Item: BMJ-UK; Article ID: rows069043;
Article Type: Standard article; TOC Heading: Practice; DOI: 10.1136/bmj-2021-069043

Practice Pointer

How to recognise and respond to reproductive coercion

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Box start

What you need to know

- Reproductive coercion refers to actions taken by a person's partner or family member to prevent or promote pregnancy, irrespective of their wishes
- Steps taken to promote pregnancy without a sexual partner's knowledge invalidate sexual consent in many countries, including the UK
- People exposed to reproductive coercion may resort to covert use of contraception
- Those at risk of reproductive coercion are often also at risk of intimate partner violence

Box end

Samantha, a 19 year old mother to a 7 month old boy, is well known to you. She has booked a telephone consultation, but when she answers she sounds panicked and states that she hasn't got long as she needs to get back home. She wants the subdermal implant you fitted one month ago removed, as she's changed her mind and wishes to try for another baby. She agrees to the face-to-face appointment you offer and hangs up.

She arrives for the appointment with her 30 year old partner, Steven. Samantha appears withdrawn and Steven answers questions on her behalf. You feel uncomfortable about the relationship dynamic and ask to see Samantha on her own. When her partner leaves the room, you inquire further about her wish to have her contraceptive implant removed. She pauses, looking visibly upset, then starts to cry.

This article offers an overview of reproductive coercion for clinicians. It focuses on reproductive coercion perpetrated against women who are heterosexual and cisgender (gender identity matching sex assigned at birth),[1] although the discussion applies to any person who has female reproductive capacity.

Reproductive coercion is any deliberate attempt to dictate a woman's reproductive choices or interfere with her reproductive autonomy. It comprises a range of behaviours, from psychological pressure through to threats of (and actual) physical and sexual violence (table 1). These are all forms of abuse. Note that an abuser—also referred to as a perpetrator—may change behaviour between pregnancy promoting and pregnancy preventing. Clinicians are often in a unique position to identify those experiencing reproductive coercion and offer immediate and ongoing support. Although common, reproductive coercion can be subtle, and barriers may prevent the woman seeking support.

Coercive control

Reproductive coercion typically takes place in the context of coercive control.[5] Coercive control is when an abuser repeatedly behaves in a way that makes a person feel controlled, dependent, isolated, or afraid. People under coercive control are making decisions under duress; their decision making autonomy about complying with or resisting the wishes of the abuser need to be seen in this context.[5] Those under coercive control may find it difficult to access healthcare because of intense surveillance of their whereabouts, activities, and communications by their abuser.

Table 1 Examples of reproductive coercion behaviours[2 3]

Pregnancy promoting/continuing	Pregnancy preventing/terminating
Psychological pressure to conceive or to continue a pregnancy	Pressure or coercion of a woman to use contraception or to be sterilised
Threats of harming a woman or her children if she does not conceive or if she attempts to prevent conception	Emotional blackmail/threats or other coercion to force a woman to have a termination of pregnancy
Forced sex without use of contraception	Covert administration of abortifacient agents to a woman
Contraceptive sabotage: confiscating/tampering with/forcibly removing/denying access to contraception	Physical violence to a woman with the intention of inducing a miscarriage

Who are the abusers?

Although abusers are most often intimate partners who are heterosexual, cisgender men, reproductive coercion can come in many guises. It can be perpetrated by cisgender women upon cisgender men[6 7]; and although few studies exist on reproductive coercion among LGBTQ+ people, it may still occur.[8 9] It can come from the wider family and can also be carried out in the contexts of conflict, sex trafficking, and sexual exploitation.[1 3]

How common is reproductive coercion?

Little documented evidence exists for reproductive coercion, although knowledge has increased in the past decade. A ComRes poll carried out for BBC Radio 4 of 1060 women between the ages of 18 and 44 living in all four nations of the UK in February 2022 found that half had experienced some form of reproductive coercion.[10] In a formal study of the prevalence of reproductive coercion among cisgender women of reproductive age attending health services in the US, between 8% and 30% of women reported ever having experienced reproductive coercion.[3] In an Australian sexual health clinic survey, 32% of heterosexual, cisgender women reported having experienced non-consensual condom removal (box 1).[11] In a large population based study in India, 12% of married women of reproductive age reported ever having experienced reproductive coercion from their current husband or their in-laws.[12] Isolation and lockdown measures are likely to have resulted in an increased prevalence of reproductive coercion during the covid-19 pandemic,[13] as was the case for several other forms of intimate partner violence.

