Reproductive Coercion and Abuse

Sam Rowlands and Susan Walker

Keywords: Reproductive coercion and abuse, Contraceptive sabotage, Pregnancy outcome control, Reproductive autonomy, Gender-based violence

Word count: 4263
Number of references: 40

____
Sam Rowlands (correspondence) and Susan Walker
srowlands@bournemouth.ac.uk

Abstract

This chapter considers deliberate attempts to interfere with a woman's reproductive autonomy in the setting of intimate partner or family relationships. Relevant decisions are those about whether to start, continue or terminate a pregnancy. Reproductive coercion and abuse is a common behaviour and there is some overlap with intimate partner violence. But its presence is often not admitted by the woman to herself, let alone disclosed to professionals. A common phenomenon is contraceptive sabotage: this includes resistance to use of condoms, piercing condoms, jettisoning contraceptive supplies, forcibly removing devices or lying about having had a vasectomy. In some cultural settings, other family members are involved in the coercion and abuse. Some women reassert their autonomy by using contraceptive methods that are concealable. Research on reproductive coercion and abuse is in its early stages. Methods of detection and response are not well developed but health professionals should be aware of the possibility that a woman in their care may be experiencing reproductive coercion and abuse. So far, little is known about the motivation of perpetrators or possible therapeutic options.

Objectives

Having read this chapter, you should be able to understand that:

- Interference with women's reproductive autonomy by sexual partners or the wider family is common
- Coercion or abuse relating to choices about use of contraception or about an established pregnancy comes in various of forms and degrees of severity
- Contraceptive sabotage is deliberate interference with agreed use of contraception, with the intent to cause pregnancy, so invalidating consent to sex
- Non-consensual condom removal is a separate entity with a hallmark of disrespect and lack of consent – there is not necessarily any intent to promote pregnancy

Introduction

A framework of reproductive justice stipulates that women should have the right to have children, the right not to have children and the right to parent children in a safe and healthy environment. In other words, women should have reproductive autonomy – this entails being free from coercion and violence. Unfortunately, many women have their reproductive autonomy compromised. Behaviours which are used to influence or control a woman's reproductive decision-making and reduce or remove her reproductive autonomy can include economic control, threats and intimidation, isolation from friends, family and from sources of support, and emotional and physical abuse. These constitute reproductive coercion and abuse (RCA). This topic is generally limited to 1:1 relationships and wider family groupings. This chapter follows suit and does not extend to reproductive coercion/violence by state actors or in the context of conflict, nor criminal sex-trafficking activity.

RCA is a construct which is distinct from intimate partner violence (IPV) but shares some associations. Whilst RCA and IPV can occur between same sex couples and can be perpetrated by women upon men, the focus of this chapter is RCA in which women are the coerced party. As with other types of gender-based violence (GBV), RCA arises from misogyny and gender inequality and is both a consequence of and a means of perpetuating patriarchal values and domination. The authors have previously referred to this phenomenon as reproductive control but, in light of further evidence from qualitative studies of the presence of violence in these complex relationships and behaviours, they have adopted the terminology reproductive coercion and abuse favoured by Tarzia (Tarzia & Hegarty, 2021). RCA is common and many women presenting to health and counselling services may be currently subject to it, may have experienced it in the past or may be at risk of experiencing it. It is therefore important that those caring for women in these services are aware of RCA and the differing forms it can take. RCA may be a factor in contraceptive 'failure' or non-adherence; frequent requests for emergency contraception; for pregnancy or sexually transmitted infection (STI) testing; or in having more than one abortion. This chapter seeks to clarify the various manifestations of RCA and outlines possible means of prevention.

Contemporary reviews of RCA cover research up to 2017 (Fay & Yee, 2018; Rowlands & Walker, 2019), the more recent one ranging wider in scope to include family pressure and criminal activity. This chapter takes into account further selected publications up to 2021.

What is Reproductive Coercion and Abuse?

Definition

Reproductive coercion and abuse comprises a wide range of behaviours, from psychological pressure such as emotional blackmail, societal or family expectations through to threats of, and actual, physical and sexual violence. It can be defined as any *deliberate* attempt to dictate a woman's reproductive choices or interfere with her reproductive autonomy. It can include physical, psychological or sexual tactics and occurs in a context of fear and/or control in an interpersonal relationship (Tarzia & Hegarty, 2021). RCA can be viewed as sitting on the intersection between sexual violence, family violence and IPV (Tarzia & Hegarty, 2021). RCA fundamentally interferes with women's reproductive autonomy generally and with their autonomous sexual decision-making more specifically (Katz et al., 2017; Rowlands & Walker, 2019). RCA is mediated through the decisions around whether or not to start, continue or terminate a pregnancy, including whether or not to use contraception. It may be exercised in relation to intercourse, conception, gestation or delivery.

