Reproductive Coercion in Aotearoa New Zealand

NATIONAL COLLECTION OF INDEPENDENT
WOMEN'S REFUGES INC

Authors

Kate Burry, Programme Development and Research Advisor

Dr Natalie Thorburn, Policy Advisor

Dr Ang Jury, Chief Executive

National Collective of Independent Women's Refuges

The National Collective of Independent Women's Refuges (NCIWR) is a central part of the solution to New Zealand's problem of family violence – both in the context of providing an immediate crisis and longer term support. In 2016/17, our network of 40 affiliated refuges received 50,645 crisis calls and provided 72,218 nights of secure accommodation within our safe houses, with direct assistance provided to 26,699 women and children. A large and growing percentage of our client base consists of children and young people under the age of 17 years, with 70% of these children under the age of 10 years.

Our workforce of some 300 FTEs (supported by a roughly equivalent number of volunteers) accepts referrals from Police, from other social service organisations, and from clients wishing to self-refer. Our focus is on continually finding effective ways to protect and assist women affected by abuse within relationships and preventing this abuse from re-occurring or escalating.

Contact

The office of the NCIWR is at: Ground floor, 275 Cuba Street, Te Aro

Postal address: PO Box 27-078, Marion Square, Wellington 6141

Phone: 04 802 5078

Contents

Introduction

Reproductive coercion remains a relatively under researched phenomenon, including as a feature of intimate partner violence in Aotearoa New Zealand. While some research on reproductive coercion has emerged from other countries, principally the United States, to date there has not been a comprehensive study of reproductive coercion in Aotearoa New Zealand, including in relation to our legal, health care, and cultural contexts.

Reproductive coercion describes behaviour from one person intended to undermine the reproductive autonomy of another, often within the context of an intimate or sexual relationship, although it can also happen in other contexts such as within family relationships. Reproductive autonomy describes someone's ability to make free, voluntary and informed decisions related to their sexual and reproductive health and wellbeing (Moore et al, 2010). Reproductive coercion, therefore, describes any act that overrides, undermines and exploits the reproductive autonomy of another person (ibid).

This research is an exploratory study into the issue of reproductive coercion in Aotearoa New Zealand[1], its identifying features, and related and concurrent issues, such as other methods of IPV used by research participants' partners. This research used a selective sampling method, targeting people who had experienced reproductive coercion by a partner via posters circulated through social media and recruitment posters put up in sexual and reproductive health clinics across New Zealand. Research participants were able to share their experiences of reproductive coercion via an online survey, and subsequently five participants gave in-depth accounts of their experiences via semi-structured interviews with the researcher. Questions focussed on features of reproductive coercion identified in the literature, namely controlled access to contraceptives, birth control sabotage, pressure to become pregnant, and controlled access to abortion. This research, given its exploratory intentions, also asked participants more broadly about their partners' behaviours during pregnancy (if they experienced a pregnancy), during labour and delivery (if they experienced giving birth), and during their post-birth recovery. Participants were also asked about their experiences seeking help and support, including whether their partner controlled or tried to prevent their access to pregnancy help, support and advice.

The findings of this research reveal that a significant number of these research participants had experienced controlled access to contraceptives, birth control sabotage and pregnancy pressure from an intimate partner. Over one third of participants had experienced a partner trying to prevent them accessing an abortion, and just over one quarter had experienced a partner attempting to pressure them into terminating a pregnancy. Just under one third had also experienced a partner deliberately trying to cause them to miscarry, for example by using physical violence. This research also explored other experiences in the sexual and reproductive lives of participants, and found close to half had experienced a partner intentionally exposing them to a sexually transmitted infection. Additionally, the vast majority of participants who had ever been pregnant had also experienced other forms of abuse from their intimate partner, such as psychological, sexual and physical abuse, alongside reproductive coercion. A significant number of participants (n 75) also shared their experiences of their partners' behaviour during labour and delivery, and the majority (62%) had experienced their partner intentionally trying to impede their recovery from birth, miscarriage or abortion. Finally, participants shared their experiences seeking support and advice around reproductive coercion and other intimate partner violence, and this research found that amongst this sample the rates of professions asking about IPV, and particularly reproductive coercion were very low. Furthermore, for those participants who did attempt to disclose abuse or reproductive coercion, the responses they received were not altogether helpful, and for some they were harmful. Participants' views about what would constitute a helpful response were also gathered in this survey, as were general messages from participants about the impacts of reproductive coercion on their health and wellbeing.

This report begins with a review of literature on reproductive coercion, and more broadly on the issues of intimate partner violence and sexual health outcomes, and violence during pregnancy. The research methods are then described, followed by a detailed discussion of the findings, including qualitative data from the survey and interviews. The research findings are then discussed from a gendered lens, before the practice suggestions and recommendations for future research are summarised.

1 There has been a study in New Zealand of miscarriage and abortion rates amongst women who have experienced pregnancy in the context of IPV. In this study of a randomized population of women who had ever been pregnant, it was found that women who had experienced IPV were more likely to experience both miscarriage and abortion: Fanslow et al, 2008.

Literature Review

Reproductive coercion (RC) is a form of intimate partner violence (IPV), and can occur in conjunction with or separate from other forms of violent and coercive controlling behaviours by perpetrators of IPV (Park et al, 2016). Pregnancy as a result of RC can also be a catalyst for the onset or worsening of abuse by the pregnant person's partner, with pregnancy representing a period of vulnerability for women experiencing partner abuse (Moore et al, 2010). While women can engage in RC towards male partners, and RC can occur in same-sex relationships and within intergenerational relations (e.g. parents or in-laws), reproductive coercion is primarily perpetrated as a power and control tactic by males towards their female partners (Park et al, 2016).

IPV includes attempted, threatened or actual psychological, physical, economic and sexual abuse perpetrated towards someone by a current or ex-partner. However, reproductive coercion is a lesser known or acknowledged distinct form of abuse that undermines the reproductive autonomy and health of the victim. Reproductive autonomy, as defined in Moore et al (2010), describes 'a woman's ability to make independent decisions about her reproduction' and reproductive control or coercion as 'any interference with this reproductive autonomy' (p.1738).

RC describes any behaviour undertaken by someone to control the reproductive autonomy and health of another person, for example through intimidation, threats, direct violence, or emotional manipulation (Moore et al, 2010). Usually (but not always) males perpetrate reproductive coercion towards biological females with whom they are in an intimate partnership. The Family Planning New Zealand website[2] outlines some key identifying factors of reproductive coercion that can occur before sexual intercourse, during sexual intercourse, and post-conception (Moore et al, 2010; Hathaway et al, 2005), including

- Hiding or throwing away a woman's pills or pill packet
- Breaking or making holes in condoms, refusing to use a condom, or taking a condom off during sex
- Removing intrauterine devices (IUDs) or vaginal rings
- Threatening behaviour that pressures a woman to become pregnant when she does not want to
- Forcing a woman to abort or continue a pregnancy when she does not want to
- Injuring a woman to cause a miscarriage
- Threatening to end the relationship, or harm the woman, if she doesn't stop using contraception
- Intentionally exposing a partner to an STI or HIV

The undermining of women's reproductive and sexual wellbeing and autonomy can involve overt instances or episodes of sexual violation (rape) and other forms of physical force (e.g. forced removal of IUDs, or physical violence during pregnancy), more coercive, non-physical behaviours, such as threatening to leave if the woman does not become pregnant, or withholding money for contraceptives, or both (Moore et al, 2010). Reproductive coercion can also include threatening behaviours intended to influence or control pregnancy outcomes or undermine contraceptive use (Miller et al., 2007; Blanc et al., 1996; Clark et al., 2008; Njovana & Watts, 1996; Watts & Mayhew, 2004; Wingood & DiClemente, 1997), forcing pregnancy then denying paternity (Moore et al, 2010), or restricting a woman's access to healthcare and support, for example antenatal care (ibid). Research has also evidenced forced sterilisation as a form of men's reproductive coercion towards women (Hathaway et al, 2005). Women may also experience coercive control around the decision to access an abortion, for example, their partners coercing them into having an abortion (Coggins & Bullock, 2003; Hathaway et al, 2005; Moore et al, 2010) or somehow preventing them from accessing an abortion, for example through sabotaging clinic appointments (Moore et al, 2010).

Regarding estimates of prevalence rates of RC, in the US it has been estimated that the prevalence rates of RC range from 15% - 25% depending on the vulnerability of the population (Park et al, 2016). Another study in the US by the National Center for Injury Prevention and Control estimates that over 10 million women have had a partner get them pregnant against their will, and over 2 million have become pregnant and 1.8 million have contracted an STI as a result of rape by an intimate partner (Black et al, 2011). Another targeted study of 1300 young women accessing family planning services found 19% of respondents had experienced pregnancy coercion and 15% had experienced birth control sabotage (Miller et al, 2010). The same study also explored the intersection between RC and IPV, and found that 75% of respondents who had been victims of RC also reported a lifetime history of IPV (ibid). Another study assessing the prevalence rates of RC and co-occurrence with IPV in a large obstetrics and gynaecology clinic in an American urban, university-based medical centre found 16% of the 737 women who were approached to participate had experienced some form of RC in their lifetime, and 32% of those women who reported RC also reported IPV in the same relationship (Clark et al, 2014). It is evident from these findings that RC cannot be extricated from a wider understanding about the nature and dynamics of IPV.

2 http://www.familyplanning.org.nz/news/2015/reproductive-coercion

One significant outcome of RC is unintended pregnancy. Unintended pregnancy can, of course, occur separately from RC, and generally pregnancy intention has been noted as a complex measure of desire, timing, and planning, mixed with emotional reactions to pregnancy and the partner's intentions (Santelli et al, 2009). However, as noted, RC involves the perpetrator's explicit undermining of the reproductive autonomy of their partner, thus unintended pregnancy in the context of RC can be linked variously to the woman's limited ability to safely and freely make her own decisions regarding sex (McFarlane et al, 2005; Silverman et al, 2011); women's impeded ability to use contraceptives (Stephenson et al, 2008; McFarlane et al, 2005; Wingwood & DiClemente, 1997; Williams, Larsen, & McCloskey, 2008), including condoms and the negotiation of their use during sex (Silverman et al, 2011; Wingwood & DiClemente, 1997; Sales et al, 2008; Teitelman et al, 2008). Physical or sexual violence, or forms of emotional and psychological abuse such as threats of harm or accusations of infidelity may result in the perpetrator having sex under his terms (i.e. his timing, and according to his demands, e.g. that a condom not be used), which could result in an unintended pregnancy for the female partner. RC may also result in an unwanted pregnancy through the perpetrators sabotaging of contraceptives or emotional pressure into pregnancy (Miller et al, 2014; Miller et al, 2010; Moore et al, 2010; Center for Impact Research, 2000; Gee et al, 2009; Miller et al, 2007).

As noted previously, RC may happen independently or alongside other forms of intimate partner violence. In one study in a sexual and reproductive clinic in North Carolina of a sample group of 1279 females, over 1/3 (35%) of women who reported physical or sexual IPV also reported either pregnancy coercion or birth control sabotage; this is compared to only 7% of participants in Miller's (2010) study reporting pregnancy coercion or birth control sabotage in the absence of physical and sexual partner violence. This study also found that the odds of unintended pregnancy increase almost two-fold where RC and IPV are co-occurring (ibid). The above point suggests that RC is more common for women who have experienced IPV, and in general fear of violence can lead to women's decreased fertility control, for example in relation to condom negotiation (Martin et al, 1999; Plichta & Abraham, 1996; Wingwood & DiClemente, 1997) and contraceptive use (Bawah et al, 1999; Pallitto & O'Campo, 2005; Biddlecom & Fapohunda, 1998).

It has also been established that men's violence towards women can worsen during pregnancy or post birth (Moore et al, 2010). In the United States, for instance, 8.4% of pregnancy-related deaths (the second most common cause of injury related deaths during pregnancy) are due to homicide, and in India 16% of all deaths during pregnancy are related to IPV (Fanslow, 2017). In a review of literature exploring the relationship between IPV and unintended pregnancy, general prevalence rates of IPV during pregnancy ranged from 3.9% to 8.3% depending on the study and definition (Pallitto, Campbell & O'Campo, 2005). This proportion of pregnant women who experience IPV increases with samples that target clinic patients to between 10% and 14.7% (Cokkinides & Coker, 1998; Johnson et al, 2003; Valladares et al., 2002). However, findings vary regarding whether women are more at risk before, during or after the pregnancy, and which types of abuse are more prevalent at different temporal phases of pregnancy (Pallitto, Campbell & O'Campo, 2005), for example higher emotional abuse during pregnancy, but a decrease in physical abuse (Castro, Peek-Asa, & Ruiz, 2003). Finally, women who are victims of IPV have been evidenced to experience generally poorer sexual health (García-Moreno et al, 2005; Coker, 2007).

Women who are forced or coerced into a pregnancy may not be mentally, emotionally and financially ready to have a child, thus coerced pregnancy and subsequent childbirth is likely to exacerbate women's vulnerabilities. Moreover, pregnancy outcomes for women whose partners are abusive or for women who otherwise do not want or are unhappy about the pregnancy are also largely worse, including experiencing a higher proportion of miscarriage, stillbirth, preterm labour, low birth weight and foetal injury, and other complications and adverse mental and physical health consequences for the mother (Fanslow, 2017; Park, et al., 2016; McFarlane, Parker, & Soeken, 1996a; Campbell et al, 1999; Cokkinnides, 1999; McFarlane, Parker, & Soeken, 1996b; Martin et al, 1996; Pallitto, Campbell, & O'Campo, 2005; Laukaran & van den Berg, 1980; Bustan & Coker, 1994; Janssen et al, 2003).

Women who are abused during pregnancy also may be at greater risk of more severe abuse from their partners or femicide, with one case-controlled study of attempted and completed femicides across ten cities in the US evidencing that, if a woman is abused during pregnancy, the risk of her becoming a victim of attempted/completed femicide increases three-fold (McFarlane et al, 2002). Violence during pregnancy is also a significant cause of maternal deaths, with homicides making up between 13 – 26% of maternal deaths across various US cities or states (Fildes et al, 1992; Dannenberg et al, 1995; Parsons & Harper, 1999; Horon & Cheng, 2001). Violent trauma during pregnancy can also lead to foetal death (Ribe, Teggatz, & Harvey, 1993; Rogers et al, 1999).

Methods

This research employed mixed methods, namely a survey collecting quantitative and qualitative information, followed by five semi-structured interviews conducted either face-to-face, or via phone or Skype. This research was conducted over several months in mid-2018, and involved two key stages of recruitment and data collection. Firstly, an online survey was sent out via social media channels, principally the Women's Refuge Facebook page and 50 posters for participant recruitment were put up on the inside of toilet cubicles in Family Planning clinics (n 40) around the country and in the Wellington Sexual Health Service clinic (n 10) in central Wellington with tear-off tabs containing the URL address for the online survey. The Facebook post was also shared 69 times to other personal and public pages on Facebook, for instance to independent Women's Refuges' Facebook pages and to some sexual and reproductive health and rights organisations such as Family Planning New Zealand.

