. Some LARC is fitted in those judged to be unfit to parent [30]. Clinicians may be actively promoting LARC because of a conviction that it is a universally good option, because managers are putting pressure on/incentivising them or because they are oblivious to any ethical controversy. Clinicians have biases, miss opportunnities to centre patients and lack curiosity about the appropriateness of solving structural problems with individual solutions [35].

Obstetric violence

The concept of obstetric violence (OV) was conceived in Latin America and relates to abuse around the time of labour and delivery [36]. The use of the word 'violence' has been resisted by healthcare professionals even in the face of factual reports of women's experiences [37] and is not used by some authors [38-40] or by the World Health Organization. However, the UN Special Rapporteur on violence against women has no hesitation in using the term OV [41]. Use of the term OV has been shown to be important in ongoing legal challenges and activism against abuses in childbirth [42]. It is hard to comprehend that, in this day and age in the USA, some incarcerated women are shackled in labour and delivery.

Violence occurs in the process of care provision, even if there is no direct intent to the conduct [37]. OV can include a culture that prevents support-givers being present or allows neglect as well as disrespect and mistreatment. OV has been described throughout the world, including in high-income countries [43]. A notorious example has been the blatant discrimination against and mistreatment of Romani women in the Central European states of the Czech Republic, Slovakia and Hungary [44]. OV appears to be more likely in women of colour; racism is at work [45]and this is implicated in the higher maternal mortality seen in women of colour [46]. Insistence on the term OV is probably more realistic than pressing for use of the term 'obstetric abuse'.

Abortion-related violence

In literature searches, abortion-related violence (ARV) inflicted on those seeking abortion by health professionals responsible for caring for them [47] needs to be distinguished from violence by anti-choice extremists against abortion providers. ARV can be viewed as a way that healthcare providers can discipline, punish and control those who challenge the norm of motherhood and re-establish authority over the abortion process in light of self-managed abortion having become a common practice [48]. ARV can be displayed as denial of or delay in access to care, intervening with curettage, threats of reporting women to the police, disbelieving details of rape, forced viewing of ultrasound images and reluctance to give pain

relief. At the extreme, the abuse has been described by survivors as humiliating, inhumane and cruel [49].

Coerced sterilisation

Women in several marginalised communities have been subjected to coerced sterilisation. Three such communities are mentioned here. Coerced sterilisation is probably a better term than those such as forced, non-consensual or involuntary sterilisation. In many cases, there are consent abuses by clinicians around the time of childbirth [50].

Indigenous, racialised and ethnic minority communities

Key groups that have been subjected to this are: Native American women in the USA and Indigenous women in Canada [51]. However, there are other smaller communities that have been discriminated against too, some only more recently having come to light. In Central America, the Garifuna peoples in Honduras have been discriminated against and put under pressure by clinicians to be sterilised or even not told they have been sterilised [52]. Such cases are only know about because of assiduous medical evaluation of those seeking asylum.

Sterilisation of women living with HIV

This phenomenon is largely driven by hospitals providing obstetric care and has been reported from at least 27 countries [53]. It is falsely justified on the basis of mother-to-child transmission which is no longer a public health problem due to the widespread availability of antiretroviral therapy. The sterilisations are typically performed soon after childbirth.

Incarcerated offenders

Female prisoners in California have been subjected to coerced sterilisation, against prison service regulations [54]. There were 1,000 cases over 20 years and nearly all the women were women of colour. The practice was banned in 2014.

Coercion to abort in pregnancies with fetal anomaly

There is a pervasive presumption among healthcare professionals that those diagnosed with fetal anomalies antenatally will wish to have an abortion – any decisions to continue the pregnancy tend to be undermined and questioned [55]. Pressure to abort sometimes also comes from partners and parents.

Macro level

Macro level abuses occur in society as a whole as a result of decisions made by state governments or national bodies; this is also called structural violence. Sexual and reproductive violence is a common abuse seen during internal conflict or wars between states. Rape, sexual slavery, forced prostitution, forced pregnancy and forced sterilisation all

constitute crimes against humanity *and* war crimes [56]. Forced contraception and forced abortion have been added to this list as a result of evolving international case law [57]. When states introduce laws or policies that target a whole nation or a particular ethnic, racial or religious subset of the population and impose measures intended to prevent births within the group, this is classed as genocide according to Article IId of the Genocide Convention and Article 6d of the Rome Statute [58,59].