Perpetrators of Reproductive Coercion and Abuse

Perpetrators of RCA are most often intimate partners but can include wider family members, acting alone or together. Misogynist cultural and social norms in society can reinforce RCA and may link individual and family behaviour. Controlling behaviours and attitudes need to be recognised and confronted at different levels by bystanders, be they family members, peers, professionals or wider society (Levy-Peck, 2017). Healthcare settings need to have clear protocols that take into account the privacy of potential/actual survivors and bar access to certain parts of consultations to potential/actual perpetrators. Treatment programmes for perpetrators must develop ways of reducing RCA behaviours (Levy-Peck, 2017).

Prevalence of and Associations with RCA

A lack of definitional clarity around RCA in the past has resulted in widely varying prevalence estimates for RCA, a poor understanding of risk factors and difficulty in demonstrating the effectiveness of interventions (Tarzia & Hegarty, 2021). Nonetheless, estimates of the extent of RCA are disturbingly high in varied global settings. In studies of the prevalence of RCA among women of reproductive age attending health services in the USA, between 8 and 30% of women reported ever having suffered RCA (Rowlands & Walker, 2019). One-third of heterosexual women surveyed in an Australian sexual health clinic reported having experienced non-consensual condom removal (Latimer et al., 2019). In a large population-

based study of RCA in India, 12% of women of reproductive age reported ever having experienced RCA from their current husband or their in-laws (Silverman et al., 2019).

RCA is associated with other indicators of poor sexual wellbeing. Those experiencing RCA are less likely to have contraceptive and sexual self-efficacy and less likely to take responsibility for the direction of sexual activity and for contraceptive use (Katz et al., 2015). Several studies have shown a positive association between RCA and unintended pregnancy. It has also been shown that the risk of unintended pregnancy doubles in those who suffer both IPV and RCA. Reproductive coercion and other forms of sexual violence, marginalisation and sexual ill-health coincide. Experience of contraceptive sabotage is positively correlated with ever having an STI, ever engaging in transactional sex (exchange of sex for money or drugs) and having multiple sexual partners in the previous six months (Willie et al., 2021). In a study of US college students, experiences of RCA co-occurred with experience of other forms of sexual violence such as stalking, sexual harassment and sexual assault (Swan et al., 2020).

These associations are found across the world. In India, women experiencing RCA are much less likely to use modern contraceptive methods (Tomar et al., 2020). In South Africa, RCA is positively associated with becoming HIV positive (McCloskey et al., 2020).

There is a strong but complex association between RCA and IPV. Women experiencing IPV are more likely to have a male partner who refuses to use contraception, to experience unwanted pregnancy and to give birth during adolescence, compared to those not experiencing such violence.

Whilst any woman can experience RCA, there is some evidence that younger women are more frequent victims . Women who have recently experienced RCA are more likely to request pregnancy testing and STI testing and to seek emergency contraception – this should be borne in mind in the face of multiple requests for these services (Kazmerski et al., 2015).

Forms of Reproductive Coercion and Abuse Perpetrated by Intimate Partners

RCA may manifest itself across a range of behaviours from pregnancy pressure to contraceptive sabotage or pregnancy outcome control. In a study from Kenya, it was found that the intersection of IPV and high rates of unintended pregnancy might be explained by reproductive coercion, including, in that context, the threat by a partner to take another wife/have a child with another woman (Boyce et al., 2020). RCA is an important factor when

considering pregnancy intention (Borrero et al., 2015). Various forms of RCA perpetrated by intimate partners are considered below.

Preventing the Use of Contraception

In a study of college women in the USA, 8% had experienced RCA and the commonest form, reported by nearly 7%, was for male partners to tell women not to use contraception (Sutherland et al., 2015). Some women may be prevented from obtaining supplies of contraception. Partners themselves may also refuse to use condoms or exhibit various degrees of condom use resistance.

Contraceptive Sabotage

Intimate partners may deliberately sabotage or interfere with a woman's attempts to use contraception. The commonest means of contraceptive sabotage are failure to practise withdrawal, as previously agreed, or non-use of condoms. Deceptive behaviour may extend to a male partner falsely stating that he has had a vasectomy (see Box 1). Contraceptive sabotage also includes various actions including piercing condoms or other barrier methods, tampering with or throwing away supplies of oral contraceptives or forcibly removing transdermal patches, vaginal rings or intrauterine devices (Rowlands & Walker, 2019).