The post on social media and the research recruitment poster (see Appendix I) asked readers if certain elements of reproductive coercion applied to an intimate relationship they had been in, for example 'Has a partner ever tried to stop you using contraceptives?', 'Has a partner ever tried to mess or tamper with your contraceptives?, and 'Has a partner ever tried to force or pressure you to become pregnant?'. If people identified with these experiences, they were invited to participate in the online survey. When people who were interested in participating selected or entered the link to the online survey, they were redirected to an information page informing participants of what the survey will ask, and what will happen with the data from the survey (e.g. a report of the findings and media releases). Participants were informed that no identifying information would be used in any reporting, and it also asked participants to think about how the survey would make them feel, informing them that they do not have to take part and that they can stop or pause the survey at any time. Participants were then asked if they consented to take part in the survey or not; if they consented, they could begin the survey, however, if they did not consent, the survey would close automatically. These messages of safety and reconfirming participants' consent to continue were repeated at the start of each series of questions, ensuring that participants had to confirm their ongoing consent in order to continue with the survey.

The survey explored experiences and the dynamics of reproductive coercion amongst participants over the age of 16, regardless of the gender of their partner[3]. Aside from basic questions to gather demographic information, survey participants were asked about their experiences of specific features of reproductive coercion, namely controlled access to contraceptives, birth-control sabotage, pregnancy coercion, controlled access to abortion either via pressure to have an abortion or prevention from accessing an abortion, harm with the intention of causing miscarriage, and intentional exposure to sexually transmitted infections (STIs). The survey also explored concurrent intimate partner violence across the three temporal periods of before, during and after pregnancy in order to explore any trends or patterns in perpetrators' abusive behaviour. Furthermore, the survey asked participants to share if they had experienced their partner controlling their access to health care and support throughout a pregnancy, their partner's behaviour throughout labour and deliver, and their partner's behaviour after their pregnancy (i.e. post-birth, miscarriage or abortion). The final set of questions explored participants' experiences seeking help.

Following this, survey participants were offered the opportunity to participate in a semi-structured interview to gather their stories of reproductive coercion by an abusive partner. Only those who responded that they were interested in being interviewed were contacted via email, and only those who responded to this email confirming their interest were subsequently interviewed except for one participant who decided later that they no longer wanted to participate in an interview. The principal researcher for this project, Kate Burry, undertook five interviews with participants, two face-to-face, two over the phone, and one via Skype. These interviews were approximately one hour in length, and while they involved guiding questions specifically related to experiences of RC, for example birth control sabotage or pregnancy coercion, these discussions were largely directed by the interviewee, and mostly took a narrative form, with participants talking through their relationships with their partners more or less in their entirety. All of the participants who were interviewed were over the age of 40, and had been out of their relationships with the abusers for at least two years.

Findings

As noted above, this research involved a comprehensive survey of participants' experiences of reproductive coercion, concurrent IPV, and experiences seeking help, followed by five in-depth interviews. The number of respondents to the survey was 162, however one person did not consent to take part in the survey thus the final sample size of survey participants was 161 respondents. Five participants were subsequently involved in a semi-structured interview with the researcher.

This section of the report first outlines survey participants' demographic information before summarising their experiences of reproductive coercion, experiences during labour and delivery and their partner's behaviour after their pregnancy, concurrent intimate partner violence, and experiences seeking support.

[3] Of the small amount of research into RC within the LGBT*+ community, there is evidence to suggest that RC is also a feature of coercive control in LGBT*+ relationships, e.g. Reed et al, 2011.

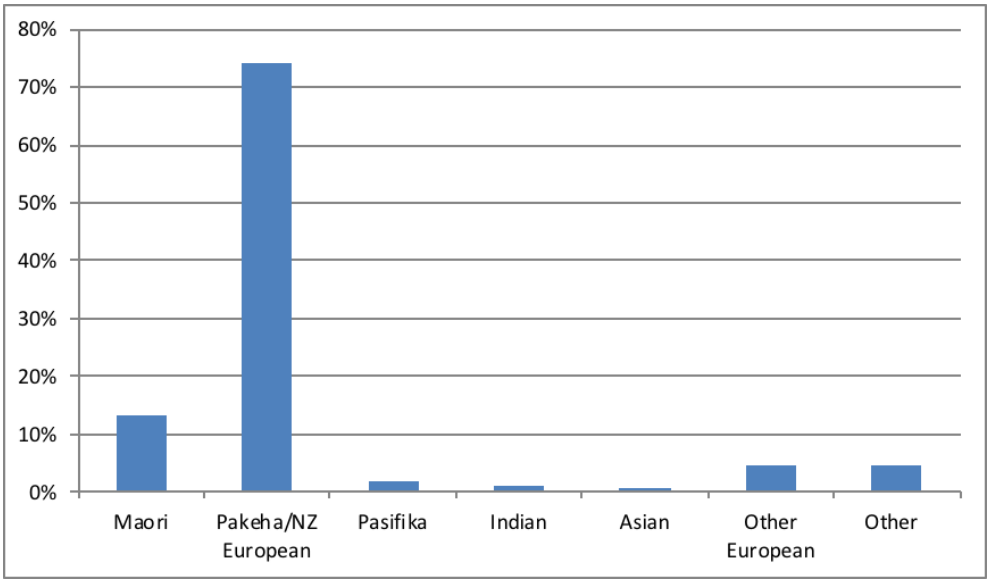
Participants' demographic information

Participants were invited to participate in this research if they were over the age of 16 and had experienced some form of reproductive coercion by an intimate partner. The first set of questions in the survey asked for participants' ethnicity, number of children, gender identity, sexual orientation, and age group.

Ethnicity

Survey participants were able to select as many ethnicities as they identified with. The majority (74%) of participants identified as Pākeha/NZ European, followed by those who identified as Māori, at 13.3% of participants. 'Other European' and 'Other' made up 4.4% of participants each, with 'Other' being specified by participants as NZ European and Colombian, Māori and Pākeha, North American, 'NZ', English, Pākeha and Asian, and 'Ango Indian Ngati Settler'. A minority of participants identified as Pasifika, Indian, and Asian (1.9%, 1.3%, and 0.6% respectively).

Figure 1: Participants' ethnicities

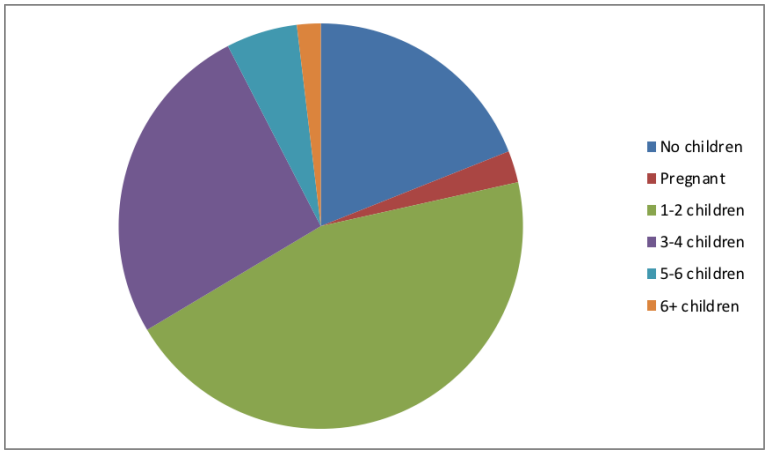


Amongst the five interviewees, two were Māori, one Scottish, one Pākeha/New Zealand European, and one was American.

Number of children

Survey participants were asked how many children they have, if they have children.

Figure 2: Number of children



The largest proportion of participants had 1-2 children, followed by 3-4 children, and no children (44.9%, 26%, and 19% respectively). Smaller proportions of participants were currently pregnant, or had 5-6, or over 6 children (2.5%, 5.7%, and 1.9% respectively).

All of the interviewees had children: one interviewee had 5-6 children, two had 3-4, and the other two had 1-2 children.

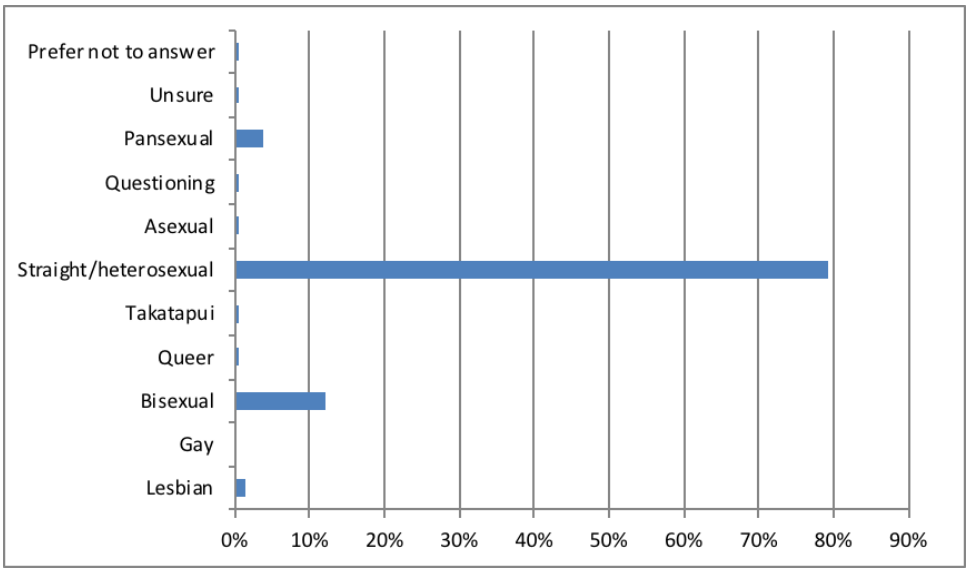
Gender identity

The vast majority of survey participants were women (96.2%), with the remaining participants identifying as non-binary (1.9%; n 3), men (1.3%; n 2), and Takatāpui (0.6%; n 1). All five interviewees were women.

Sexuality

Participants were also asked to identify their sexual orientation. The majority of survey participants and all of the interviewees identified their sexuality as straight/heterosexual (79.1%), followed by bisexual (12%). The remaining participants identified as pansexual (3.8%), lesbian (1.3%), and 'Queer', 'Takatāpui', 'Asexual', 'Questioning' and 'Unsure' all made up 0.6% (n 1) of participants each. One person selected that they would 'Prefer not to answer'.

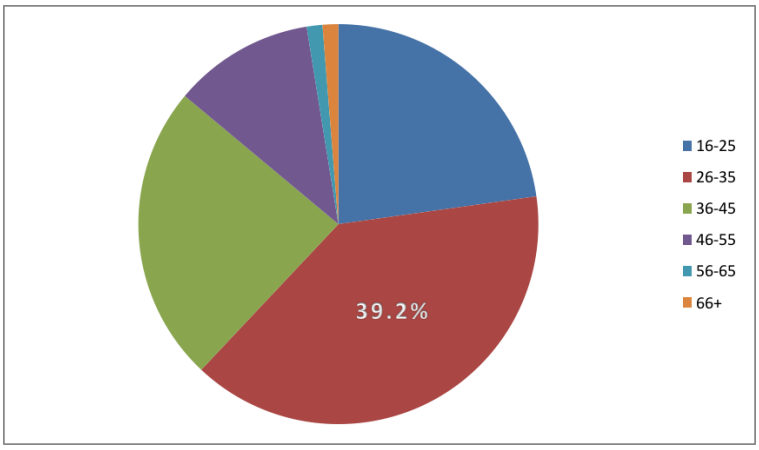
Figure 3: Participants' sexualities



Age groups

The largest proportion of survey participants fell in the 26-35 age group (39.2%), followed by 36-45 (24%) and 16-25 (22.8%).

Figure 4: Participants' age groups



The 46-55 age group made up 11.4% of participants, and the 56-65 and 60+ age groups each made up 1.3%.

Reproductive coercion

The first series of questions explored research participants' experiences of reproductive coercion by an intimate partner. This section will discuss the experiences of research participants of each of the key features of reproductive coercion identified in the literature: controlled access to contraceptives, birth control sabotage, pregnancy coercion, and controlled access to abortion. This research also looked at other elements of the participants' sexual and reproductive lives, such as partners intentionally exposing them to STIs, and their experiences of their partner during labour and delivery, and during recovery from pregnancy, namely their behaviour post-birth, abortion or miscarriage. The findings from the survey and interviews are discussed below. Where information from the interviews is used, this has been indicated.

Controlled access to contraceptives

The vast majority of participants in the survey had experienced a partner controlling their access to contraceptives, for example preventing them from going to a clinic for contraception, telling them that they cannot use the pill or get an inter-urine device (IUD) inserted, or otherwise making them fearful or apprehensive about using contraception. Ten participants skipped this question, and of the 152 that responded, 83.6% had experienced their partner controlling their access to contraceptives.

Participants were also invited to share their experiences of their partners controlling their access to contraceptives; 110 participants shared their experiences. Partners' controlling of access to contraceptives ranged from refusing to wear condoms, preventing them from attending a clinic to get a prescription for contraceptives, and emotional manipulation or economic abuse.

> 'Refusing to use a condom, stopping me from going to the doctor or pharmacy by claiming we couldn't afford it.'
>
> 'Not allowing me the money to go to the doctor to get contraceptives. Refused to wear a condom.'
>
> 'He wouldn't wear a condom but thought the pill would make me fat so I wasn't allowed to take it, and said the IUD and other alternatives cost too much.'
>
> 'Refused to give me my money to get contraceptives, believed they are bad chemicals that I should avoid etc. [He] actively tried getting me pregnant so I'm more compelled to stay.'
>
> 'Refused condoms [and] would not let me have access or means to get to the doctor or a sexual health clinic.'
>
> 'Something would 'happen' to the car or just some excuse to why we couldn't get to the doctor's for IUD etc.'
>
> '[He] refused condoms and would not allow me to go on the pill or jab because he said I would get fat.'
>
> Over time, he coerced me using religious reasons not to use any contraceptives.'
>
> 'If I tried to make a doctor's appointment, he would come. Only once did I ever make it there alone and got the jab, but he caught on quick to what I had done and [I] was never allowed to go again by myself.'
>
> 'Got mad, told me I was selfish and called me names when I told him I had a prescription for the pill.'
>
> 'Removed condom during sex, had sex with me when I was sleeping. When I tried to obtain the morning after pill, he would distract me and occupy my time or threaten suicide to make it harder to get it in time.'

As the examples above reveal, perpetrators of reproductive coercion use a variety of behaviours to control their partners' ability to manage their sexual and reproductive bodies. Condom use (notable for having the dual purpose of protection from pregnancy and sexually transmitted infections), while often requested, was usually denied by the male partner. Other forms of protection from pregnancy were also controlled in various ways, for example by using threats, put-downs, control of finances needed to access contraceptives, and sabotaging transport options to get to clinics. All of these examples represent an undermining of participants' sexual and reproductive autonomy, or the right to make decisions regarding the protection and function of one's reproduction and the conditions of sexual consent.

Tampering

Participants in the survey were also asked if they had experienced a partner tampering with their contraceptives to try and bring about pregnancy, such as poking holes in condoms, throwing away contraceptive pills, or forcing the removal of an IUD or implants. Of the 148 respondents to this question (14 people skipped), 59.5% had experienced a partner tampering with their contraceptives.

Of those participants who had experienced a partner tampering with their contraceptives, 80 went on to describe instances of contraceptive sabotage.