Any woman can be subject to reproductive coercion. Groups that have been identified as potentially at higher risk—based on low quality evidence and our experience—are listed in box 2.

Box start

Box 1 Non-consensual condom removal

Non-consensual condom removal is a type of contraceptive sabotage seen more in short term or casual sexual encounters.[3] The abuser removes the condom without their sexual partner being aware.[31] Debate is ongoing as to whether non-consensual condom removal (known informally as “stealthing”) is primarily a form of reproductive coercion or whether it is a form of sexual violence.

Those who have been subject to non-consensual condom removal are less likely to be seeking concealable contraception and they may appreciate referral to sexual assault services.[31] Nonetheless, valuable lessons can be learned from studies of intimate partner violence about providing trauma informed, woman centred care, and from the LIVES[32] and CARE[33] models which were developed for the healthcare context.

Box end

Box start

Box 2 Women who may be at higher risk of reproductive coercion

- Women whose relationships with partner and/or family are subject to an imbalance of power or control. Control or coercion could be physical, psychological, sexual, or economic
- Women who have experienced domestic violence, intimate partner violence, or previous reproductive control
- Women who have engaged in transactional sex (exchange of sex for money or drugs)[14]
- Women whose partner has other concurrent partners[2 15]
- Younger women, particularly adolescents[22 23]
- Women with mental health problems and/or learning disabilities[2 15]

- Women who are socioeconomically disadvantaged [15]
- Women who are unemployed[18]
- Those who are socially isolated and have limited access to social support systems and community services[13]
- Drug and/or alcohol users[11]
- Those from racially marginalised backgrounds,[2] especially migrants[22]
- Those from cultural backgrounds that are patriarchal[22]
- Women who do not speak the language of the country in which they are seeking medical help[24]
- Women who attend frequently for emergency contraception or for pregnancy or sexually transmitted infection testing, including those who have low sexual self-efficacy[3]
- Those who have unplanned pregnancies and/or are having more than one abortion; particularly be aware of those who have coerced abortions as this can be seen in organised criminal activity[3 15]
- Pregnant women who access healthcare after the first trimester or conceal pregnancies[4]

Box end

How does reproductive coercion present?

In addition to unintended pregnancy, reproductive coercion is associated with greater risk of sexually transmitted infections[14] and with poorer mental health and psychological distress.[15] Indicators of reproductive coercion include repeated requests for emergency contraception, pregnancy testing, sexually transmitted infection testing, and/or termination of pregnancy. Such resistance strategies represent important acts of agency by women but can easily be misinterpreted as poor health literacy or wasting health resources.[16] Women experiencing reproductive coercion that goes beyond psychological pressure are more likely to request highly effective contraceptive methods: injectables, implants, intrauterine contraceptives, or sterilisation.[17]

Australian studies show that cisgender women are more likely to disclose reproductive coercion at subsequent contacts, rather than at a first contact with a clinician[15 18] and it is typically not raised as a primary problem in consultations.[19] Women with language or cultural barriers are further prevented from disclosure, particularly if a relative is asked to translate during a consultation. As with other forms of intimate partner violence, women who experience reproductive coercion may not recognise or acknowledge how abnormal their partner's behaviour is,[4 20] and feel that they cannot disclose because of the risk of serious repercussions. As well as violence toward the woman, such consequences can include withdrawal of finances, blocking access to friends and family, or harm to existing children.

Reproductive coercion often occurs concurrently with sexual violence in relationships.[21] Women are far less likely to disclose sexual violence even when they have already disclosed physical or psychological abuse.

Discussing reproductive coercion in the consultation

Because reproductive coercion is so prevalent, a case can be made for educating all women about it, especially those of reproductive age. The ARCHES (addressing reproductive coercion in health settings) intervention, which includes offering an information card on reproductive coercion (supplementary file) and asking some of the example questions in box 3, may be a helpful way to introduce the subject during clinical encounters. However, no validated screening tools exist for reproductive coercion. Questions tend to follow the approach of "sensitive inquiry" similar to that used when there are concerns about domestic violence.[25] Questions need to be specific: only asking vague questions such as "how are things at home?" is, in our view, unlikely to lead to someone disclosing being subject to reproductive coercion.