Legislative and Judicial Responses to Contraceptive Sabotage

Contraceptive sabotage interacts and overlaps with sexual coercion and violence. In such cases, consent to sex has been given on the understanding that contraception will be used. Contraceptive sabotage thus invalidates consent – but there are complicated arguments as to how any legal redress would be sought against saboteurs. The criminalisation of contraceptive sabotage has been strongly supported by scholars (Chesser & Zahra, 2019). Singapore has amended its Penal Code so that consent to sex obtained by deception or false representation is criminalised and specifically mentions this in relation to the use of contraception (Republic of Singapore, 2019). A Canadian court convicted a man who pierced holes in a condom before having sex with a woman who subsequently conceived. It was found that the consent was invalidated by fraud/deception and that the increased risk of pregnancy constituted a risk of 'serious bodily harm'. The perpetrator received an 18-month custodial sentence (Supreme Court of Canada, 2014). In many other jurisdictions cases are not litigated or those that are result in no conviction being made. A Court of Appeal case in the UK has clarified the concept of 'conditional consent' and what types of deception are considered sufficient to invalidate consent – see Box 1.

Box 1 Case Study: R v Lawrance

[The next two paragraphs to be placed in a box]

Jason Lawrance linked up with Ms A via a dating website in the UK. They met up and, prior to sex, JL assured her that he had had a vasectomy. Later, he admitted he had lied about his fertility. Ms A became pregnant and had an abortion. JL was convicted of rape under the Sexual Offences Act 2003 at a Crown Court. JL appealed against his conviction and was successful (UK Court of Appeal, 2020).

The judgment considered the circumstances in which deception by an accused man was capable of invalidating ostensible consent. Only deception that is 'closely connected' to the nature or purpose of sexual intercourse was deemed to invalidate consent. Lying about whether a condom would be worn or whether the penis would be withdrawn prior to ejaculation were considered by the Court to be sufficiently closely connected because they physically change the nature of penetration. In contrast, a lie about fertility is not, because it is not related to the performance of the sexual act. In other words, everything hinges on the fact of ejaculation in the woman's body rather than the quality of the ejaculate.

Non-consensual Condom Removal

Contraceptive sabotage includes non-consensual condom removal (NCCR), known informally as 'stealthing' and first expounded on by Alexandra Brodsky (Brodsky, 2017). NCCR is defined as the non-consensual, surreptitious removal of a condom before or during penetrative sex, when consent has been given specifically for condom-protected sex i.e. it is done without knowledge or consent (Czechowski et al., 2019). NCCR has features that differentiate it from contraceptive sabotage in general. The perpetrator is motivated primarily by dislike of condoms rather than by seeking to promote pregnancy (Tarzia et al., 2020). It appears that NCCR is more commonly seen in the context of short-term or casual encounters without the dependency characteristic of RCA (Tarzia et al., 2020).

NCCR as a form of sexual violence has been shown to be associated with sexual aggression, hostility towards women, adversarial heterosexual beliefs and rape myth acceptance (Davis, 2019). Perhaps unsurprisingly, perpetrators are more likely to have ever been diagnosed with an STI and more likely to have had a partner with an unplanned pregnancy than other men (Davis, 2019).

NCCR is a legal grey area in many jurisdictions, perhaps because it does not fit neatly into existing frameworks of crimes of a sexual nature (Chesser & Zahra, 2019). A Swiss Court convicted a man who removed a condom during sex of rape; at the Court of Appeal, the verdict was changed to a 'sex act with a person incapable of resistance' and he received a 12-month suspended sentence (Criminal Court of Appeal - Vaud Canton, 2017).