> 'My contraceptive pill would go 'missing'.
>
> 'He poked holes in the condoms.'
>
> 'I wanted to use a condom but she wouldn't let me wear one (I'm a transgender woman, ex was a cisgender woman).'
>
> '[Interview] I gave a friend of mine some condoms. Then the next night or something, I had her call me saying, 'look, I've just found pin holes in the condoms.'
>
> 'Promising to pull out during sex but never did.'
>
> 'Flushing contraceptives pill down the toilet; refusing to wear a condom or removing a condom; cancelling appointment made to have IUD fitted.'
>
> 'Threw the Pill down the toilet. Threw the Pill into the rubbish bin, took out rubbish to rubbish truck.'
>
> 'Pretended to put a condom on and then when I fell pregnant told me he had not been wearing them.'
>
> 'He grabbed my pills and destroyed them all. I had condoms for us to use as well. He destroyed them all and said if I fall pregnant I have no choice but to have the baby. He also stopped me from going to my appointment to get a new supply of pills and condoms.'
>
> 'Destroying (burning) my whole prescription for contraceptive pills and physically preventing me from seeing a doctor or chemist (or anyone)'
>
> 'My pill would go missing, reminders on my phone to take the pill would disappear, [he] would make me feel bad for taking the pill.'
>
> 'Broke into my house after we split and stole six months' worth of contraceptives amongst other things, as well as my money and community services card for doctors.'
>
> 'I tried the pill but when he found them he got mad and put them down the sink. The time I put my foot down with condoms, he poked a needle through some and mixed them all up. Told me "good luck".'

Common methods participants' partners use to tamper with their contraceptives included disposing of pills and tampering with condoms or removing them without consent (discussed further below). Contraceptive tampering may also, as indicated by the above examples, be carried out alongside controlling access to alternative forms of contraception, and alongside other forms of abuse, such as sexual violence. This reveals how reproductive coercion and control can occur at multiple points along a time continuum, for example prior to sex through controlled access to pregnancy management and effective contraceptive use, and during sex, for example by interfering with condoms by poking holes in them, or deception over their use.

Pregnancy coercion

Survey participants were also asked if a partner had ever tried to pressure them to become pregnant. The majority, 63.4%, who responded to this question (142 participants; 20 skipped) had experienced pregnancy pressure or coercion by a partner. Once again, participants were also invited to share their experiences of a partner trying to pressure or coerce them into a pregnancy, and 70 participants chose to share their experiences.

> 'He told me he was going to get me pregnant so I could never leave him, so I went to the doctor and got on the pill. My ex-partner found my pills that I had hidden in my bag and popped each pill into the bin and took the rest off me.'
>
> 'First he refused to wear a condom and this continued throughout our relationship despite him having other partners, and the fact I couldn't tolerate contraceptive pills. He put tremendous pressure on me to have a child to him as my first [child] was not his. This involved coercion and threats to kill himself (and sometimes me with him). He claimed he didn't feel like a man because he failed to impregnate me. Eventually I became pregnant even though I was emotionally and financially not ready.'

‘He was a very abusive man and I was constantly being controlled and hit/kicked/head-butted etc. He wanted me to get my Jadelle rods out of my arm so we could have a second baby. I didn’t want a second baby (not with him anyway) as I was in the process of trying to leave him. He won that battle and accompanied me to the doctors to have the Jadelle rods removed. Within a couple of months I was pregnant.’

‘[Interview] Shortly before the end of the relationship, when he became convinced that I had had an abortion. I hadn’t, it kind of seemed similar to the ways that he would sometimes accuse me of cheating on him. So he was trying to guilt me into doing other things for him based on the fact that I had killed his child and ‘shouldn’t I be so ashamed of myself,’ and ‘shouldn’t we have another baby to replace the one that you killed?’ The crazymaking around it was just unreal.’

‘My partner lied about his ability to get me pregnant and claimed to be infertile in order to deliberately get me pregnant.’

‘Having unwanted (me) sex with me. Saying if I didn’t do it, he would get someone who will. Telling me he was going to get me pregnant so I could never leave him.’

‘[Interview] He always went on about him wanting a football team, and how that’s what humans are supposed to do – reproduce. I was exhausted, I had rheumatoid arthritis, so it means I can’t be on the right medication while I’m pregnant or breastfeeding. I was losing weight, and the baby was losing weight.’

‘Had a bad experience with pregnancy and birth so didn’t want any more children. Was gaslit and called selfish and unmotherly for not wanting more. And told that my other child needed a sibling and that [I] would be dumped with nothing and no support and [that] nobody wants damaged goods. Am a rape survivor...so that’s one of his favourite lines.’

‘Saying not having a baby was making him want to kill himself.’

‘It was “Gods choice to open and close the womb”. If I wanted to use any contraceptives it was considered not trusting God. Also frowned on the idea of using any natural method like fertility awareness, and hated abstaining.’

‘Wanted his lady to be “pregnant and barefoot in the kitchen”. I didn’t want to be pregnant.’

‘Told me I could see my family if I got pregnant.’

‘It was always a measure of how much I love him - that if I do, I would want to have a baby with him, if I said I didn’t want to or wasn’t ready it often turned violent because he believed I must be cheating or didn’t love him or didn’t want to be with him.’

The examples above evidence the coercive behaviours that victims of reproductive coercion may be subject to, and often alongside controlled access to contraceptives and other means of birth control sabotage. In many stories brought up by research participants was a direct and explicit intention by their partners to force pregnancy as a method of control and entrapment in the relationship. Essentially, for these participants, their reproductive capacity was used as a tool to establish power and control, and to bring about further physical, emotional, and financial vulnerability.

Abortion control

An important measure of sexual and reproductive autonomy is the ability to freely make a decision regarding accessing an abortion. Participants in this research were asked about any experiences of partners controlling their access to an abortion, that is, either being prevented from accessing an abortion by a partner or being forced to have an abortion by a partner. Notably, like other experiences of reproductive coercion, coercion regarding access to abortion was cause for significant distress for participants as the behaviours of partners directly contravened, overlooked, or removed their reproductive decision making via the use of violence, threats, or emotional and psychological abuse.

Of the 141 respondents to the question regarding experiences of a partner trying to prevent access to an abortion procedure, 34.8% had experienced this. Participants were also invited to share more about their experiences of their partners preventing their access to an abortion, and 45 participants shared their experiences.

‘Every time I tried to book an appointment he would threaten me or make wild accusations that I only wanted to abort because I cheated. I never cheated on him. He threatened to stab me and the baby to death if I tried to abort’.

‘My partner announced my pregnancy and that I was terminating on Facebook to everyone I knew so that his friends and family sent me harassing messages until I agreed to remain pregnant.’

‘My ex would threaten me with “if you want an abortion, I may as well beat it out of you”.’

‘He would say things like “you want to kill our baby”. In his art he would draw things that related to a dying foetus. At 15 I found it extremely traumatic.’

‘I’ve never been able to handle the thought of abortion personally for myself, but when I was pregnant our relationship was very abusive already and I was questioning keeping it as I didn’t want to bring a child into that environment, he told me I wasn’t allowed to do that and gave me no choice. I was only 16 and very controlled by him as he cut off all of my family.’

‘Hid my keys to prevent me leaving the house and took my wallet so I had no way to pay for other travel and also called me a murder.’

‘He told me that if I had an abortion that he would take me to court to get custody of my eldest child. He is a defence lawyer so I was worried he would definitely win. I felt I had no other choice.’

‘Torment….announced pregnancy to friends and family at only 5 weeks to prevent me going ahead. Would send me daily pictures of baby foetuses that were aborted telling me I’m a murderer.’

Participants in this research also asked if they had experienced a partner trying to coerce them into getting an abortion. Twenty seven percent had experienced a partner coercing them to have an abortion. Slightly more participants (31.7%) had experienced their partners deliberately trying to bring about a miscarriage, for example using physical violence. Participants were invited to share their experiences of a partner coercing them into getting an abortion or making deliberate attempts to bring about a miscarriage.

‘My ex tampered with condoms then bullied me into terminating.’

‘He would threaten me [that] if I kept the baby he would kill me, he went around telling everyone the baby isn’t his, he would elbow my lower stomach and hit it so I’d have a miscarriage.’

‘I was pressured to abort my first child. My partner who I was engaged to at the time made it clear he didn’t want anything to do with the baby and began behaving oddly. I was kicked out and ended up homeless for a few months because I wouldn’t abort.’

‘When I was 17 and pregnant my then BF [boyfriend] shoved the pills down the back of my throat when I started to back out of the termination.’

‘Pushing me over onto my stomach, kicking my stomach.’

‘Constant violence during pregnancy. Upping the violence.’

‘He made a herbal smoke that he thought would cause a miscarriage (discovered through internet research) and he blew it in my face.’

‘[My] ex-husband repeatedly beat me and kicked me in the stomach saying the baby was not his.’

‘I was pushed down the stairs to try and make me miscarry because I was having a girl and he said he can’t have girls.’

‘Manipulate me to drink alcohol (I spat the drink out when he wasn’t looking as I hadn’t decided if I’ll keep or abort the baby), [try] to force me to miscarry by tripping me up and blaming it on the alcohol (even though I didn’t drink any) or have an ill baby from alcohol.’

‘I was kicked in the lower abdomen about 6 times when I told a previous partner that my period was a couple of days late.’

‘I was pushed when I was 12 weeks pregnant into the corner of a couch, when he was the one who convinced me to ‘not use protection’ and ‘he wanted a baby’. That day he said it was all a mistake, this baby is a mistake.’

‘At 20 weeks, I was beaten a raped so aggressively I was hospitalized. Fortunately baby was fine. Then later in the pregnancy at 7 months, he pushed me down a story of concrete steps outside the back door.’

‘Was thrown down stairs repeatedly kicked in the tummy, not allowed to eat or drink.’

The horrific examples above of abortion being used as a form of coercive control over participants’ reproductive bodies, and the instances of violence intended to bring about miscarriage reveal the extent of the abuse of women’s sexuality and reproductive capacity in particular in their partners’ attempt to gain power and control.

Monitoring and controlling sexuality

One theme that came up multiple times from participants in this research was their partners monitoring their sexuality as a form of coercive control, and as a way to facilitate reproductive coercion. Specifically, the monitoring of sexuality often occurred in the form of accusations of infidelity should a woman wish to access and use contraceptives, and, conversely, the non-use of contraceptives was asserted as a sign of love, devotion, duty, and fidelity. Examples of participants' partners monitoring and controlling their sexuality came up in response to all of the targeted questions about the different elements of reproductive coercion mentioned above.

> 'My former partner refused to allow me to use contraceptives as he said this was only necessary if you are a prostitute not able to stay in a monogamous relationship. On the occasion that I did sneak oral contraceptives, when he found them he threw them away saying if I am faithful then I won't get pregnant too fast.'
>
> 'If I persisted [that condoms be used] he would either act hurt that I didn't respect his wishes or get mad and tell me things like I must want condoms because I sleep with others.'
>
> 'If I had contraception, he would say I'm being a slut.'
>
> 'He didn't like the idea of me being on the pill and told me that I was only on the pill so I could fuck someone else and not fall pregnant.'
>
> 'Hid pills in his shed and threw them in the bin when I found them. His reason I'd only need pill if I was sleeping with other men.'
>
> 'Would say things like if I love him then I'll want to have a baby, or why don't I want a baby with him do I want one with someone else.'

The implication here is that women hold a reproductive duty to their partner, and therefore hold no reproductive autonomy within their relationship. Women's decisions related to their bodies are essentially circumscribed by their partners' prescribed roles regarding gender and expressions of sexuality and reproduction, and by their partners' removal of choice by referencing sexual mores regarding decisions around contraceptives to incite shame around their use.

Controlling sexual and reproductive health outcomes

The refusal, sometimes accompanied by threats and violence, to wear condoms and tampering with condoms has already been mentioned as a common example of reproductive coercion. Non-use of condoms, or inconsistent use, can also entail risks to the sexual and reproductive health of the sexual partner. Participants were asked about experiences of their partners intentionally exposing them to a sexually transmitted infection (STI) or the human immunodeficiency virus (HIV), and many participants also shared experiences of adverse sexual and reproductive health outcomes due to the abusive and coercive behaviours of their partner.

Regarding the question specifically on participants' partners intentionally exposing them to an STI or the HIV, almost half (42.2%) of the 135 participants who responded to this question had experienced this. Some participants (n 46) also provided detailed accounts of intentional exposure to an STI or HIV by a partner.

> 'He had herpes and knew about it for years beforehand. I found out after we broke up.'
>
> 'Gave me herpes. Without telling me he had it. 4 years later and I'm still pissed off about it. Considering there is no cure and I have to take medication every day for it.'
>
> 'Refused to stop sleeping with other woman, [behaved] forcefully when I asked for a condom after already been given 2 STDs.'
>
> 'I got herpes from him. It was clearly from him and when confronted he admitted he knew but hadn't told me.'
>
> 'Hep C [Hepatitis C] and B [Hepatitis B] he never told me he had until after I gave birth to our first child.'
>
> 'He took off the condom part way through sex without me agreeing, and I later found out he had given me an STI. I had a clean STI check before this happened. I didn't know about the STI until I ended up in hospital with complications from it.'
>
> 'He knew he had chlamydia, he had had it for quite some time and managed to get the condom off during sex by being very vigorous and giving me the STD he knew he had.'
>
> 'He had chlamydia (thanks to the numerous women he had cheated on me with), and found out from one of them but didn't tell me. Weeks later she contacted me herself to let me know. That infection has severely compromised my fertility and am now going through my 3rd round of IVF (with a different partner, my now husband) to try to have a baby. It feels like this has ruined my life.'

The issue of people knowingly exposing their partners to STIs is not only an instance of sexual violation, but also representative of a breach of trust, as this often occurred alongside infidelity, and sexual entitlement by the perpetrator. Reproductive coercion and other forms of abuse were also noted as adversely impacting the sexual and reproductive health of participants in other accounts that were not specifically related to the above question.

> 'I have Endometriosis and was refused doctor's appointments. When I had a miscarriage, I was forced to stay at home on an isolated farm until it was obvious I needed medical support and then he came and talked for me at the appointment. He refused to allow me to answer or to explain anything for myself, then refused to pay for or fill the prescription given.'

> 'Would not let me use contraceptive pill to control period and hormones because he had the snip and thought it meant I was cheating.'

> 'Following a very difficult pregnancy with my second child due to GORD[4], shirodkar stitch[5] and being 35 I requested a tubal ligation as I could not put myself through that again. My husband at the time refused to go to the appointment with me and therefore the consultant would not follow through as it appeared my husband did not agree!'

> 'When I had my IUD removed I got screened for cervical cancer. Test came back with positive for having cancer cells. I had to go through a lot of procedures and operations. My ex-partner started verbally and emotionally abusing me saying that I was useless to him because I was unable to fall pregnant.'

> 'My ex forced me to have sex almost immediately after termination and I got an infection and thought I would die. He insisted I walked down staircase to get to the car - he wouldn't get an ambulance; he would not help me even though I was in such a bad way – huge clots and material exiting my body.'

As well as exposure to STIs (and, therefore, higher risk for exposure to HIV), pregnancy coercion, and other forms of violence (discussed below), the attempts to control access to medical support and procedures related to sexual and reproductive health also adversely impacted some participants health and wellbeing. Some of the conditions noted by research participants, such as Endometriosis, are conditions that can involve high levels of pain and can therefore impact overall quality of life if proper management of the condition is impeded or undermined.

Non-consensual condom removal

The non-consensual, often covert removal of a condom during sex was a common phenomenon mentioned by participants. Non-consensual condom removal is an example of sexual violation, as well as presenting risks to the sexual and reproductive health of the other partner. This experience was mentioned 47 times by participants in this research.

> 'I am a single female (not in a romantic relationship) and I have had MULTIPLE men refuse to wear a condom while having sex with me, or remove a condom without my knowledge while having sex with me.'

> 'We were having sex using a condom and I saw him throw the condom over the other side of the room during us being intimate. He didn't say anything about it, wouldn't stop having sex with me after he had taken the condom off, and he knew I wasn't on the pill at that time and that I didn't want to become pregnant.'

> 'We always used condoms but it wasn't until he finished I realised he hadn't used one at all that time. I was so shocked, I cried and cried. I don't think he even vaguely understood what a violation it was. [...] I could never really forgive him for the breach of trust and lack of respect for my consent and bodily autonomy.'