See the patient alone for part of the consultation, to help facilitate disclosure or allow exploration of suspected reproductive coercion.[26-28] Ask the partner, relative, friend, or other escort to wait outside, making it clear to them that this is routine.

Box start

Box 3 Asking about reproductive coercion: examples of questions

If not pregnant

Does your partner support your decisions about when or if you want to become pregnant?

Is your partner supportive of your ongoing use of contraception?

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 interfered with the contraceptive method you were using?

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 regarding the pregnancy?

Displaying educational posters in reception areas, toilets, and other highly visible areas alongside helpline numbers and safety cards can help raise awareness and empower women who are not yet ready to speak to healthcare professionals about their concerns[29]

Box end

Educating all patients about reproductive coercion

ARCHES is a primary and secondary prevention intervention that has three main aims: to educate patients about how reproductive coercion and intimate partner violence can affect sexual and reproductive health, to suggest harm reduction strategies (for example

contraception support), and to provide supported referrals to services.[26] It combines a small card with a one minute discussion.[30] The healthcare worker gives patients two cards so they can pass one on to a friend to encourage discussion and support amongst women.[30]

Below is an adapted example of a script that can be used to briefly introduce the card during a consultation:

"I would like to give you a card that we have been giving to all women about healthy and unhealthy relationships. It has useful information about your reproductive choices and what to do if a partner or family member interferes with these choices. Many of our patients share how often this happens. We give a second card for you to pass on to a friend."[26]

How to support women experiencing reproductive coercion

When reproductive coercion is identified, recognise the woman as the expert in her own reproductive health.[35] Ensure management and referral are person centred, trauma informed,[36] and holistic.[35] Care should promote a sense of safety, reduce anxiety, establish trust, and clarify available options. Encouraging women to assert their reproductive autonomy may well be limited by the controlling relationship they are in.[37] Women may make the decision to stay in a relationship for more pragmatic reasons, for example because of financial dependency or existing children. Seek to ensure that women do not feel judged.

Doing no harm is the prime consideration. Bear in mind that interventions, albeit well meaning, have the potential to have an undesired and negative impact on a woman's life. An open, compassionate communication style is appreciated.[34] Provision of information and support do not necessarily depend on disclosure.

This article may seem to underplay the role of interventions that include the person or family responsible for the reproductive coercion; this is partly because, as yet, no evidence base for these exists. In more complicated cases that involve family, a discussion with safeguarding leads with a more detailed risk assessment would likely be necessary before proposing any further intervention with the patient.

Offering practical support

Offering women contraceptive choices, in particular concealable methods, is a major contribution that clinicians can make.[3 38] Concealable contraception, such as intrauterine contraception (IUDs) with threads cut shorter, may be an option for some women. Consider referring these patients to specialist services for a more detailed discussion about the risks and benefits, since shortened threads may make device removal more difficult. Copper IUDs

have the advantage that they do not eliminate or disrupt cycles for those whose partners monitor their periods. A progestogen-only injectable can be self-administered.[39] Oral contraceptives can be transferred out of pharmacy packaging into, for example, a vitamin pill container. Emergency contraception can be supplied in advance of need.

Support and follow-up can be continued whether or not a woman discloses reproductive coercion. Patients may not disclose their concerns at the initial visit, so it may be helpful to plan follow-up to build rapport and trust, as women are more likely to disclose reproductive coercion after multiple encounters.[15]

Other forms of support may include options for termination of pregnancy and ensuring that the woman has safe access to emergency contraception or checks for sexually transmitted infection as needed. Discuss details of local support groups or charities. By mentioning these resources and options, women gain knowledge which can enable them to use harm reduction strategies and improve their reproductive autonomy.

If offering referral to a domestic violence or sexual assault service, consider making a "warm" referral: this is where you, or an on-site advocate, offer to make a phone call to the service and give the patient the phone number for a named support worker.

When should reproductive coercion be reported?