Women's Actions to Reassert Reproductive Autonomy by Contraceptive Use

Women's attempts to reassert reproductive autonomy in the face of RCA include seeking contraceptive methods that can be used covertly (Boyce et al., 2020; Kibira et al., 2020). It

has been reported that covert use of contraception is a widespread practice to resist RCA in Africa in response to the gender power dynamics in patriarchal settings and in the context of pronatalist norms and policies (Kibira et al., 2020; Silverman et al., 2020). Contraceptive concealment may be difficult and, in some situations, dangerous. Unfortunately, some women in violent relationships may risk an escalation of violence if they try to negotiate contraceptive use. If an intimate partner is likely to discover contraceptive supplies, other forms of contraception may provide a greater chance of concealability. Injectables are 'invisible' but, when a woman is in a situation of intimate partner control, leaving the home to obtain contraception may be difficult. Healthcare professionals may need to be alert to the woman's need to conceal contraception when discussing contraceptive methods, especially in situations where her choice seems difficult to understand, or after a disclosure of IPV and/or RCA. Survivors of RCA may request access to contraceptive services in places, during times and with people that avoid the intimate partner's knowledge and involvement. Telehealth and self-administration of injectable contraception are important options here.

Reproductive Coercion during Pregnancy

Once a pregnancy has become established, RCA can take the form either of forced continuation or forced termination of a pregnancy, against the woman's wishes.

Coerced Continuation of a Pregnancy

RCA can include insistence on continuation of a pregnancy which the woman regards as unintended or unwanted . Attempts to access surgical abortion may be sabotaged by preventing a woman accessing a clinic. In these circumstances, medical abortion may be more accessible than surgical abortion to a woman being subjected to RCA, especially if performed according to a no-test, telemedical protocol. This is an aspect of a woman's choice of methods which providers of abortion need to be aware of.

Forced or Perpetrator-induced Termination of a Pregnancy

Reproductive coercion may also involve forced termination of a pregnancy. Partners may coerce a woman into having a therapeutic abortion or a woman may be assaulted with the intention of causing a miscarriage. Covert administration of abortifacients to terminate a pregnancy has been reported and prosecuted (Rowlands & Walker, 2019).

Reproductive Coercion and Abuse Beyond the Intimate Partner

Perpetration of RCA may extend beyond a single intimate partner and may be part of a pattern of wider family, societal or criminal abuse.

Control over Family Size by the Wider Family

In some cultural settings, the wider family – and in particular older female relatives – may have societally endorsed control over reproductive decision-making. Mothers-in-law in patrilineal societies may strongly influence reproductive decisions on the composition of the family (Char et al., 2010), although this need not necessarily be coercive. Family-based reproductive coercion is often linked with the status of women and how this is affected by their ability to reproduce (Boyce et al., 2020; Gupta et al., 2012). Links between IPV and wider family abuse during pregnancy, at delivery and postpartum have been reported in two studies of IPV in India (Raj et al., 2011; Silverman et al., 2019).

Impact

There is some overlap between the impact of RCA on mental and physical health and the impact of IPV, which is covered elsewhere in this book. So far, little is known about the impact of RCA. Associations have been found specifically between RCA and negative mental health outcomes in the general population in Côte d'Ivoire (McCauley et al., 2014), in women attending for counselling about pregnancy options in Australia (Price et al., 2019) and in women continuing their pregnancies in Liberia (Willie & Callands, 2018).

Prevention, Detection, Education and Harm Reduction

Recognising the existence and extent of RCA provides opportunities for prevention and harm reduction. Prevention and intervention can be complicated by the fact that women subjected to RCA may not necessarily view their relationship as unhealthy or abusive, especially if there is no physical violence. The degree of control that a male partner can exert will vary.

Considering RCA as a public health problem allows prevention to be conceptualised in terms of primary, secondary and tertiary prevention. Primary (universal/population level) prevention at its most ambitious would depend on societal modification of attitudes and behaviour. An overall approach is needed to enhance gender equity, non-violent and non-coercive conflict resolution and respect for reproductive autonomy within intimate relationships (Levy-Peck, 2017). It may include enabling women to acquire the necessary skills and education to avoid entrapment in coercive relationships and, crucially, to provide early assistance to women seeking to exit such relationships. Secondary prevention would identify existing cases of RCA using standardised questions concerning risk factors (see below). Appropriate health service settings for secondary prevention are maternity, early pregnancy, sexual assault, SRH and abortion services and in general practice. Ethically, a

prerequisite to the identification of cases is the capacity to provide effective interventions, including harm reduction. Tertiary prevention would involve support to individuals and families that cannot extricate themselves from the RCA, to minimise harm, and to provide support for survivors.

Screening questions have been formulated to help healthcare professionals identify women who are subject to RCA – see Box 2.

Box 2 Standardised Questions for Identification of Cases of RCA

[The following ten lines to be placed in a Box]

If not pregnant:
Does your partner support your decision about when or if you want to become pregnant?

If not trying to become pregnant:
Has your partner ever tried to get you pregnant when you did not want to be pregnant?
Has your partner ever forced you to do something sexually that you did not want to do or refused your request to use condoms?