The non-consensual removal of condoms during sex, and the frequency with which this was reported by participants, speaks to a concerning level of dismissal over the sexual decisions of participants by their partners, and the underlying entitlement over women's sexual matters by their often male sexual partners.

Sexual violence

Sexual violence includes any sexual behaviour that someone does to another person without their full, voluntary and informed consent. Therefore, the examples above of non-use of condoms when one person had wanted them to be used, the non-consensual removal of condoms, and the tampering with condoms and other contraception when one party didn't know or did not agree, are all instances of sexual violence or violation. There were also multiple examples of overt and coercive sexual violence that participants shared, often with the intention from the perpetrator of bringing about a pregnancy.

---

[4] Gastro-oesophageal reflux disease (GORD) describes the inflammation of the lining of the oesophagus due to stomach acid leaking up (refluxing) from the stomach.

[5] The shirodkar stitch is a stitch put into the cervix to keep it closed during pregnancy for the purpose of preventing miscarriage or premature birth when the cervix has been weakened.

'(In a lesbian relationship) Not allowing me to use any birth control and trying to force me to have a threesome so that I would become pregnant with a stranger's child.'

'I was raped repeatedly till I was pregnant. This happened with my second and third child and four miscarriages in between.'

'He threw away the pill then raped me.'

'Pinning me down so I cannot get up then ejaculating inside of me.'

'Throw away pills and keep raping me to get me pregnant.'

'He forced me to have sex almost every day to get me pregnant. I never wanted to get pregnant. But I felt I had no choice or he'd hurt or come after me if I didn't comply.'

The above examples make explicit the integral role of sexual violence in reproductive coercion, specifically pregnancy pressure. As previously noted, reproductive coercion generally represents a sexual (and reproductive) violation from the perpetrator towards their sexual (and often romantic) partner as reproductive coercion involves the intention to undermine or override the sexual and reproductive decision making of the other person, therefore disregarding their consent.

Physical violence

Actual or threatened physical violence may be used by perpetrators to enforce their sexual and reproductive goals on their partner. Actual or threatened physical violence may, therefore, occur alongside other behaviours intended to control and enforce particular sexual and reproductive outcomes.

'I was 18 and my partner, 28, gave me the bash and strangled me till the blood vessels in my eyes burst because he found my contraceptive pills in my bag. He covered the hand marks he left around my throat with hickies.'

'He would throw away my birth control pills. I then, with help from my doctor, managed to secretly get an IUD which was fine for a while until he discovered it in which he then forcefully ripped it out of me. Once I fell pregnant, he then refused to let me have an abortion'.

'My first love and father of my five children would beat me if I ever suggested using condoms, and beat me twice when I went on the depo [Depo Provera]'

'Was 26 weeks pregnant [when he] gave me the bash cos I caught him cheating I had my daughter early.'

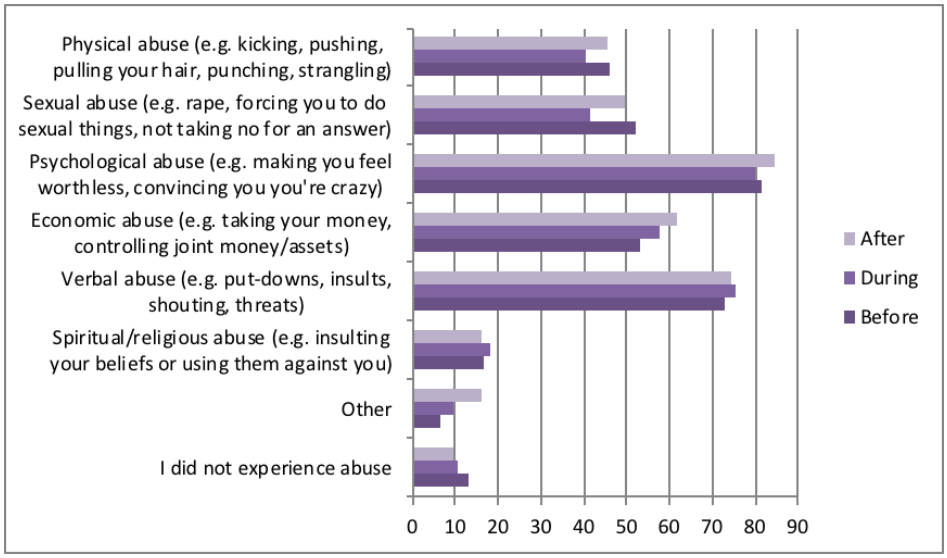
'I miscarried my baby at 14 weeks gestation. My now ex/father of my five children beat me and threw me into a wall, also would tell me to commit suicide. So on top of the hidings and stress I believe that is why I miscarried.'

Physical force and violence was often, as apparent in the above examples, used as a further method to control reproduction, and enforce compliance with the reproductive intentions of the perpetrator.

Concurrent abuse from an intimate partner and pregnancy

This research aimed to understand the connection between intimate partner violence and reproductive coercion as a form of control, and the relationship between the temporal phases of a pregnancy (i.e. pre-conception, post-conception, and post-pregnancy) and the extent and types of abuse used by the perpetrator. These connections were gathered in the survey by asking participants to select any abuse they had experienced from an intimate partner before, during, and after a pregnancy (i.e. after giving birth, or having a miscarriage or abortion). Participants were also invited to elaborate on their partner's behaviour at each temporal phase of their pregnancy, for example to describe any changes or consistencies in their behaviour.

Figure 5: Abuse and temporal phases of pregnancy



The 'Other' category primarily included behaviours that could be described as psychological abuse, including isolation (including taking petrol out of the family vehicle, as well as physical isolation in remote areas), gaslighting, controlling behaviour (including prevention from eating, sleeping, and going to the toilet), harm towards pets, and threats of harm or homicide.

Overall, the number of research participants who experienced no concurrent IPV by their partner alongside their partners' use of reproductive decreased at each temporal stage of pregnancy. This entails that there was an overall increase in abusive behaviours by participants' partners during and after their pregnancy, and the rates of concurrent intimate partner violence were overall high in this sample of research participants. There were, however, some decreases in some types of abuse by participants' partners during their pregnancy, specifically physical abuse, sexual abuse, and psychological abuse. Verbal, economic, spiritual/religious, and 'other' abuse all increased, however, during pregnancy. After participants' pregnancy (after birth, miscarriage or abortion), psychological and economic abuse notably increase, as does 'other' forms of abuse. Sexual and physical abuse also increased after pregnancy as well compared with during participants' pregnancies. Spiritual/religious and verbal abuse were the only methods of abuse by participants' partners to decrease overall after pregnancy compared with during pregnancy, however only marginally.

While the rates of abuse remain overall consistently high throughout participants' pregnancies, a hypothesis for the overall decrease in the instances of physical, sexual and, to a lesser degree, psychological abuse is that these types of abuse may have been perceived by the perpetrator as no longer as 'necessary' for establishing power and control during pregnancy given perhaps the greater physical and emotional vulnerability that can accompany pregnancy. On the other hand, economic and verbal abuse in particular increase during pregnancy, namely using and controlling household finances to establish financial vulnerability and dependency, and using put-downs and other verbal insults intended to incite shame and degradation, may be 'enough' for perpetrators to maintain control and power over their partners.

Research participants were also invited to share further their experiences of their partners at each temporal phase of their pregnancy. For the stage before pregnancy, 37 participants elaborated on their partners' behaviour.

> 'To begin with before we were married he was very attentive and charming. I now know this was grooming and I was naive. The day after we were married he knocked me to the ground for the first time. He wanted a family straight away and I wanted to wait "until he trusted me". Once he continued to beat me while I was pregnant I knew I had to get out.'
>
> 'There was love-bombing and repeated crossing of my boundaries (like coming over drunk when he knew it set off my PTSD from a past experience)'
>
> 'It [the abuse] was less frequent before we had kids. But there were incidents that required medical treatment.'
>
> 'Very abusive, possessive, controlling and suicidal when I tried to stand my ground.'
>
> 'Grooming and what I would call rescue chivalry. Telling me we would always be bonded if I had his baby.'
>
> 'He would say things like, all he wanted was a child and he would get better if he had a child. I believed him.'

‘Possessive. Controlling.’

‘He was charming before I got pregnant. Once I had the child he turned….’

‘It was really low level. Got much worse after getting pregnant and then worse again after baby was born and I was stuck.’

‘He seemed to be kind and caring but his behaviour changed after our child was born.’

‘He fluctuated between extremely abusive and very in love which was confusing and difficult to understand due to my extremely low self-esteem.’

‘Intense in wanting me to move in, saying how much family meant.’

As the examples above reveal, for some participants, their partners’ controlling, possessive and other abusive behaviour was present before they became pregnant, while for others, there was a notable worsening of abuse during and after their pregnancy. This last point was substantiated in the 42 comments by participants in relation to their partners’ behaviour during their pregnancy.

‘He hated me more.’

‘Tried to coerce me into marriage. Simultaneously claimed the baby was not his and that I’m a murderer if I “kill” his child.’

‘[Interview] During pregnancy, I was subjected to violence because he knew I was vulnerable. At night, he’d be out and come back and drag me out of bed to cook. If I didn’t wake up or get up, he’d pour cold water over me in bed’.

‘Violence was much more extreme and regular.’

‘His behaviour became far more aggressive and controlling as the pregnancy progressed. He used my pregnancy as a means to keep me in the relationship.’

‘Became more controlling and accusing me of looking at other men. Told me things had happened that didn’t happen.’

‘Two different men. But both changed the moment I confirmed pregnancy. One became jealous and passive aggressive and neglectful of relationship. Other turned to drugs and became violent towards me and my older child.’

‘While I was pregnant his attitude did change. He was more attentive towards my needs and made sure that I and the babies were fine. I was well looked after by him, although the abuse was not as bad before I was pregnant it didn’t stop the abuse. It only redirected his focus to the health of his bloodline. He wanted the utmost care for his offspring. He would tell me to turn my church friends away, if I didn’t it meant I was cheating on him, […] and [he’d] make wild accusations like the pregnancy was made by these men and they must have somehow gotten me pregnant. I fell pregnant again not long after that pregnancy with twins because he would force me to have sex with him every day or every second day if he believed in his mind that I cheated. They’re now 3. He forced me to have sex during this pregnancy too. I wasn’t meant to have sex at all during both of those pregnancies because I was a high risk pregnancy. But it didn’t stop him. I had to have the abuse stop, so I sent away the church. But not before I cried for their help to no avail on their part.’

‘His behaviour was at his worse with my second child after he found out it was a girl. I had to stop working cause of complications so he beat me up for not bringing in money in. I had to be stopped going into pre term labour from one of the beatings I received.’

‘He became harsh towards me and totally lacked understanding of my physical and emotional vulnerability at that time.’

‘He became more possessive like he thought I was more likely to cheat on him whilst pregnant which was counter intuitive and believes that hitting me as long as it wasn’t in the abdomen was not going to affect the baby.’

Many of the participants who elaborated on their partners’ behaviour during their pregnancy noted some change, and for the majority this change involved a worsening of abusive, controlling and violent behaviour. There was one participant, however, who described the change in her partner’s behaviour during pregnancy as becoming increasingly protective over her as the carrier of his child, while simultaneously controlling her access to support networks and sexuality via accusations of infidelity to coerce sexual intercourse.

For the final temporal phase of pregnancy, namely post-birth, miscarriage or abortion, 43 participants described their partners' behaviour, and any changes they noted.

> 'This was even worse as he continuously demanded to know who the father if the child was. It was him.'
>
> 'He told me if I ever took up with another man and had children he would come and shoot us all. He hounded me through lawyers and letters. I lived in fear for 20 years that he was coming to shoot me and my family.'
>
> 'Control was here before I was pregnant, and then it ramped up while I was pregnant, and then when I had the kids it ramped up too. I think it correlated to how stuck I was with him too. Once it became really hard to extricate myself from him, he really got into it.'
>
> '[Interview] The thing was, after pregnancy, he'd actually be better, he'd buy me... well, kind of provocative dresses, but he'd buy me things after I'd had the babies, more so than when I was pregnant, I got treated better after. But then I started to think it's because he wants to put me back in the 'barefoot and pregnant' thing again.'
>
> 'He would make me feel worthless, stay out all night and see other woman and try to convince me it was my own issues causing the problems in our relationship. When I tried to leave he would get physical and threaten his own life trying to convince me to stay.'
>
> 'After my termination, the mental abuse became worse.'
>
> 'Made me feel guilty about having a period.'
>
> 'Became extremely controlling, accusing me of having sex with other people, not letting me leave the house, not letting me see my friends, not giving me any money towards bills and rent when I was on maternity leave, broke my things.'
>
> 'He isolated me from the world. He kept tabs on me while he was at work, calling every hour to check in on where I was, where his baby was, what I was doing, what his baby was doing. If anyone text (especially friends), called (even telemarketers), emailed (even junk mail), Facebooked, messenger (even forwarded messages) or came over (including door knockers)... Every day I had to prove my innocence. Every single day. If he thought I'd cheated, he'd bend me over and force me to have sex. I had no choice in the matter. He just did it. Even right after my c section. I wasn't allowed to have sex, but it didn't stop him. He still did it anyway. It caused me to heal slowly. I ended up in hospital again because of it. I bleed profusely. But to him he got off and saw I didn't cheat because he got to fuck me to prove I hadn't. I was never allowed to shower without his permission. I was never allowed to leave the house even to check the mail or hang out my washing. I was not allowed to do anything or risk being forced to have sex. Risk getting hit. Risk having a few hours long argument of my innocence to his wild accusations.'
>
> 'He asked me when I was going back to work in the birthing room. He expected me to do it all myself. He broke my ribs and threw me on my eldest who was 3 months at the time. He was at his worse after the second one was born. He made fun of my stretch marks and called me fat. This is when abuse was a regular thing almost every day.'
>
> 'He started behaving violently, such as throwing things and wanting to harm the baby by shaking.'
>
> 'He treated me "well" when I was pregnant because I was the incubator. After, I was no longer needed so he became much crueller.'
>
> 'His behaviour changed markedly once was pregnant, no physical or sexual abuse. I terminated the pregnancy and his behaviour reverted back to previous.'
>
> 'Once the baby was born he became critical of my parenting, housework, sex drive etc. etc.'
>
> 'Neglect of me and what baby and I required. He would not get medical things I heeded and baby needed. He would keep waking the baby and chastise me over my exhaustion.'

Once again, many of the participants who elaborated on their partners' behaviour after their pregnancy noted a worsening of abusive, controlling, and violent behaviour. As noted in the above accounts, the control over sexuality through (false) accusations of infidelity was a common theme, and was used by perpetrators to justify their use of control, isolation and violence, particularly sexual violence.

Childbirth and abuse from an intimate partner

As an additional question, for participants who gave birth, they were invited to share their accounts of how their partners (i.e. often the fathers of the child being born) behaved during labour and delivery. This question about how their partner behaved during labour and delivery was solely qualitative, providing a space for participants' descriptions of their partners' behaviour, and 75 participants chose to respond to this question.