The exact details of reporting reproductive coercion to safeguarding agencies or partner organisations depend on national laws and local guidance. Information will need to be shared with colleagues in most cases , especially with respect to minors and those who lack mental capacity, and where children are at risk.[3] Reproductive coercion should be raised as a safeguarding concern with the adult/children's safeguarding lead and this may require a referral to social services, particularly if children are involved, as it may suggest other forms of intimate partner violence. If there is an immediate danger to the patient's life, any child's life, or risk of harm to the public, discuss with the patient the urgent need for the healthcare professional to report reproductive coercion for their safety (at times this is not possible) before contacting the on-call safeguarding specialist while the patient is still in the consulting room. If possible, explain to the patient your concerns about the situation and seek their consent to disclose what they have told you. Sensitivity is required as many will be apprehensive of police and social service involvement. Patients from migrant backgrounds, for example, may be particularly anxious about revealing their immigration status.

Box start

Additional educational resources for clinicians

Faculty of Sexual & Reproductive Healthcare, 2020. Service standards for sexual and reproductive health consultations.
https://www.fsrh.org/standards-and-guidance/documents/fsrh-service-standards-for-consultations-june-2020/

World Health Organization, 2014. Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook. https://apps.who.int/iris/handle/10665/136101

ANSIRH Reproductive Autonomy Scale, 2014. https://www.ansirh.org/research/ongoing/reproductive-autonomy-scale

Futures Without Violence, 2018. Adopt the evidence-based CUES intervention to support survivors and prevent violence.
http://ipvhealth.org/health-professionals/educate-providers/

Futures Without Violence, 2013. Addressing intimate partner violence reproductive and sexual coercion: a guide for obstetric, gynecologic, reproductive health care settings.
https://www.futureswithoutviolence.org/userfiles/file/HealthCare/Reproductive%20Health%20Guidelines.pdf (original ARCHES card is on pages 23 and 24)

Box end

Box start

UK specific resources for patients

Refuge 24-hour National Domestic Abuse Helpline. 0808 2000 247

Rape Crisis. 0808 802 9999

Karma Nirvana. 0800 5999 2478

Women's Aid. https://www.womensaid.org.uk/about-us/contact/

Imkaan. https://www.imkaan.org.uk/get-help

Rights of women. https://rightsofwomen.org.uk/get-information/violence-against-women-and-international-law/coercive-control-and-the-law/

End violence against women. www.endviolenceagainstwomen.org.uk

Brook. https://www.brook.org.uk

Box end

Box start

Education into practice

- What questions might you build into consultations to identify women who have experienced or are at risk of reproductive coercion?
- How could you use the ARCHES model in your practice or adapt a similar card that could be given routinely to women seeking contraceptive advice?

Box end

Box start

Sources and selection strategy

We searched MEDLINE, CINAHL, PsycINFO, SocINDEX, the Cochrane Library, Embase, Academic Search, and the British Library for articles published in English. The search terms used were "reproductive coercion", "reproductive control", and "contraceptive sabotage". We limited the search to peer reviewed articles in English published since 2010. We also reviewed the reference lists of these articles for other relevant publications.

Box end

Box start

How patients were involved in the creation of this article

Through our networks, we were able to hear from an individual who had personal experience of reproductive coercion and who had also supported those experiencing it. We also received comments from two individuals interviewed in the programme *File on 4: Controlling my birth control* on BBC Radio 4.[40] The text incorporates comments made by all of the above, including changes to the examples of questions to ask in the section on discussing reproductive coercion.

Box end

Web Extra: Supplementary file: Suggested wording for information card, based on the ARCHES intervention

Contributors: All three authors were involved in drafting and revising the article for intellectual content. The final version for publication was approved by all authors, who agree to be accountable for all aspects of the work. SR is guarantor and corresponding author.

Competing interests: We have read and understood the *BMJ* policy on declaration of interests and have no relevant interests to declare.

Provenance and peer review: commissioned; externally peer reviewed.

We thank the Women's Voices Involvement Panel of the Royal College of Obstetricians and Gynaecologists and Alys Harte and Rachel Stonehouse at BBC Radio 4 for help in obtaining patient views. We are also grateful to the reviewers and editors who provided helpful suggestions for ways to improve the article.

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