If already pregnant:
Do you and your partner agree on what you should do about your pregnancy?
Are you worried your partner will hurt you if you do not do what he wants with the pregnancy?

If RCA is detected, a range of support may be offered, tailored to the woman's needs at the time. Advice about contraception should take place within the wider context of helping women minimise or escape from situations of domestic violence and abuse. Help with negotiating condom use may be useful. When necessary, concealable methods may be offered, if a woman is unable to escape the abuse at that time. Healthcare professionals can also ensure that women know how to access emergency contraception.

Providers themselves are likely to need training in responding to RCA. There are examples of educational materials on RCA that have been developed for provider and advocate training (Burton & Carlyle, 2015; Cappelletti et al., 2014). An educational intervention in SRH clinics, which comprised enhanced screening, assisting the client to access local services and sexual assault resources, combined with tailored harm reduction strategies, such as concealable contraceptive methods, was found to reduce the odds of pregnancy coercion by 71% and to significantly increase the odds of ending a relationship due to perceptions that it was unhealthy (Miller et al., 2011).

The 'Addressing Reproductive Coercion in Health Settings (ARCHES)' Intervention Study was a cluster randomised controlled trial evaluating the effectiveness of a brief, clinician-delivered universal education and counselling intervention to reduce IPV, RCA and unintended pregnancy compared to standard-of-care in family planning clinic settings (Tancredi et al., 2015). As well as education for healthcare professionals, it supplied palm-sized brochures for clients, which described healthy and unhealthy relationships and offered information about harm reduction and IPV-related resources. The trial did not show a reduction in RCA or IPV but participants reported that they had improved knowledge of IPV resources such as a domestic violence hotline and felt more able to enact harm reduction behaviours (Miller et al., 2016).

There is scope for addressing wider cultural gender relationships in schools, and a need for the development and evaluation of specific educational materials around reproductive autonomy for students in secondary or tertiary education, as part of relationships and sex education.

Implications for Service Providers and Policymakers

Those working in health and social care specialties relating to women's health, and in general practice, should be aware of RCA. Healthcare professionals should be alert to RCA in consultations with women who are displaying behavioural patterns such as persistent lack of use of contraception (despite not wishing to become pregnant), frequent requests for emergency contraception, frequent attendances for pregnancy testing or STI testing and requests for more than one abortion. Women attending health services with escorts should, at some stage, be seen alone so that these sensitive issues can be raised and, if necessary, explored.

Despite the benefits and acceptability of screening for IPV and abuse, fewer than half of healthcare providers routinely do so (Alvarez et al., 2017). Factors that may motivate healthcare professionals to identify more cases have been described and are complex. These include a greater willingness to screen very young women, or in cases where children are at risk, and motivation to screen where harm has been noted or the provider perceives the woman to be 'at risk'. The experience or perception of being able to make a difference or improve the situation, and the importance of routinising such enquiry have also been found to be motivating factors (Burton & Carlyle, 2020).

There are now standardised questions for RCA detection (Box 2) and interventions that can assist in reducing its harms. Pathways and mechanisms of referral to other agencies need to be available to staff, as a matter of routine clinical policy, to enable them to respond

appropriately if RCA is disclosed. Information may need to be shared with safeguarding agencies, especially with respect to younger women, or those who lack mental capacity.

Policy must be underpinned by comprehensive, multi-sectoral and rights-based approaches. Public health policymakers need to take account of RCA as a causative factor in unintended pregnancy. Research findings reinforce the importance of relationships and sex education, including respect for partners and open communication about contraceptive use. Practical advice can focus on strengthening conflict resolution, skill building and awareness.

Unanswered Questions and Future Research

There remains much to be learnt about RCA and NCCR and how they affect women (Fay & Yee, 2018; Rowlands & Walker, 2019). Qualitative research has given a particularly rich insight into the subject and more is needed, for example relating to intent, fear and control (Tarzia & Hegarty, 2021). More focus is needed on the non-physical elements of abusive relationships and to survivors' voices, coping methods and resistance strategies. Also, more needs to be understood about whether RCA relates to a particular partner or whether RCA experiences with one partner negatively impact future sexual relationships.

More understanding of perpetrators' motivations for engaging in RCA is needed. Further research should be conducted into the reasons why partners engage in RCA behaviours, as well as women's perceptions of partner intent. Young people are especially vulnerable to RCA and research is needed which focuses on their dating relationships.