> 'Useless. [He] was on his cell phone the whole time my midwife had to yell at him to get off his damn phone and start supporting me through the pain and my fear etc. as he was oblivious to anything I was going through.'
>
> 'He made the entire thing about him. He and my father had a standoff during my labour. He was upset that the attention was on me and not him and he attempted to control every decision and refused to allow me to be alone with medical staff. He made my entire labour and delivery incredibly stressful. He controlled who I was allowed to talk to for support during labour and prevented me from having access to anyone but him then denied me any support at all.'
>
> 'Terrible, he argued with my mother in the hospital telling her he wanted to get a paternity test which was completely insulting and degrading as there was no way it was anyone else's. He also made me feel ashamed when I had to go into surgery for my C-section referring to me like an animal on a farm.'
>
> 'Two separate ex partners, both telling me it was taking too long, rushed me home the day I gave birth on separate occasions.'
>
> 'As charming as can be in front of other people. If we were alone he would use the gas and not let me have any.'
>
> 'He was drunk and took the gas from me when people would leave the room.'
>
> 'Negligent, not coping and angry. Became angry that I needed to go to hospital. Took gas off me and used it for recreation.'
>
> 'He wasn't there more than 5 mins at a time, smoking was more important. After birth told me I done well then went to a friends and slept with another girl cause I was in hospital and couldn't give him what he needs.'
>
> 'Completely detached, ate my food, read a book then left. Later complained about how he felt.'
>
> 'He sat in the corner on his phone, did nothing to help me, asking how long it would take etc., started arguments and was rude. With all three births he was abusive towards me when time came to go to hospital, refusing to take me, called me names whole way to hospital. Smashed and punched the wall because he was tired and didn't want to go to the hospital. Drove like an idiot and threatening to kill us all. Told me to get out and walk with the second (middle of night 30 minutes' drive on rural road to anywhere, with no service) because I was in pain and moaning (being "dramatic").'
>
> 'Didn't take me seriously when I said I was in labour and made me feel guilty and bad for my waters breaking in our bed. Swore at me for messing up his day.'
>
> 'Not supportive. Because I wasn't allowed a phone, I had to walk 2km with my 2 year old at 3am to my mum's house to call my midwife. My water had broken and I was in active labour. The baby was born 3 weeks early and we still had the capsule on layby. My parents gave him some money to pay off the remaining cost and collect the car seat. He took the money and left for 3 days while I was in hospital with a new born baby.'
>
> 'Second child he took off immediately after the baby was born then returned to say I was needed at home. Brought [my] other child in at my lunchtime so [the] child [would] eat my lunch. I went home and had to cook him dinner. He had not bothered to shop. It was as if nothing had happened. I soon became exhausted as had unwell toddler and baby developed reflux . I became a shell of myself.'

Participants were also invited to share how their partner was during their recovery from birth, and whether their partner did anything to make their recovery more difficult or worse. Of the 103 participants who responded to this question of whether they had experienced a partner impeding their recovery from birth, 62.1% had experienced this. The majority (n 63) also chose to elaborate on what their partners did to make their recovery from birth worse.

> 'Forced sex, made me tend to his every need, would wake me up if I was asleep, said things like it shouldn't be that hard for me why am I finding it so hard, would go out and leave me alone with the older kids and a new baby, didn't care that I had mastitis or was sick and wouldn't help me take care of the children.'
>
> 'He was aggressive in seeking sex days after the birth (but fortunately did not force me to have sex) he became very sulky that I would not (could not) have sex with him and was jealous of the attention on me and the baby.'

> ‘Refused to contact midwife after I started bleeding and cramping heavily hours after birth. I passed out on floor and he left me there.’
>
> ‘Forced me into sex four days after our second child was born and making me have to perform oral sex almost every night after our children were born until I stopped bleeding.’
>
> ‘After my abortion my partner would not let me take pain medication for the severe cramping I felt afterwards.’
>
> ‘After my C-section which had major complications the day I got home I was told I was lazy and needed to clean the house and put washing away and sort the kids even though I was told to be in bed rest.’
>
> ‘Made me have sex with him after my mum left. I think I was about 10 days post-partum. I had very bad tearing from birth so it was very painful. And he refused to wear a condom so I was very scared that I would get pregnant. I had no money to get birth control and no access to a clinic even if I had money because I wasn’t allowed to go out.’
>
> ‘Sex before was healed. Refused to call midwife to help me hours after birth. Wouldn’t let me buy new clothes like maternity bras to feed baby and would punch and chest barge me while my breasts where tender. He still does this if he comes anywhere near me.’
>
> ‘Prevented me from accessing post-abortion counselling and medical appointments.’
>
> ‘I had c-sec with first. He left me at the hospital I was expected to cook and clean straight after I got home (I opened the stitches and had to be restricted) he wouldn’t take me to the doctor or allow me to contact midwife. It was a whole night before midwife came back to check on me, I have lasting nerve damage because of it. He raped me after each birth far too early after. With second I had very severe tearing, he broke several of the stitches. I still have pain during sex because of this.’
>
> ‘He said he needed sex and forced me to have intercourse 48 hours after birth which stopped my stitches healing correctly and as I had haemorrhaged severely after the birth the persistent sexual intercourse prevented my body being able to recover I ended up continuing to bleed heavily offer 6 weeks after birth and on examination by a doctor was advised of the scar tissue and damage inflicted by the repeated encounters.’

Sexual violence post birth was an experience commonly cited by participants resulting often in serious complications to their recovery, and, for some, lasting damage. Furthermore, there was a common theme of having to fulfil domestic duties immediately post-partum, which has clear gendered implications of women being consigned to (and solely responsible for) the domestic domain, irrespective of other competing pressures or challenges.

In one of the interviews, the interviewee also shared her ex-partner’s attempts to control her care of and bonding with her infant:

> ‘He wouldn’t allow me to breastfeed the baby. He wanted me to pump my breastmilk into bottles and feed the breastmilk from bottles only. Early on I was just like, oh whatever, and I fed the baby from my breast and I fell asleep, as you do. So the baby and I are sleeping there on the bed and the baby is breastfeeding, and my ex came in and started throwing things around the room, he was so angry that I would do that there and at the time, I was two days postpartum and I was like okay I won’t do it anymore, and I never breastfed my baby again’.

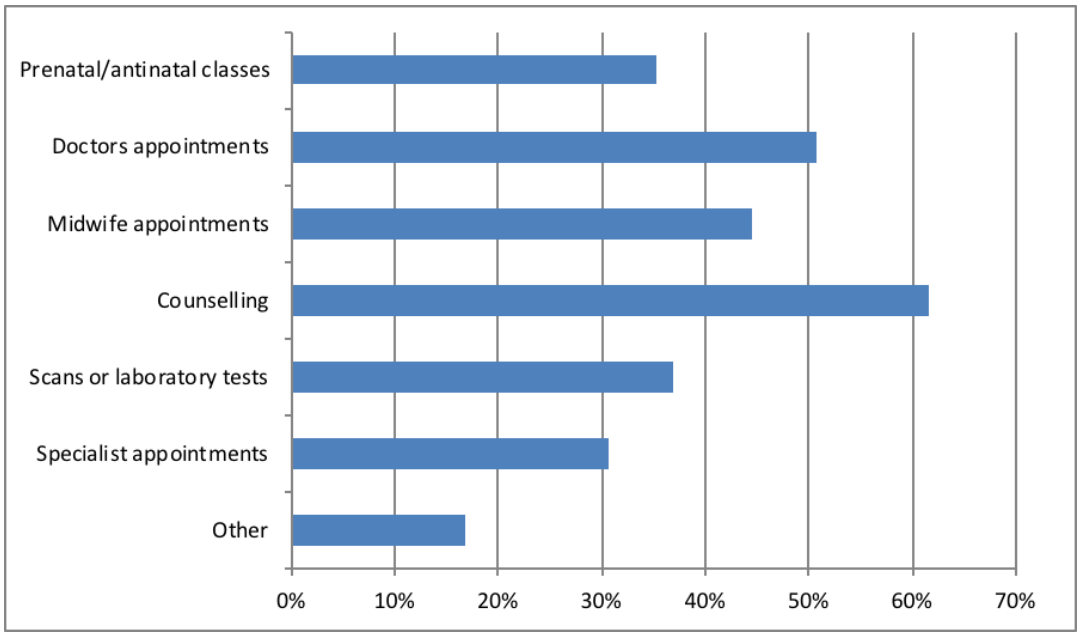
This account above from the interviewee is a horrific example of the extent of perpetrators’ coercive control, and the impacts that that behaviour can have on mothers’ health, and also on infant and child health and their ability to bond with their mothers.

Experiences seeking support

The final phase of this research explored participants’ experiences seeking support from professionals and others, such as family and friends, for pregnancy care and support, and for help and advice regarding their experiences of abuse and/or reproductive coercion. Participants were also asked for their advice for how professionals could better respond to instances of reproductive coercion.

Participants were asked if their partners’ controlled or prevented their access to pregnancy support and care, and 65 participants responded to this question (97 skipped). Overall, the findings from this sample suggest high rates of controlled access to pregnancy support and care, which also entails that any risks associated with their pregnancy may not have been picked up on, so health care support may have been delayed.

Figure 6: Controlled access to pregnancy care and support



'Other' for this question included cancelling appointments and check-ups, controlling access to special diets and other recommendations from health professionals, resulting for one participant in anaemia, hair loss and other health complications. One participant noted that their partner, rather than limiting access to healthcare and check-ups, would enforce increasingly regular medical assessments. While less than half of research participants responded to this question, the high rates of these participants' access to support and healthcare during pregnancy being controlled or prevented is concerning given the subsequent limited window of opportunity for undertaking assessments of pregnancy progress and any risks or complications, as well as support in exploring options for pregnancy termination, or pregnancy and birth plans.

Access to counselling was notably controlled or prevented, with over 60% of respondents to this question experiencing this. Thus, not only could this continued coercive control during pregnancy result in adverse physical health outcomes due to the lack of, limited, or delayed access to medical support, check-ups, and other pregnancy support and information, but it is likely that it could also impact the emotional and mental health and wellbeing of the pregnant person.

As the graph above suggests, people may be limited in their ability to access healthcare and support during pregnancy by their partner. This research also explored the experiences of participants who did access healthcare and other support, including whether they were provided the opportunity to disclose their abuse and reproductive control or coercion by their partner. Under one third (29.9%) of participants had experienced a professional specifically asking if they were being abused by their partner when seeking pregnancy or contraceptive support. Furthermore, only 4.4% had experienced a professional specifically asking about whether they were experiencing reproductive control or coercion from a partner. Participants noted that the opportunity to be asked sensitively and non-judgementally if they were being abused, without their partners present, was important. Timing was also highlighted as an important factor in participants' ability to disclose abuse, namely not asking abuse survivors if they are being abused if they are in a state of heightened stress and fear.

For some participants who were asked about abuse from a professional, they had not yet gained a perspective that their partners' behaviour was abusive, especially if their partner had not been physically violent, so professionals' ability to provide more information and context around specific behaviours indicative of abuse and reproductive coercion may also enable disclosure.

> 'I only recently realised I was being abused because he was not hitting me. I did not know it was abuse.'

Some participants noted the importance of professionals asking about abuse, and some participants also provided specific recommendations around how to enable disclosure, namely to initiate the discussion more subtly to allow space for disclosure rather than being too direct which could cause people being victimised to shut down. Some suggestions from participants for how this conversation could start include

> 'I think professionals should ask in a more subtle matter, for example: If you need any extra support, feel free to share. Instead of 'are you being abused?'.'

> 'Abuse is such a loaded word ... I would encourage a conversation about what life looks like vs being

asked if I was abused. I would never have admitted it at the time.'

'Being asked specific questions that I could just nod or shake to because I had pretty much lost my voice.'

'If they asked risky questions with more empathy and a kinder attitude. Act like they actually care.'

Participants were also asked to note if they had sought help, advice, or support for their partners' reproductive coercion from a variety of providers and personal networks, and to rate how helpful or unhelpful they found their responses. The responses of those who sought support (n 105), who they sought support from, and how helpful they found the responses of those whom they had sought support from revealed that the vast majority did not seek support or advice from professionals for reproductive coercion. Family and friends were the most common sources of advice, help and support for experiences of reproductive coercion, with support and advice from friends being rated overall as more helpful than family. These low rates of support and advice seeking are perhaps connected to the findings noted above regarding the low rates of participants being asked about abuse, and the even lower rates of participants being asked specifically about reproductive control and coercion. Furthermore, a number of participants also noted controlled or restricted access to health and support during pregnancy which also limits the opportunities for support seeking, as well as the limited knowledge about abusive behaviours and thus the ability for participants' to identify their partners' behaviour as such.

Participants in this research were also asked to elaborate on what they perceive made disclosure recipients' responses helpful, acceptable or unhelpful. While some participants were asked, and some subsequently disclosed that they were being abused, many were not asked, or when they were asked and subsequently disclosed, were met with inappropriate, non-responsive, unhelpful, or even harmful responses.

'I told my Doctor that my husband 'hated me' at a postnatal visit. The Doctor didn't ask about abuse, he gave suggestions for me to provide more sex. Kind of the opposite of what I needed.'

'I feel that my obstetrician had clues and opportunity to help me but chose not to act on them.'

'[Interview] I went to them and said I'm sad, I'm feeling bad all the time, I'm such a fuck-up. I'm a terrible person, a terrible wife, can you help me? And they were like okay sure let's talk about ways to spice up the bedroom! That's the wrong way to be a psychiatrist. They didn't ask any of the questions to figure out what was actually happening, they didn't key into the idea that actually I'm not really the cause of the problem. So actually those professionals both did more harm than good.'

'It takes so much to ask for help the first time, it took me 8 years to ask someone for help. I was told they were busy and that a social worker would be in touch with me but I never heard back from anyone. I never asked for help again until I ended up in hospital and a nurse recommended I get help and support to deal with my situation. Another nurse told me I was a stupid girl for getting an STI, so I never followed up on getting support because I thought everyone would think it was my fault anyway.'

'Family violence worker said I'd just had a baby and I was hormonal, counsellor sided with my abusive partner.'

'I tried to talk to my GP about it and she said just told me she thought I was depressed and that was it no follow up or anything.'

'All pretty much laughed it off and said I couldn't ask my partner to get a vasectomy (he's 18 years older than me and I have a blood clot issue and some other issues that make a lot of birth control options un useable).'

'I think for the church, they didn't believe me. Or I looked too hysterical and dramatic for it to be truthful.'

'They were dismissive and the impression throughout was that it was my fault. I felt dirty/worthless/humiliated.'

'My issue with him removing condoms was raised while we having couples counselling and the (male) counsellor didn't share my sense of outrage and violation which kind of validated the behaviour for my husband.'

'Multiple professionals did not recognise my descriptions of abuse, as abuse. Instead they blamed me, just like I was already doing. They reinforced my ex's message. I stayed years longer, because of it.'

'When I had the abortion the doctor was terrible. He told me I was lazy for not using contraception and slut shamed me. He was then the person who performed the abortion and I felt very violated. I would have felt more supported if he hadn't been such a horrible twat.'

'I think I felt uncomfortable discussing it with my doctor as my doctor made me feel like contraception was my responsibility when I would tell my doctor that I missed pills or lost packets and he would tell me that I needed reminders on my phone or to look after them better so I felt uncomfortable admitting to my doctor that my partner was hiding them.'

Healthcare practitioners gave the impression that being pregnant was a "wonderful thing", that I should be happy to be pregnant; made it very difficult to speak up and say it was an unwanted pregnancy.'

Several participants also noted that their ability to disclose was impeded because their partner who was inflicting the abuse was in the room at the time of the questioning.

'A lot of them asked me questions when he was in the room and so I was unable to answer honestly.'

'I was either never asked, even though I had bruising and wasn't healing well, or my ex was present as well.'

'Being asked in front of him was a big one. Others would tell me to just leave him which wasn't possible at the time as it was when I tried to leave he caught us and seriously harmed both myself and daughter.'