Sexual and reproductive violence

The term sexual and reproductive violence (SRV) is used for violence in the context of large-scale human rights violations in humanitarian crises [57], for example armed conflict [60], civil unrest, mass migration or in state prison camps. SRV may be common in war but is by no means inevitable [61]. The SRV seen in Ukraine is the latest in a long list seen at macro level (Table 1) [62,63]. In these different scenarios, the SRV was often only one aspect of extreme violence and killing. It is not only men who perpetrate these atrocities. Use of the word 'violence' in SRV is certainly appropriate in view of the appallingly violent nature of the abuses (Table 1).

[Editors: Table 1 about here]

Military attacks on maternity hospitals

Bombing and shelling of civilians in hospitals in which antenatal, intrapartum and postnatal care is being given comes within the definition of a war crime. Reports of this type of atrocity have come from Idlib, Syria in 2016 [64], Kabul, Afghanistan in 2020 [65]and Mariupol, Ukraine in 2022 [66].

Population control

Population control has been seen in extreme forms taking place over many decades in China and India [67]. This involves the use of incentivisation, pressure or force to administer or insert long-acting reversible contraceptive methods, to force sterilisation and to force abortion. All three of these abuses have been used in China (although the latter was not official state policy); only sterilisation has been used in India. In China, Uyghur women have been targeted in Xinjiang and in India *dalits* have been targeted in all States [67]. When a government incentivises motivators and healthcare professionals, then there can be other subsidiary pressures at work too, driven by the policies [68]. 'Population reduction by coercion' would seem a more accurate term for population control. It is important to distinguish between comprehensive family planning programmes offering a full range of contraceptive options to users in a person-centred fashion and programmes that systematically target populations in order to reduce fertility rates [69].

In Peru, the implementation of the Fujimori regime Programme of Reproductive Health and Family Planning (1996 – 2001) purported to alleviate poverty generally but in fact targeted

solely Indigenous peoples in rural areas where fertility rates were twice those in urban areas [58]. Forced sterilisations were performed on thousands of mainly Quechua-speaking people which, as defined above, is genocide.

Romani women in Central Europe have been targeted for sterilisation. State social services directives in operation in the former Czechoslovakia between 1972 and 1993 ordered the curbing of fertility rates in the Romani community as a 'socio-prophylactic' measure [70,71].

In Mexico, there have been reports of targeting poor, Indigenous people as part of a population control policy [72]. Clinicians were set sterilisation targets and consent procedures were not followed.

On the French overseas island *département* of Réunion in the 1960s and 1970s, thousands of coerced abortions (often combined with coerced sterilisation) were performed on the basis that the colonising administration deemed the island overpopulated [73]. This went on despite French abortion law not having been liberalised until 1975.

Eugenic laws

State-sponsored, coerced sterilisation to 'eliminate' the 'breeding' of those with physical, mental and intellectual disabilities was carried out in a number of jurisdictions, starting in the late 1920s [51,71,74]. Some of these laws were racist in terms of their implementation. Many people were misclassified as having intellectual disability. Examples of such laws are given in Table 2. All have now been repealed apart from that in Taiwan [75]. Compensation schemes have been forthcoming in some jurisdictions but apologies are less common. Nowadays, cases where sterilisation on medical grounds is proposed mostly go through the courts which provides adequate safeguards against any abuse [74]. But, the dark days when these atrocities were performed should never be forgotten. And they still colour service users' views and preferences.

[Editors: Table 2 about here]

Restrictions on access to diagnosis and treatment

Restrictions on any sexual and reproductive health service can be considered a macro level abuse. Assisted reproductive technologies (ART) have been denied to those who do not fit the standard married, heterosexual, cisgender picture [76]. Also upper age limits for treatment have been applied [77]. Obstructions to, or denial of, access are possibly better terms than restrictions.