Research is also needed on the effectiveness of primary, secondary and tertiary prevention measures for RCA. So far, there are no robust evaluations of collaborative models of care or referral pathways. As always, in an era of over-stretched healthcare professionals working with limited resources, the most efficient and effective means of using routine consultations to identify and reduce the harms of RCA need to be identified and disseminated. Evidence-based guidelines and training are currently lacking (Tarzia et al., 2019).

Summary

- RCA is any deliberate attempt to interfere with a woman's reproductive autonomy – it infringes women's reproductive rights.

- RCA is common but may not be revealed.

- RCA is primarily carried out by intimate partners but is also perpetrated by the wider family.

- RCA may consist of pregnancy pressure, contraceptive sabotage or pregnancy outcome control.

- RCA is associated with poor use of contraception. Past experience of RCA adversely affects women's feelings of agency during sexual and contraceptive interactions.

- Contraceptive sabotage invalidates consent but its definition as a crime is legally complex and very few jurisdictions have developed a meaningful approach to prosecuting it.

- Non-Consensual Condom Removal is a type of contraceptive sabotage but is not necessarily related to pregnancy promotion. It is primarily a form of sexual violence, often with disrespect and selfishness underlying it. As a general rule, NCCR is seen in the context of short-term relationships, in contrast to RCA in longer-term relationships.

- Women exposed to RCA may seek out concealable methods of contraception, although they risk possible retaliation if this were to be discovered.

- Few strategies for prevention of RCA have, so far, been developed.

- Professionals working in a range of women's services should be aware of the existence of RCA and equipped to detect it.

References

References

Alvarez, C., Fedock, G., Trister, K., & Campbell, J. (2017). Provider screening and counseling for intimate partner violence: a systematic review of practices and influencing factors. *Trauma, Violence, & Abuse*, *18*(5), 479-495. https://doi.org/10.1177%2F1524838016637080

Borrero, S., Nikolajski, C., Steinberg, J. R., Freedman, L., Akers, A. Y., Ibrahim, S., & Schwarz, E. B. (2015). "It just happens": a qualitative study exploring low-income women's perspectives on pregnancy intention and planning. *Contraception*, *91*, 150-156. https://doi.org/10.1016/j.contraception.2014.09.014

Boyce, S. C., Uysal, J., DeLong, S. M., Carter, N., Undie, C., Liambila, W., Wendoh, S., & Silverman, J. G. (2020). Women's and girl's experiences of reproductive coercion and opportunities for intervention in family planning clinics in Nairobi, Kenya: a qualitative study. *Reproductive Health*, *17*, 96. https://doi.org/10.1186/s12978-020-00942-7

Brodsky, A. (2017). "Rape-adjacent': imagining legal responses to nonconsensual condom removal. *Columbia J Gender & Law*, *32*, 183-210. https://doi.org/10.7916/D8708D06

Burton, C. W., & Carlyle, K. E. (2015). Screening and intervening: evaluating a training program on intimate partner violence and reproductive coercion for family planning and home visiting providers. *Fam Community Health*, *38*(3), 227-239. https://doi.org/10.1097/fch.0000000000000076

Burton, C. W., & Carlyle, K. E. (2020). Increasing screening for intimate partner violence and reproductive coercion: understanding provider motivations. *Violence Against Women*, *27*(11), 1913-1929. https://doi.org/10.1177%2F1077801220969875

Cappelletti, M., Gatimu, J., & Shaw, G. (2014). *Exposing reproductive coercion: a toolkit for awareness raising, assessment, and intervention*. FWHC, NCADV, NOMAS https://www.communitysolutionsva.org/files/RCtoolkit%281%29.pdf

Char, A., Saavala, M., & Kulmala, T. (2010). Influence of mothers-in-law on young couples' family planning decisions in rural India. *Reprod Health Matters*, *18*(35), 154-162. https://doi.org/10.1016/S0968-8080(10)35497-8

Chesser, B., & Zahra, A. (2019). Stealthing: a criminal offence? *Currents Issues in Criminal Justice*, *31*(2), 217-235. https://doi.org/10.1080/10345329.2019.1604474

Criminal Court of Appeal - Vaud Canton. (2017). *Decision No. 145 of 8 May 2017* www.findinfo-tc.vd.ch

Czechowski, K., Courtice, E. L., Samosh, J., Davies, J., & Shaughnessy, K. (2019). "That's not what was originally agreed to": perceptions, outcomes, and legal contextualization of non-consensual condom removal in a Canadian sample. *PLoS One*, *14*(7), e0219297. https://doi.org/10.1371/journal.pone.0219297