'They needed to ask me questions when he was not there.'

Other barriers to disclosure include shame, embarrassment, fear, and concern that they will be blamed and judged for the abuse.

'Fear and dread of the consequences stopped me from telling while I was with my husband. Shame stopped me telling people afterwards. Not many people know what I went through although my daughter is now 37 years old.'

'I wasn't able to tell anyone until after I had left the relationship. His control was what stopped me. I don't think I clearly understood how he had orchestrated it until I was away from him.'

'I haven't said anything to most people about it because I'm scared they'll call me stupid for letting it happen and not holding my boundaries.'

'I was very embarrassed, I felt like I was stupid for getting myself in that situation. I also felt so crazy, I didn't know what was real any more. I think the feeling of shame is what stopped me. I still haven't told anyone and it has been nearly 12 years since I left him.'

'Fear of disbelief, fear not being helped, fear of partner finding out.'

'I never told anyone about it voluntarily because I didn't want to acknowledge it was happening. I answered the questions that health professionals asked me but downplayed how bad it was. I didn't see my family very often but that was part of his manipulation and control. When I did see them I didn't tell them because of shame. My family are devout Christians and I was already pregnant outside of wedlock so I didn't feel like I could really talk to them about any of the difficulties I was having with my pregnancy or with my ex-partner.'

'My husband had everyone around us fooled. He always played the doting husband/father. He never dropped his act. So I was scared no one would believe me. He threatened to use my depression to his advantage, so no one would believe me.'

Participants were also asked what would have helped them, or, if they had received a helpful response to a disclosure, what did help them in that response. Being heard, not judged, believed, and supported to understand and put into perspective their partner's behaviours as abuse were all noted. Some also identified helpful responses as those where professionals supported them practically, including supporting their decisions about their bodies, or with a direct referral to someone who would be able to provide practical support. Notably, in order to disclose and therefore in order for the professional to provide help and support, participants specified that it was necessary for them to be met privately, without their partners. Professionals should also be conscious of their own biases and prejudices regarding what they assume victims and perpetrators are like or would present as.

'Listening, coming up with solutions that work around contraceptive methods.'

'They were very straight up and honest about the risks I was being put through and the lack of respect it showed to me that he refused to wear a condom.'

'[Interview] I wish the psychologists had asked the right questions and been able to find out the root cause, teasing it out from me without me being able to articulate it. Because I couldn't at that time. Being able to figure out that this was an abusive relationship and that was where it [the sadness and depression] started from. It's almost as if they needed me to walk in and say, 'Hello, I'm in an abusive relationship, please help me'. No one's going to do that! No one in that is ever going to say that. So they need to be aware of what it looks like and what those patterns are and to be alert for patients presenting as that.'

'Believing that I was telling the truth and what reason would I have to make my reality up, feeling like I wasn't being heard took a huge toll on my self-esteem and wanting to seek out help in the future.'

'Follow through from my GP in regards to my mental health, I was extremely depressed and was walking a very fine line on the brink of suicide. Some referral to counselling would have been incredible. I felt very

abandoned after gathering the courage to seek help.'

'Having an appointment which was just me and the midwife or doctor would have made me feel better to talk more openly as I always had my ex-partner right there.'

'They gave me someone to talk to and open up about things when I felt I couldn't talk.

Just listening to what I had to say.'

'Acknowledgement, non-judgement. I appreciated that the counsellor listened carefully and asked few, but pointed questions, allowing me to unravel the issues myself. This facilitated my own self-reflection.'

'If more professionals were able to recognise signs of abuse. Even when it's not the 'expected' demographic (I am highly educated, professional job, articulate... it happens to all groups).'

'Keeping me fully informed of my options and rights would have been more supportive rather than telling me what to do based on their opinions.'

'I think it would have been helpful to know about reproductive coercion. No one said anything about it and I didn't even realise I was in it.'

'Ensure women get a chance to speak one on one every meeting. And asking how the person feels about being pregnant [...]. If the person is unhappy in appearance, asking why rather than expecting them to open up. Also ensuring the conversation is not able to be heard by others or in a room with a closed door not behind a curtain.'

'[The professionals were] understanding and put things in place to make me safe while the police did their job. [They] were non-judgemental and listened to me without telling me what I should do.'

'The nurse I saw at Family Planning fitted me in for an emergency appointment and gave me lots of support. She gave me new condoms, some pregnancy tests and morning after pills. Also a script for more morning after pills should I need them, following my disclosure.'

'The counsellor pointed out that his behaviour was not ok. That it was not about me, rather it was about him.'

'No judgement, including pity.'

'I had to see doctor to get a termination. They were helpful because they supported the termination.'

'Acknowledging that his actions and attitude were the issue was a big step towards realising my self-worth and how I was exposing myself to a difficult emotional situation.'

'[The professional] directed me to do a course at Women's Refuge which saved me.'

'Helping to clarify that the behaviour was abuse; support to develop strategies to leave the relationship.'

'Validation and not dismissive. They reassured me it's not just in my head.'

'Non-judgemental, listening, professional and knowledgeable, gentle.'

Finally, participants were asked what they would like professionals to know about reproductive coercion, and 71 participants shared their views.

'You don't even realise it's abuse at the time you think it's just a normal reaction or that all men want sex etc. without condoms. It seems so normal until you hear someone explain what it is and why it's wrong.'

'Reproductive coercion is also attached to marital rape. The rape follows the destruction of the contraception. The shame of both silences women. We feel so stupid and naive. I still beat myself up for being so naive, for not seeing the signs, for not knowing the signs to look for, for thinking I could fix things so he would treat me better.'

'It's devastating. I was raped as a teenager and what my partner did felt worse than that. He got me pregnant against my will and then forced me into keeping the baby. There are no criminal proceedings for that and no way to prove what he did but it is the single thing that has had the biggest devastating impact on my life. I just can't explain the damage he caused.'

'Education is always good, be professional but not distant. I felt like I had to hide taking the depo and sneak around to get it. I felt like I was betraying him by refusing, lying and keeping those secrets from him, the guilt was hard. I didn't feel I had control over my body even though I KNEW having a child would be bad for me and the child. I knew there were issues with his ex-wife and their child, and didn't want that for my child or me.

It felt like he was trying to get more leverage over me by having a child, he could use the child against me. I loved him but couldn't handle his abusive behaviour, I know what it does to children in abusive relationships and I wanted no part of it again. I think that whole experience with him has stopped me ever wanting a child, which is sad. I think I would resent the child if I did become pregnant. There was no respect to how I felt or [what I] wanted, sometimes it was scary, it was hard to distract him and without being abused. I was very sensitive about being with guys again and was probably a little paranoid about always using contraception.'

'They [professionals] need to ask the questions and also explain to men. Also, while I love my children and wouldn't change them for anything, I also now have 4 kids to someone who isn't a great role model or partner but as I can't and don't trust him to be alone with my children, I would never leave.'

'From a victim stand point, he is much stronger than me. He will hit me and seriously hurt me if I don't comply. 'It can't be rape, we're in a relationship.' Apparently it's my fault I can't get an abortion or I can't get pills that he destroys. They just get destroyed once I get them. Condoms, pills destroyed. Police are no help. They don't believe you at all, unless you have a bruise they can see, they won't help you press charges.'

'It has impacted me more than ever now I have a baby to this man which I never wanted or planned. My life will never be the same, I will never be the person I was before he did this to me. I will never trust any man again. Support and a listening ear away from him and feeling safe and relaxed, got me to break the silence about what he done. Counselling is amazing help. Knowing that you're not being judged by what you say and that it's ok to say what has happened. Knowing that he won't find out you have opened up.'

'He controlled every aspect of my life even my own body. I cannot stress enough how much I felt that I had no control over my body. The weeks before my periods would be due I'd become terrified in case it didn't come and I was pregnant. I remember one particular period when it was a week late due to stress and I sat and cried for hours. I googled how to have an abortion, naturally so he wouldn't find out. I felt guilty and a terrible person.'

'This can be a major way that women are controlled by their partner, but one of the hardest to talk about. It can impact their whole lives. My life may be totally different if I had not been groomed and coerced into a sexual relationship. I also would have had more options to leave or seek help if I had not been constantly pregnant and breastfeeding. Churches also need to make it loud and clear that sex is not a wifely duty. Secular professionals need to be aware of how brainwashed these wives can be, and gentle about leading them back to believe they have a voice.'

'Don't assume. As a Caucasian passing, private school, upper class looking woman - no-one entertained the idea that I was being abused and coerced. I lied and avoided aid for years, from 14-16 when I received an abortion. Religious influence, from the partner's opinion, can influence a partner's actions. While I'm agnostic, my partner was Catholic and believed in the sanctity of 'life'. Abuse was never asked, or investigated unless I raised an issue of concern with my counsellor or friends.'

'That it might not be accompanied by physical violence or serious abuse, but might just be undermining a woman's consent, respect and bodily autonomy.'

'If you don't ask the questions it's highly unlikely this form of intimate partner violence will be disclosed voluntarily. You can safely assume the reality of the situation is worse than what has actually been disclosed.'

'It's not talked about like other violence so it's embarrassing.'

Much of what participants articulated about what they felt professionals needed to know about reproductive coercion summarises the serious violation that it represents, and the potentially life changing outcomes of this type of coercion. Participants' autonomy over their own bodies was ignored, dismissed, and often intentionally undermined by perpetrators, and for many participants their autonomy was further deflated by professionals blaming them for unwanted pregnancy or STIs, and even making reference to moral imperatives regarding women's lives and reproductive capacity.

Discussion

This research sought to understand the issue of reproductive coercion with a sample of participants who chose to share their experiences, to gain insight into how people's, and particularly women's, reproductive autonomy may be undermined by their partners. This research explored previously identified features of reproductive coercion (i.e. controlled access to contraceptives, birth control sabotage, and pregnancy pressure or coercion), as well as exploring more broadly participants' experiences of their partners' behaviour before, during and after pregnancy, during post-partum recovery, and their experiences seeking support. This section of the report will discuss and analyse the above findings in relation to literature on the topic of reproductive coercion and violence during pregnancy. This discussion will analyse the research findings at along the temporal continuum identified in Moore et al (2010), and in relation to the intentional obstruction of participants' reproductive autonomy. This discussion will also employ a gendered analysis of

reproductive coercion given the largest proportion of research participants were women.

Moore et al (2010) identify three temporal periods at which perpetrators' behaviours intended to control reproductive outcomes may occur: before sexual intercourse (e.g. controlled access to contraceptives, and pregnancy pressure and coercion), during sexual intercourse (e.g. birth control sabotage), and post-conception (e.g. controlling pregnancy outcomes, for example for it to end in a birth or an abortion). At these three temporal phases, the perpetrator intentionally impedes their partner's reproductive autonomy to exert greater control over them (ibid). Reproductive autonomy can be described as 'a woman's ability to make independent decisions about her reproduction' (ibid, p. 1738). Therefore, reproductive coercion or control describes 'interference with this autonomy', namely 'when women's partners demand or enforce their own reproductive intentions whether in direct conflict with or without interest in the woman's intentions' (ibid, p. 1738). Reproductive coercion from a male partner towards a female partner also has particularly gendered ramifications, and has been observed as an enactment of patriarchal or masculine power (Connell, 1987; Moore et al, 2010). The main domains this enactment of masculine power span across are in relation to labour, or reifying women's domestic and childrearing duties; power, or exercising authority and control over women's sexuality and reproductive capacity; and cathexis, or men's commandeering of women's sexual, emotional and intimate experiences and enforcing child-rearing (Connell, 1987; Moore et al, 2010).

The findings of this research span across the three temporal phases identifies above, exploring research participants' experiences of reproductive coercion by a partner before sexual intercourse, during sexual intercourse, and post-conception. This research also gathered participants' experiences of concurrent intimate partner violence by their partner before, during and after pregnancy, and their partners' behaviour during labour and delivery, and post-partum. Many of the accounts from participants of their partners' reproductive coercion can also be analysed from the lens of the enactment of masculine power across the three domains identified above.

Experiences of reproductive coercion pre-sexual intercourse

The first temporal phase identified above for perpetrators' intentional control of their partners' reproductive outcomes was before sexual intercourse, including pregnancy pressure, controlled access to contraceptives, and some instances of contraceptive sabotage. All of these experiences of reproductive coercion pre-sexual intercourse were captured in this research, and are analysed below.

The majority of research participants, 83.6%, had experienced their partner controlling their access to contraceptives, and these experiences ranged from participants' partners inhibiting their ability to access transport to attend clinic appointments, body shaming them, namely telling them they will become fat if they take contraceptives, controlling finances to prevent them from being able to pay for appointments and contraceptive prescriptions, and outright refusal to use contraceptives, such as refusal to use condoms. Just under 60% of participants also experienced their partner tampering or sabotaging their method of contraceptives, and some of those experiences were in the temporal phase prior to sexual intercourse, for example disposing of or destroying contraceptives. Finally, participants' partners trying to coerce or pressure them into pregnancy (experienced by over 60% of participants) can also occur before sexual intercourse, in the form of verbal threats, for example threats of harm towards themselves (such as suicide threats) or towards their partner, and other methods of emotional abuse and manipulation, such as name calling and accusations of infidelity.

Strong themes of enactment of masculine power across the domains of labour, power, and cathexis were apparent in the behaviour of participants' partners at this temporal phase. Power and cathexis in particular were apparent in participants' accounts of their partners' reproductive control prior to sexual intercourse. In multiple accounts from participants, their partners cited pregnancy as a method for entrapping them in the relationship, thereby explicitly exploiting their sexual and reproductive experiences and vulnerability for the purpose of controlling them to the extent that they cannot leave the relationship. For some participants, their partners specifically cited gendered expectations in their justification of their coercive behaviour, for example one participant recalled 'He claimed he didn't feel like a man because he failed to impregnate me', and others recalling their partners' accusations of them being 'selfish' and 'unmotherly' if they did not proceed with actively trying to get pregnant.

Another key theme in participants' accounts of their partners' behaviour was the monitoring of their sexuality in order to coerce non-use of contraceptives. Namely, participants' recalled their partners accusing them of infidelity if they were to use or were found to be using contraceptives. This behaviour is both an example of perpetrators exercising power and authority over women's sexual experiences and biological vulnerability, and of male appropriation of women's sexual experience in order to mandate child-rearing (Connell, 1987; Moore et al, 2010). These examples of men's monitoring of women's sexuality are explicit examples of men's attempt to control their reproductive autonomy, and to circumscribe their capacity to act according to their own sexual and reproductive intentions.

This exploitation of women's vulnerability in relation to their reproductive capacity is exacerbated in the context of broader threats from their partners towards their sexual, physical, psychological, economic, and sometimes spiritual safety and security. Participants recalled their partners threatening to abandon them if they do not become pregnant, or threatening further isolation from their support networks. For one participant, threats included referencing religious beliefs, namely that contraceptive use is akin to showing distrust in God. There were also several accounts of participants' partners threatening suicide and/or to harm or kill them if they did not become pregnant. Furthermore, alongside fear, some perpetrators also incited guilt and shame in order to coerce women into pregnancy, including one example from an interviewee of her partner making a false accusation of her having had an abortion, with another pregnancy being her only option for atonement.