Restrictive abortion laws

Access to abortion is an integral part of SRH services. Most jurisdictions have a criminal law on abortion and these abortion laws differ widely [78]. Restrictive laws force women to continue pregnancies against their will. There is global guidance on abortion services that is both clinically evidence-based and addresses legal concerns [79]. There is a general incremental trend over time toward more liberalised abortion laws, with a few glaring exceptions [80]. However, liberalised laws do not necessarily translate into good access [81]. Restrictive laws force women into having unsafe abortions. Again, 'obstruction of' or 'denial of access to' abortion is a better descriptor than 'restrictive'.

Discussion and conclusions

Reproductive coercion and abuse is a term best reserved for abusive behaviour at a micro level. Abuses mediated through healthcare systems and national policies are of a different order and nature.

The types of abuse of SRHR seen in households, communities and nations around the world are complex, wide-ranging and shocking. All the forms of coercion and violence mentioned in this article, occurring at any of the three levels, deny women their human rights. In many types of abuse at meso and macro levels, it is clear that racism plays a part.

Many examples of abuse are hidden or come to light by indirect means. At micro level, survivors are often guarded about disclosure because of possible consequences to themselves or their children. At meso level, less extreme forms of medical malpractice may go unchallenged; more extreme abuses may escape notice due to inadequate clinical governance and clinician-patient power imbalances, especially in cases of survivors from marginalised communities. At macro level, individuals feel powerless against state oppression, especially when there is a law or enforceable policy facilitating the abuses.

As clinicians make up the bulk of the readership of this journal, the section on meso level abuses needs some serious reflection by them as to whether any of these practices could be happening in their workplace. Certain procedures mentioned in the macro section carried out by healthcare professionals under legitimate laws at the time can, in certain circumstances, be classed as crimes against humanity or genocide; this should give pause for thought at the very least.

Care needs to be taken not to use terminology that waters down the intensity of the description of the abusive behaviour. 'Control' and 'restriction' may be accurate descriptors of the dynamic in some individual cases but typically there is an evolution and the types of behaviour mentioned escalate. In addition, there is a wide potential spectrum of behaviour, with extreme violence being possible. When does pressure become coercion and coercion become abuse? Words like 'violence' and 'abuse' may not be very palatable to clinicians or

politicians but they are accurate. Clear, direct, accurate messaging is important in the education of everyone but, in particular, all professionals who may come across abuse of SRHR in the course of their work.

It needs to be acknowledged that this topic is, so far, under-researched and that new analyses are still under way which will give us further insights and enable a deeper understanding of abuses of SRHR. As such, this article is only a brief summary of the status quo and inevitably incomplete. Hopefully, consolidating understanding and accurately describing SRHR abuses will be of some practical use for clinicians, highlight important areas for policymakers to work on and make apparent gaps in knowledge which researchers can fill by conducting suitably designed studies.