Davis, K. C. (2019). "Stealthing": factors associated with young men's nonconsensual condom removal. *Health Psychology*, *38*(11), 997-1000. https://doi.org/10.1037%2Fhea0000779

Fay, K., & Yee, L. (2018). Reproductive coercion and women's health. *J Midwifery Womens Health*, *63*(5), 518-525. https://doi.org/10.1111/jmwh.12885

Gupta, J., Falb, K., Kpebo, D., & Annan, J. (2012). Abuse from in-laws and associations with attempts to control reproductive decisons among rural women in Côte d'Ivoire: a cross-sectional study. *BJOG*, *119*(9), 1058-1066. https://doi.org/10.1111/j.1471-0528.2012.03401

Katz, J., Poleshuck, E. L., Beach, B., & Olin, R. (2015). Reproductive coercion by male sexual partners: associations with partner violence and College women's sexual health. *J Interpersonal Violence*, *32*, 3301-3320.

Katz, J., Poleshuck, E. L., Beach, B., & Olin, R. (2017). Reproductive coercion by male sexual partners: associations with partner violence and College women's sexual health. *J Interpersonal Violence*, *32*(21), 3301-3320. https://doi.org/10.1177/0886260515597441

Kazmerski, T., McCauley, H. L., Jones, K., Borrero, S., Silverman, J. G., Decker, M. R., Tancredi, D., & Miller, E. (2015). Use of reproductive and sexual health services among family planning clinic clients exposed to partner violence and reproductive coercion. *Matern Child Health J*, *19*(7), 1490-1496. https://doi.org/10.1007/s10995-014-1653-2

Kibira, S. P. S., Karp, C., Wood, S. N., Desta, S., Galadanci, H., Makumbi, F. E., Omoluabi, E., Shiferaw, S., Seme, A., Tsui, A., & Moreau, C. (2020). Covert use of contraception in three sub-Saharan African Countries: a qualitative exploration of motivations and challenges. *BMC Public Health*, *20*, 865. https://doi.org/10.1186/s12889-020-08977-y

Latimer, R. L., Vodstrcil, L. A., Fairley, C. K., Cornelisse, V. J., Chow, E. P. F., Read, T. R. H., & Bradshaw, C. S. (2019). Non-consensual condom removal, reported by patients at a sexual health clinic in Melbourne, Australia. *PLoS One*, *13*(12), e0209779. https://doi.org/10.1371/journal.pone.0209779

Levy-Peck, J. Y. (2017). Perpetrators and reproductive coercion. In P. McOrmond-Plummer, P. Easteal, & J. Y. Levy-Peck (Eds.), *Perpetrators of intimate partner sexual violence, a multidisciplinary approach to* (pp. 112-122). Jessica Kingsley.

McCauley, H. L., Falb, K. L., Streich-Tilles, T., Kpebo, D., & Gupta, J. (2014). Mental health impacts of reproductive coercion among women in Côte d'Ivoire. *Int J Gynecol Obstet*, *127*(1), 55-59. https://doi.org/10.1016%2Fj.ijgo.2014.04.011

McCloskey, L. A., Hitchcock, S., Eloff, I., Dinh, P., & Masemola, K. (2020). The role of reproductive coercion in women's risk for HIV: a case-control study of outpatients in Gauteng, South Africa. *Int J Gynecol Obstet*, *151*(3), 377-382. https://doi.org/10.1002/ijgo.13373

Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., Schoenwald, P., & Silverman, J. G. (2011). A family planning clinic partner violence intervention to reduce risk associated with reproductive coercion. *Contraception*, *83*(3), 274-280. https://doi.org/10.1016%2Fj.contraception.2010.07.013

Miller, E., Tancredi, D. J., Decker, M. R., McCauley, H. L., Jones, K. A., Anderson, H., James, L., & Silverman, J. G. (2016). A family planning clinic-based intervention to address reproductive coercion: a cluster randomized trial. *Contraception*, *94*(1), 58-67. https://doi.org/10.1016/j.contraception.2016.02.009

Price, E., Sharman, L. S., Douglas, H. A., Sheeran, N., & Dingle, G. A. (2019). Experiences of reproductive coercion in Queensland women. *J Interpers Violence*. https://doi.org/10.1177/0886260519846851