For some women, this experience of guilt had a more specific connection with gender roles, namely their partners' reference to male power and control and female submission and domestic duties, therefore relating to the masculine exercising of power in the domain of labour (Connell, 1987; Moore et al, 2010). Participants shared various experiences of their partners' referencing their gendered obligations, such as using child-rearing as a measure of love and commitment to their male partner, and referencing the 'barefoot and pregnant in the kitchen' gendered ideal. Many participants also experienced their partners using particularly gendered put-downs to reduce their sense of autonomy in relation to their sexuality and reproductive ability, for example use of words such as 'slut', 'selfish', 'fat', and 'unmotherly'. These insults make reference to the gendered stereotype of women as maternal, selfless, and endlessly sexually available and appealing to their male partners, and are used here as a way to incite worthlessness and inadequacy in these women, and thus to attempt to manipulate and control their sexual and reproductive outcomes.

For some participants, they made a more general reference of their partner making them 'feel bad' about using contraceptives, and for others they were implicated and therefore manipulated into becoming culpable for reproductive coercion and other male assaults made against them. Examples of participants' experiences of being blamed as victims include a rape survivor who was told by her partner that no one else would want her as she is 'damaged goods', and another participant whose partner poked holes in some condoms and mixed them up with undamaged condoms, before saying 'good luck' thereby putting the onus on her regarding whether or not a damaged condom would be used during sexual intercourse. These final examples relate to the perverse situation apparent in many participants' accounts of having almost sole responsibility for birth control and, subsequently, holding the blame for any unintended or adverse reproductive or sexual health outcomes (including by some professionals), yet at the same time having their autonomy over sexual and reproductive decision making impeded or taken away from them.

Experiences of reproductive coercion during sexual intercourse

Participants in this research also shared experiences of reproductive coercion during sexual intercourse that broadly fall into non-consensual removal of condoms during sex, sexual violence, and physical violence. These overt exploitations of power by the perpetrators during sexual intercourse are in direct violation of the sexual and reproductive autonomy of the participants. As with the analysis of the above accounts, reproductive coercion during sexual intercourse can be analysed as enactments of male power in order to circumscribe women's sexual and reproductive decision making, and their general labour.

One notable theme that came out of participants' accounts of their partners' behaviour was non-consensual removal of condoms during sex, either overtly or covertly. Others also described their partner tampering with condoms, and for some their partners damaging of condoms was only discovered later, for example after they became pregnant. These instances are examples of sexual violation because of the lack of explicit, voluntary and informed consent involved in both the non-consensual removal of condoms during sex, and the intentional interfering with condoms that are then used during sexual intercourse. Multiple participants in this research described the above forms of sexual violation with intention to cause pregnancy, and several also described violent rape by their partners, often following their partners discarding or destroying their birth control. These examples represent a serious violation of participants' sexual and reproductive autonomy, and reveal a significant abuse of power on the part of the perpetrators. These examples can also be analysed in relation to cathexis, with the male perpetrators apparent appropriation of the female participants' sexuality and reproductive potential for their own objectives.

Physical violence (or the threat of) can also be understood through a similar analysis of male enactment of power or authority over women's bodies. Physical violence in the context of reproductive coercion involved punitive and sometimes life threatening outcomes for female participants who were discovered by their partners to be using contraceptives (or sometimes even merely expressing their desire to use some form of contraception), or the violent removal of long-acting reversible contraceptives (LARCs), such as the intrauterine device (IUD). In these situations, these female participants were attempting to assert or act according to their reproductive decisions and intentions, thus their partners' behaviour in response to their attempted enactment of their reproductive autonomy reveals the extent of the reproductive control of participants' partners.

The use and threat of sexual and physical violence and the non-consensual removal of condoms during sex is both an enactment of male power, and an attempt to exacerbate power inequalities within the relationship by increasing the sexual, reproductive, physical, and emotional vulnerability of the female partner. In these examples from participants, sexual intercourse essentially becomes an experience where they are used as a means to their partners' sexual and reproductive intentions via a range of behaviours used by their partners intended to circumvent, undercut and directly contradict their thoughts, intentions and decisions about their sexual and reproductive experiences and future.

Experiences of reproductive coercion post-conception

For participants who experienced pregnancy, many also experienced their partners' attempts to control their outcomes of their pregnancy. Some participants experienced their partners' efforts to prevent their access to a pregnancy termination, to try and force them to get an abortion, or their partners attempting to bring about miscarriage. This research also explored participants' experiences of their partners' behaviour during labour and delivery, and, for participants who gave birth, their partners' behaviour post-birth.

For participants who experienced a pregnancy, they were invited to report and elaborate on experiences of their partner trying to control their pregnancy outcomes. Around a third of participants had experienced a partner preventing

them from accessing an abortion, 27% experienced a partner trying to coerce them into terminating a pregnancy, and over 30% experienced a partner deliberately trying to bring about a miscarriage. Furthermore, 75 participants described experiences of their partners' behaviour during labour and delivery, and 62.1% of 103 participants experienced their partners impeding their recovery from birth, miscarriage or abortion.

Actual and threatened physical violence were used by perpetrators across all instances of coercion in relation to abortion and miscarriage. For participants who wanted to terminate their pregnancy, threats of violence were used to instil fear in participants over accessing safe abortion procedures, such as the threat by one participant's partner that, if she wanted to access an abortion, he would beat her and the baby to death. For participants who experienced their partners pressuring them to get an abortion, violent threats were also used by several participants' partners, including in the majority of these cases where the participant had been forced into the pregnancy by that same partner. Actual physical violence was more common in instances of participants' partners' attempts to bring about miscarriage, particularly physical violence directed at participants' abdomen. Again, some participants described physical violence by their partners to bring about miscarriage in instances where their partner had forced the pregnancy in the first place.

For some participants, their partners' behaviour to influence the outcome of the pregnancy involved greater emotional and psychological abuse, such as drawing dead foetuses and using labels such as 'murderer'. Threats also sometimes took the form of threats of further isolation from family and other support networks, or accusations of infidelity to manipulate participants' decision to access an abortion as a confirmation that the baby was someone else's. Perpetrators also enacted their power over pregnancy outcomes by controlling participants' access to household finances and transport options. Some participants also recalled their partners' attempts to bring about miscarriage in the form of trying to force participants to ingest substances that would harm the foetus, such as the interviewee describing her ex-partner blowing a herbal smoke in her face because he had read that this concoction could induce miscarriage.

Participants' partners' controlling their pregnancy outcomes represents an abuse of perpetrators' power over their reproductive lives, and this is particularly apparent given that many of these instances of participants' partners controlling their access to abortion, or trying to force abortion or miscarriage were subsequent to them forcing or coercing the pregnancy. These examples reveal the extent of the predominantly male perpetrators' appropriation of the predominantly female participants' sexual and reproductive experiences for their own goals, or for their own expressions of power and control. For women's experiences during labour and delivery, again their partners' behaviour can be analysed across the domains of power and cathexis, that is, the attempt to exercise authority over, and usurp women's reproductive experiences. Perverted examples of participants' partners attempting to exercise authority and control over their experiences during labour and delivery include participants' accounts of their partners' jealousy over the attention they received during their labour and child-birth and their partners' attempts to redirect the attention onto themselves.

Participants' accounts of their partners impeding their recovery from birth represent in particular perpetrators' attempts to exercise power over the labour domain of gender relations (Connell, 1987; Moore et al, 2010). Common themes include forced sexual intercourse too soon after birth or caesarean section, and forcing participants to undertake domestic chores too soon after birth or caesarean section; in several cases this forced sex and household labour resulted in participants' stitches being ruptured in their vagina or abdomen. Some participants also experienced their partners trying to impede recovery through not allowing them to get sleep, through emotional stress by acting sulky and jealous of the attention being given to the new baby, and by their partners refusing to access midwife and medical support in situations of post-natal blood loss and other health concerns, such as mastitis. One interviewee also shared her experience of her partner preventing her from breastfeeding and kissing her infant.

Several participants described the ongoing impacts of their partners' attempts to impede their recovery, such as chronic pain during sex, numbness and scar tissue. These examples reveal an attempt by perpetrators to control the gendered relations of the household by enforcing their partners' domestic labour to the extent that that their experiences, including their experiences of pain, are overlooked and circumscribed by the male partners' forced expectations of domesticity. These examples are also clear instances of the male partner exercising power over and exploiting their female partners' sexual experiences and vulnerability due to their reproductive labour.

Intimate partner violence, reproductive coercion and sexual and reproductive health

This research also explored intentional exposure to STIs (and HIV) amongst participants, concurrent IPV, and controlled access to pregnancy support and healthcare by an intimate partner. Participants also shared adverse sexual and reproductive health outcomes in accounts not directly in response to targeted questions about STI exposure and controlled access to healthcare. These findings reveal a significant proportion of research participants had experienced adverse sexual health outcomes as a result of intentional behaviours by their partners, and a high level of concurrent IPV across all temporal phases of reproductive coercion.

Almost half of participants in this research had experienced a partner intentionally exposing them to sexually transmitted infections, namely, their partners had known about having an STI but had not disclosed this to their sexual partner and had proceeded to have unprotected sex with them. For multiple participants who elaborated on this experience, this intentional exposure to an STI by their partner resulted in them also contracting the infection. At other points throughout this research, participants also revealed adverse sexual and reproductive health (SRH) out-

comes that often coincided with controlled access to contraceptive and other SRH services, as well as rape, including in the period after childbirth. Participants' accounts of their partners' behaviours that were intended to bypass participants' rights to make decisions in the best interests of their health, wellbeing, and their general sexual and reproductive functioning (emotionally and physiologically) reveal the extent and long term impacts of these behaviours.

Participants' partners' attempts to limit their autonomy over their sexual and reproductive bodies and decisions also meant that for some, their options for seeking healthcare and support during pregnancy was controlled and limited. Of the 65 research participants who responded to the question about whether a partner had controlled or prevented their access of pregnancy healthcare and support, the majority had experienced their partner limiting or preventing their access to counselling and doctor's appointments, while over one third had had their prenatal/antenatal, specialist or scan appointments controlled, and over one in five had had their midwife appointments restricted or controlled. This controlled access to support for some participants continued after birth, with several recalling partners restricting their access to medical and midwife support in the case of post-natal haemorrhaging.

This research also explored patterns of intimate partner violence across the temporal phases of a pregnancy to grasp any patterns of perpetrators' use of any other abusive behaviours alongside reproductive coercion, for example to explore whether there was a worsening or easing of abuse after pregnancy compared with before or during. Concurrent IPV (physical, psychological, sexual, verbal, and spiritual abuse) remained high at each temporal phase of pregnancy, with those who experienced no abuse from their partner decreasing at each stage to less than 10% of participants experiencing no abuse after pregnancy, revealing an overall increase in concurrent IPV during and after pregnancy. Interestingly, during pregnancy, psychological, physical, and sexual abuse from participants' partners overall decreased, however these types of abuse increased again after pregnancy, with experiences of psychological abuse by participants' partners increasing to 85% after pregnancy. However, economic, verbal, and spiritual/religious abuse all increased during pregnancy, with economic abuse subsequently increasing again after pregnancy to over 60% of participants, potentially evidencing perpetrators' increased use of less obvious forms of control and enforced dependency. 'Other' also increased during and after abuse, with 'Other' mostly describing behaviour that could be identified as psychological abuse, such as isolation, gaslighting, and monitoring and controlling behaviour.

For those who elaborated on their experiences of their partners' behaviour at each temporal stage of their pregnancy, they noted an intensifying and worsening of the abusive behaviours by their partners that is not necessarily evidenced in the quantitative data. During pregnancy, and again after pregnancy, respondents noted a worsening of their partners' abuse, and that they were 'crueller', more critical, more controlling and possessive, and did more things to make them feel worthless. It seems by these accounts that the physical, emotional and psychological vulnerability that accompanies pregnancy, as well as the perpetrators efforts to control and manipulate their partners to bring about reproductive outcomes that they want, can be used in particular ways to establish and exacerbate the masculine power and control within the gendered dynamics of the relationship.

Research implications and limitations

Participants in this research indicated that there were opportunities for screening of both IPV and of reproductive coercion, and had suggestions for how this could be approached and how disclosures could be responded to by professionals. Key suggestions include:

- Education and information on reproductive coercion and intimate partner violence so people can understand their experiences and have the words to describe it
- Privacy during appointments with professionals, namely, having appointments without their partners and others present
- Approaching conversations with sensitivity and empathy, and asking questions genuinely rather than as a tick box exercise or with preconceptions about the person who walks in and their relationship
- Asking questions broadly about their partners' behaviours and how they feel about their relationship and pregnancy
- Providing information on the client/patients' options and rights (including immediately post birth), and following through with actions, solutions or referrals where necessary based on what the client/patient wants (e.g. discrete and long-acting and reversible methods of contraception, or referrals for an abortion)
- Meeting any disclosures of abuse and reproductive coercion with non-judgement, belief and support the client/patient to put their partner's behaviours into context, i.e. reassuring them that it is not their fault that t heir partner is abusing them

The above points are important given the large proportion of participants in this research who reported not being asked about IPV, and the even larger number who were not asked about or given information on reproductive coercion. A number of participants in this research also shared experiences of professionals responding to disclosures with unhelpful, unresponsive, and even harmful responses that in some cases reinforced feelings of shame or even blamed them for their unplanned pregnancy or STI when this had been forced or coerced by their partner. These experiences from participants also reveal a need for professionals to have a better understanding of reproductive coercion.

This research explored the ways that the sexual and reproductive bodies of people, and particularly women, can be used and abused by their intimate partners, and the severe and potentially long-term adverse outcomes for victims of reproductive coercion. This research also has several limitations that are important to note, as well as areas for further research. As identified at the start of this report, this research was intended as an exploratory study into reproductive coercion in Aotearoa New Zealand, and thus does not assess prevalence rates across the New Zealand population. Consequently, further research could be done to assess prevalence rates of reproductive coercion to determine the scale of the issue in New Zealand. There is also significant potential for future projects to sample specific parts of the population and explore their experiences of reproductive coercion; for example the LGBT*+ community, given the low response rate to this survey by this group. Research could also be undertaken to further explore violence during pregnancy, including as a risk factor for more frequent and severe intimate partner violence, and, following Moore et al (2010), to explore further the temporal phases of reproductive coercion in relation to IPV, namely whether RC comes before other forms of violence, concurrently, or after violence, or all of the above.