Figure 1. Three levels of sociological analysis

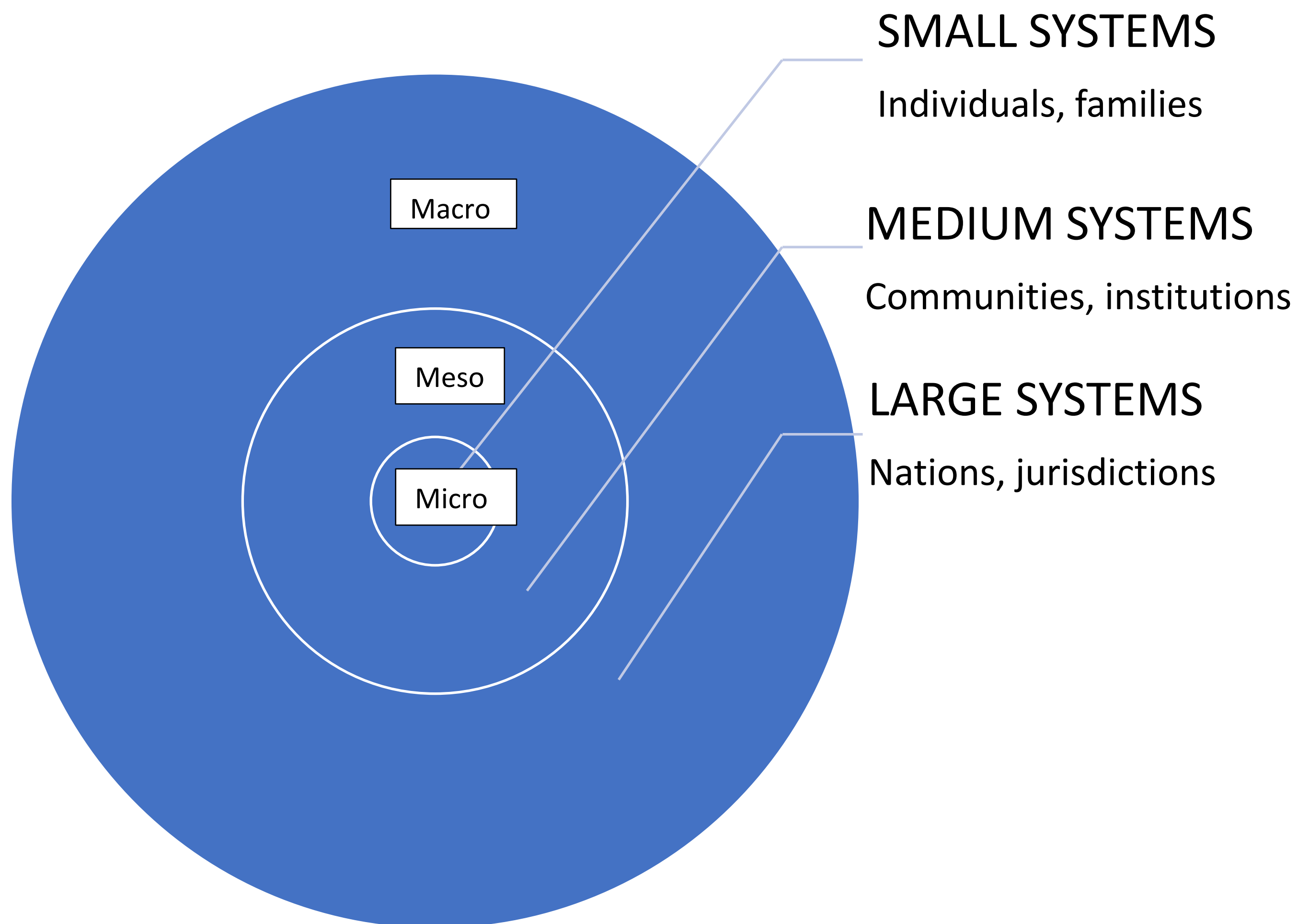

Table 1. Sexual and reproductive violence at macro level

Years	Country	Perpetrators	Targeted people	Nature of SRV
1933 - 1945	Germany	Nazi regime	Jews, homosexuals, Roma etc	FS
1975 - 1979	Cambodia	Khmer Rouge	Cambodians	FM
1982 - 1983	Guatemala	Government and militia	Mayan	R, FC, SEA, FS, FA
1991 - 2002	Sierra Leone	Revolutionary United Front	Civilians	R
1992 - 1995	Bosnia	Serbs	Muslims	R
1994	Rwanda	Hutu	Tutsi	R
1989 - 2003	Liberia	Liberians United for Reconciliation and Democracy	Refugees	R, SEA
1998 - 2003	Democratic Rep of Congo	Armed groups	Rural women and girls	R, SEA
2014 - 2019	Iraq	Islamic State militants	Yazidi	SEA, FC, FA
2015	Myanmar	Government	Rohingya Muslims	FC,
2002 - present	N Korea	Government	Incarcerated defectors	FA
2014 - present	Xinjiang, China	Chinese Communist Party	Uyghurs	FC, FS, FA
2022	Ukraine	Russian army	Ukranians	R

R = rape; FC = forced contraception; FA = forced abortion; FP = forced pregnancy; FS = forced sterilisation; FM = forced marriage; SEA = sexual exploitation and abuse

Table 2. Eugenic laws allowing coerced sterilisation

Jurisdiction	Start date	End date	Number of survivors paid under compensation scheme	Government apology
Alberta, Canada	1928	1972	< 500	1999
British Columbia, Canada	1933	1973	No scheme	No apology
Germany	1933	1945	23,420	2007
Japan	1948	1996	< 1,000	2019
Sweden	1935	1975	c. 1,700	1997
Taiwan	1984	Still in force	NA	NA

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