Raj, A., Sabarwal, S., Decker, M. R., Nair, S., Jethva, M., Krishnan, S., Donta, B., Saggurti, N., & Silverman, J. G. (2011). Abuse from in-laws during pregnancy and post-partum: qualitative and quantitative findings from low-income mothers of infants in Mumbai, India. *Matern Child Health J*, *15*(6), 700-712. https://doi.org/10.1007%2Fs10995-010-0651-2

Republic of Singapore. (2019). *Criminal Law Reform Act 2019 s 376H* www.sso.agc.gov.sg/Acts-Supp/15-2019/

Rowlands, S., & Walker, S. (2019). Reproductive control by others: means, perpetrators and effects. *BMJ Sexual & Reproductive Health*, *45*(1), 61-67. https://doi.org/10.1136/bmjsrh-2018-200156

Silverman, J. G., Boyce, S. C., Dehingia, N., Rao, N., Chandurkar, D., Nanda, P., Hay, K., Atmavilas, Y., Saggurti, N., & Raj, A. (2019). Reproductive coercion in Uttar Pradesh, India: prevalence and associations with partner violence and reproductive health. *SSM - Population Health*, *9*, 100484. https://doi.org/10.1016/j.ssmph.2019.100484

Silverman, J. G., Challa, S., Boyce, S. C., Averbach, S., & Raj, A. (2020). Associations of reproductive coercion and intimate partner violence with overt and covert family planning use among married adolescent girls in Niger. *EClinicalMedicine*, *22*, 100359. https://doi.org/10.1016/j.eclinm.2020.100359

Supreme Court of Canada. (2014). *R v Hutchinson [2014] 1 SCR 346 (Can)* https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/13511/index.do

Sutherland, M. A., Fantasia, H. C., & Fontenot, H. (2015). Reproductive coercion and partner violence among college women. *JOGNN*, *44*, 218-227. https://doi.org/10.1111/1552-6909.12625

Swan, L. E. T., Mennicke, A., & Kim, Y. (2020). Reproductive coercion and interpersonal violence victimization experiences among college students. *J Interpers Violence*. https://doi.org/10.1177%2F0886260519898424

Tancredi, D. J., Silverman, J. G., Decker, M. R., McCauley, H. L., Anderson, H. A., Jones, K. A., Ciaravino, S., Hicks, A., Raible, C., Zelany, S., James, L., & Miller, E. (2015). Cluster randomized controlled trial protocol: addressing reproductive coercion in health settings (ARCHES). *BMC Women's Health*, *15*, 57. https://doi.org/10.1186%2Fs12905-015-0216-z

Tarzia, L., & Hegarty, K. (2021). A conceptual re-evaluation of reproductive coercion: centring intent, fear and control. *Reprod Health*, *18*, 87. https://doi.org/10.1186/s12978-021-01143-6

Tarzia, L., Srinivasan, S., Marion, J., & Hegarty, K. (2020). Exploring the gray areas between "stealthing" and reproductive coercion and abuse. *Women & Health*, *60*(10), 1174-1184. https://doi.org/10.1080/03630242.2020.1804517

Tarzia, L., Wellington, M., Marino, J., & Hegarty, K. (2019). How do health practitioners in a large Australian public hospital identify and respond to reproductive abuse? A qualitative study. *Aust NZ J Public Health*, *43*(5), 457-463. https://doi.org/10.1111/1753-6405.12923

Tomar, S., Dehingia, N., Dey, A. K., Chandurkar, D., Raj, A., & Silverman, J. G. (2020). Associations of intimate partner violence and reproductive coercion with contraceptive use in Uttar Pradesh, India: how associations differ across contraceptive methods. *PLoS One*, *15*(10), e0241008. https://doi.org/10.1371/journal.pone.0241008

UK Court of Appeal. (2020). *R v Lawrance [2020] EWCA Crim 971* https://www.bailii.org/ew/cases/EWCA/Crim/2020/971.html

Willie, T. C., Alexander, K. A., Caplon, A., Kershaw, T. S., Safon, C. B., Galvao, R. W., Kaplan, C., Caldwell, A., & Calabrese, S. K. (2021). Birth control sabotage as a correlate of women's sexual health risk: an exploratory study. *Women's Health Issues*, *31*(2), 157-163. https://doi.org/10.1016/j.whi.2020.10.003

Willie, T. C., & Callands, T. A. (2018). Reproductive coercion and prenatal distress among young pregnant women in Monrovia, Liberia. *Health Care Women Int*, *39*(9), 968-974. https://doi.org/10.1080/07399332.2018.1490740