Conclusion

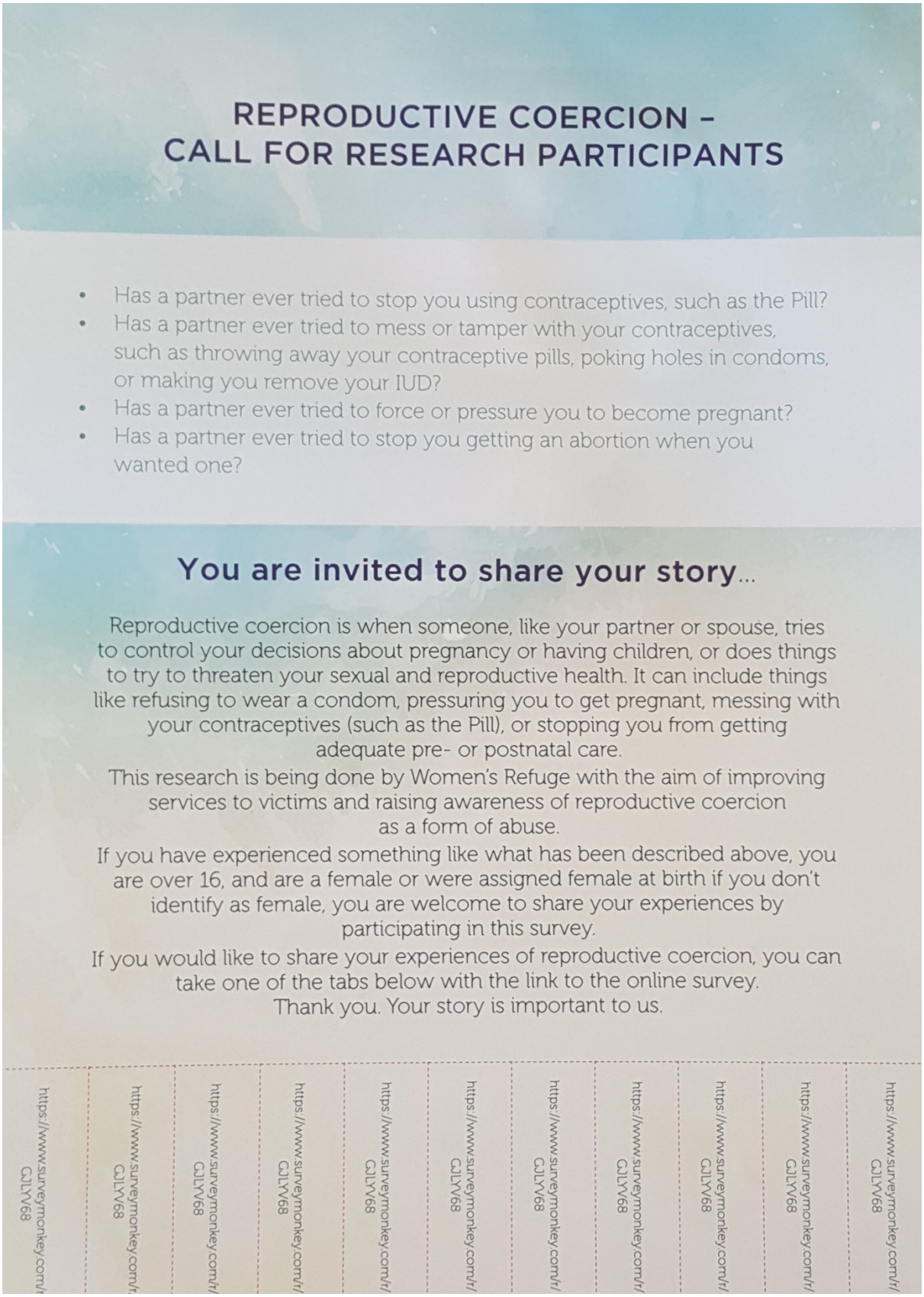
The findings discussed above of 161 survey participants and five interviewees reveal a significant number of this sample experienced reproductive coercion by an intimate partner, with partners controlling access to contraceptives affecting over 80% of participants, followed by experiences being coerced or pressured into pregnancy, with over 60% experiencing this, and partners tampering with contraceptive methods, with just under 60% experiencing this. These three types of behaviours were key features of reproductive coercion identified in the literature, alongside some research looking into abortion control and coercion by intimate partners which was also experienced by approximately one third of participants in this research. Furthermore, over 30% of participants in this research experienced a partner intentionally trying to bring about a miscarriage.

This research also explored more broadly participants' experiences of their partners' behaviour in relation to their sexual and reproductive health and rights, specifically their experiences of partners intentionally exposing them to STIs and/or HIV, controlling or preventing access to pregnancy care and support, and their experiences of their partners during labour, delivery and their post-partum recovery. This research also sought to understand the potential connection between pregnancy and intimate partner violence by exploring participants' partners' behaviours at three temporal phases of pregnancy. Finally, participants were invited to share their experiences of seeking help, support and advice, and their insights into what responses would be beneficial for people surviving reproductive coercion.

The intention was this research was to explore the issue of reproductive coercion in Aotearoa New Zealand with a targeted sample of individuals who identified that they had experienced some kind of reproductive coercion from a partner. The findings of this research reveal that this is an issue worth pursuing and understanding more about, including prevalence rates across the population, and suggests that there are particular gendered power dynamics integral to this phenomenon linked to issues of gender roles and stereotypes, and sexual mores that ultimately may influence reproductive autonomy.

Appendix I

Figure 7: Recruitment poster used in SRH clinics



References

Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens, M.R. (2011). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Blanc, A. K., Wolff, B., Gage, A. J., Ezeh, A. C., Neema, S., & Ssekamatte-Ssebuliba, J. (1996). *Negotiating reproductive health outcomes in Uganda.* Calverton, MD: Macro International Inc and Kampala, Uganda: Institute of Statistics and Applied Economics, Makerere University.

Bawah, A. A.; Akweongo, P.; Simmons, R.; Phillips, J. F. (1999).Women's fears and men's anxieties: The impact of family planning on gender relations in northern Ghana. *Studies in Family Planning,* 30(1), 54-66.

Biddlecom, A. E.; Fapohunda, B. M. (1998). Covert contraceptive use: Prevalence, motivations, and consequences. Studies in Family Planning, 29(4), 360-372.

Bustan, M. N., & Coker, A. L. (1994). Maternal attitude toward pregnancy and the risk of neonatal death. *American Journal of Public Health, 84*(3), 411-414.

Campbell, J.; Torres, S.; Ryan, J.; King, C.; Campbell, D. W.; Stalling, R. Y.; Fuchs, S. C. (1999). Physical and nonphysical partner abuse and other risk factors for low birth weight among full term and preterm babies: A multiethnic case-control study. *American Journal of Epidemiology, 150*(7), p. 714-726.

Castro, R.; Peek-Asa, C.; Ruiz, A. (2003).Violence against women in Mexico: A study of abuse before and during pregnancy. *American Journal of Public Health, 93*(7), 1110-1116.

Center for Impact Research. (2000). *Domestic violence & birth control sabotage: a report from the teen parent project.* Chicago: Center for Impact Research.

Clark, C. J., Silverman, J., Khalaf, I. A., Ra'ad, A. B., Al Sha'ar, Z. A., Al Ata, A. A., et al. (2008). Intimate partner violence and interference with women's efforts to avoid pregnancy in Jordan. *Studies in Family Planning, 39*(2), 123-132.

Clark, L. E.; Allen, R. H.; Goyal, V.; Raker, C.; Gottlieb, A. S. (2014). Reproductive coercion and co-occurring intimate partner violence in obstetrics and gynecology patients. *American Journal of Obstetrics and Gynecology, 210*(42), p. 1-8.

Coker, A. L. (2007). Does physical intimate partner violence affect sexual health? A Systematic Review. Trauma, Violence and Abuse, 8(2), p. 149-177.

Cokkinides, V. E.; Coker, A. L.; Sanders, M.; Addy, C.; Bethea, L. (1999). Physical violence during pregnancy: Maternal complications and birth outcomes. *Obstetrics & Gynecology, 93*(5), p. 661-666.

Coggins, M., & Bullock, L. F. (2003). The wavering line in the sand: the effects of domestic violence and sexual coercion. *Issues in Mental Health Nursing, 24*, 723-738.

Connell, R. W. (1987). Gender and power: Society, the person and sexual politics. Stanford: Stanford University Press.

Dannenberg, A. L.; Carter, A. M.; Lawson, H. W.; Ashton, D. M.; Dorfman, S. F.; Graham, E. H. (1995) Homicide and other injuries as causes of maternal death in New York City, 1987 through 1991. *American Journal of Obstetrics and Gynecology, 172*(5), p. 1557-1564.

Fanslow, J. (2017). Intimate partner violence and women's reproductive health. *Obstetrics, Gynecology and Reproductive Medicine, 27*(5), pp 148-157.

Fanslow, J.; Silva, M.; Whitehead, A.; Robinson, E. (2008). Pregnancy outcomes and intimate partner violence in New Zealand. *Australian and New Zealand Journal of Obstetrics and Gynaecology, 48*, pp. 391-397.

Fildes, J.; Reed, L.; Jones, N.; Martin, M.; Barrett, J. (1992). Trauma: The leading cause of maternal death. *The Journal of Trauma: Injury, Infection, and Critical Care, 32*(5), p. 643-645.

García-Moreno, C., Jansen, H. A. F. M., Ellsberg, M., Heise, L., & Watts, C. (2005). WHO multi-country study on women's health and domestic violence against women. Geneva: World Health Organization (WHO).

Gee, R. E.; Mitra, N.; Wan, F.; Chavkin, D. E.; Long, J. A. (2009). Power over parity: intimate partner violence and issues of fertility control. *Journal of Obstetrics and Gynecology, 201(148), p. 1–7.*

Hathaway, J. E., Willis, G., Zimmer, B., & Silverman, J. G. (2005). Impact of partner abuse on women's reproductive lives. *Journal of the American Medical Women's Association, 60*(1), 42-45.

Horon, I. L.; Cheng, D. (2001). Enhanced surveillance for pregnancy associated mortality in Maryland, 1993-1998. *The Journal of the American Medical Association, 285*(11), p. 1455-1459.

Janssen, P. A., Holt, V. L., Sugg, N. K., Emanuel, I., Critchlow, C. M., & Henderson, A. D. (2003). Intimate partner violence and adverse pregnancy outcomes: A population-based study. *American Journal of Obstetrics and Gynecology, 188*(5), 1341-1347.

Johnson, J. K., Haider, F., Ellis, K., Hay, D. M., & Lindow, S. W. (2003). The prevalence of domestic violence in pregnant women. *BJOG: An International Journal of Obstetrics and Gynaecology, 110*(3), 272-275.

Laukaran, V. H., & van den Berg, B. J. (1980). The relationship of maternal attitude to pregnancy outcomes and obstetric complications: A cohort study of unwanted pregnancy. *American Journal of Obstetrics and Gynecology,136*(3), 374-379.

Martin, S. L.; English, K. T.; Clark, K. A.; Cilenti, D.; Kupper, L. (1996). Violence and substance use among North Carolina pregnant women. *Journal of Emergency Medicine, 15*(1), 127-128.

Martin, S. L.; Matza, L. S.; Kupper,L. L.; Thomas, J. C.; Daly, M.; Cloutier, S. (1999). Domestic violence and sexually transmitted diseases: The experience of prenatal care patients. *Public Health Reports, 114*(3), 262-268.

McFarlane, J.; Campbell, J. C.; Sharps, P.; Watson, K. (2002). Abuse During Pregnancy and Femicide: Urgent Implications for Women's Health. *The American College of Obstetricians and Gynecologists, 100*(1), p. 27-36.

McFarlane, J.; Malecha, A.; Watson, K.; Gist, J.; Batten, E.; Hall, I.; Smith, S. (2005). Intimate partner sexual assault against women: frequency, health consequences, and treatment outcomes. *Obstetrics & Gynecology, 105*(1), p. 99–108.

McFarlane, J.; Parker, B.; Soeken, K. (1996a). Abuse during pregnancy: Associations with maternal health and infant weight. *Nursing Research, 45*(1), 37-42.

McFarlane, J.; Parker, B.; Soeken, K. (1996b). Physical abuse, smoking, and substance use during pregnancy: Prevalence, interrelationships, and effects on birth weight. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 25*(4), p. 313-320.

Miller, E., Decker, M. R., Reed, E., Raj, A., Hathaway, J. E., & Silverman, J. G. (2007). Male partner pregnancy-promoting behaviors and adolescent partner violence: findings from a qualitative study with adolescent females. *Ambulatory Pediatrics, 7*, 360-366.

Miller, E.; Decker, M. R.; McCauley. H. L.; Tancredi, D. J.; Levenson, R. R.; Waldman, J.; Schoenwald, P.; Silverman, J. G. (2010). Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception, 81*(4), p. 316-322.

Moore, A. M.; Frohwirth, L.; Miller, E. (2010). Male reproductive control of women who have experienced intimate partner violence in the United States. Social Science & Medicine, 70(11), p. 1737-1744.

Njovana, E., & Watts, C. (1996). Gender violence in Zimbabwe: a need for collaborative action. *Reproductive Health Matters, 4*(7), 46-55.

Pallitto, C. C.; Campbell, J. C.; O'Campo, P. (2005). Is Intimate Partner Violence Associated With Unintended Pregnancy? A Review of the Literature. *Trauma, Violence and Abuse, 6*(3), p. 217-235.

Pallitto, C. C.; O'Campo, P. (2005). Community level effects of gender inequality on intimate partner violence and unintended pregnancy in Colombia: Testing the feminist perspective. *Social Science and Medicine, 60*, 2205-2216.

Park, J.; Nordstrom, S. K.; Weber, K. M.; Irwin, T. (2016). Reproductive coercion: unlocking an imbalance of social power. *American Journal of Obstetrics and Gynaecology, January, 2016*.

Parsons, L. H.; Harper, M. A. (1999). Violent maternal deaths in North Carolina. *Obstetrics & Gynecology, 94*(6), p. 990-993.

Plichta, S. B.; Abraham, C. (1996).Violence and gynaecological health in women< 50 years old. *American Journal of Obstetrics and Gynecology, 174*, 903-907.

Reed, S. J.; Miller, R. L.; Valenti, M. T.; Timm, T. M. (2011). Good gay females and babies' daddies: black lesbian community norms and the acceptability of pregnancy. *Cult Health Sex, 13*, pp. 751-65.

Ribe, J. K., Teggatz, J. R., & Harvey, C. M. (1993). Blows to the maternal abdomen causing fetal demise: Report of three cases and a review of the literature. *Journal of Forensic Science, 38*(5), 1092-1096.

Rogers, F. B., Rozycki, G. S., Osler, T. M., Shackford, S. R., Jalbert, J., Kirton, O., et al. (1999). A multi-institutional study of factors associated with fetal death in injured pregnant patients. *Archives of Surgery, 134*(11), 1274-1277.

Sales, J. M.; Salazar, L. F.: Wingood, G. M.; DiClemente, R. J.; Rose, E.; Crosby, R. A. (2008). The mediating role of partner communication skills on HIV/STD-associated risk behaviors in young African American females with a history of sexual violence. *Archives of Pediatrics & Adolescent Medicine, 162*(5), p. 432–438.

Santelli, J. S.; Lindberg, L. D.; Orr, M. G.; Finer, L.B.; Speizer, I.(2009). Toward a Multidimensional Measure of Pregnancy Intentions: Evidence from the United States. *Studies in Family Planning, 40*(2), p. 87-100.

Silverman J.; McCauley, H. L,; Decker, M. R.; Miller E.; Reed E.; Raj, A. (2011). Coercive forms of sexual risk and associated violence perpetrated by male partners of female adolescents. *Perspectives on Sexual and Reproductive Health, 43*(1), p. 60–65.

Stephenson, R.; Koenig, M. A.; Acharya, R; Roy, T. K. (2008). Domestic violence, contraceptive use, and unwanted pregnancy in rural India. *Studies in Family Planning, 39*(3), p. 177–86.

Teitelman, A. M.; Ratcliffe, S. J.; Morales-Aleman, M. M.; Sullivan, C. M. (2008). Sexual relationship power, intimate partner violence, and condom use among minority urban girls. *Journal of Interpersonal Violence, 23*(12):1694–712.

Valladares, E., Ellsberg, M., Pena, R., Hogberg, U., & Persson, L. A. (2002). Physical partner abuse during pregnancy: Arisk factor for low birth weight in Nicaragua. *Obstetrics and Gynecology, 100*(4), 700-705.

Watts, C., & Mayhew, S. (2004). Reproductive health services and intimate partner violence: shaping a pragmatic response in Sub-Saharan Africa. *International Family Planning Perspectives, 30*(4), 207-213.

Williams, C. M.; Larsen, U.; McCloskey, L. A. (2008). Intimate partner violence and women's contraceptive use. *Violence Against Women, 14*(12), p. 1382–96.

Wingood, G. M., & DiClemente, R. J. (1997). The effects of an abusive primary partner on the condom use and sexual negotiation practices of African-American women. *American Journal of Public Health, 87*(6), 1016-1018.