Reproductive Coercion and Abuse: Key Issues for Safeguarding in Abortion, Contraception and Maternity Care Settings

Dr Pam Lowe
Dept of Sociology and Policy
Aston University

September 2023

Contents

Acknowledgements

This project was funded by a British Academy Innovation Fellowship (IF\220042), I would like to thank them for their support. Special thanks go to the Centre for Reproductive Research and Communication at BPAS for hosting me during the fellowship. This project would not have been possible without their encouragement and assistance. This project would not have been possible without the involvement of the health professionals and staff working in specialist services who agreed to be interviewed or attended the stakeholder workshops, and I would also like to thank them for their involvement.

Contact Details

Dept. of Sociology and Policy, Aston University, Birmingham, B4 7ET
Email: p.k.lowe@aston.ac.uk

Reproductive Coercion and Abuse:

Key Issues for Safeguarding in

Abortion, Contraception and Maternity Care Settings

Executive summary

Reproductive coercion and abuse (RCA) occurs when power and control is exercised over the autonomous pregnancy decision-making of another. Interpersonal RCA occurs between individuals, when someone seeks to reduce another's individual autonomy over reproductive decision-making through coercive or controlling behaviour, deception, manipulation, threats, violence, or other forms of abuse. This includes regulating everyday behaviour in relation to the prevention or promotion of pregnancy, and/or access to reproductive healthcare services.

RCA can also be institutionalised through laws, regulation, policy or practices when control is exerted on a non-clinical basis. Institutional RCA involves targeting groups or individuals to accept specific reproductive healthcare interventions, withholding them, or making access to other services dependant on their use.

This research aimed to investigate policy and practice in abortion, contraception, and maternity care across the UK, undertaking qualitative research with healthcare professionals and experts in interpersonal violence, and it focuses on the safeguarding needs of those at risk of pregnancy.

Understanding and responses to RCA are based on normative understandings of women, men and heterosexuality, in which pregnancy is generally seen as a natural life stage, and abortion is stigmatised.

Pregnancy promoting reproductive coercion (e.g. pressure to become or stay pregnant) is more common than pregnancy preventing abuse (e.g. abortion coercion). Yet the regulation and policy framework has developed with more attention on risks for those seeking abortion with little attention to the issues for maternity care.

Awareness of RCA is generally low amongst women, and this is especially the case where people may not have a sense that they have a right to make their own pregnancy decisions. This can be an issue in some minority communities, but also where there are other issues such as modern slavery or living at risk of gangs and groups.

Most healthcare professionals have some general awareness of RCA, but many have not received any specific training around the issue. Routine screening for issues such as domestic abuse and child sexual exploitation often does not include specific questions about reproductive coercion. Maternity care staff were more likely to feel uncomfortable about screening for reproductive coercion than staff in the other services.

Even when abuse was disclosed in maternity settings, it was unlikely that questions would be asked to ascertain if it was a forced pregnancy, and screening often took place in the second trimester when referral to abortion care would be more difficult or impossible due to gestational time limits.

The routine welcoming of partners to maternity appointments seems to have significantly reduced meaningful opportunities to screen for reproductive coercion and abuse. It is important that time

and space is created in maternity care for women to be regularly seen on their own if safeguarding is to be improved.

Policy and routine practice in abortion care means that there are routine opportunities for women to disclose a risk of coerced abortion. Telemedicine has enhanced the flexibility of services for women living with abuse through decreasing travel and increasing the control women have over appointments. If concerns arise, staff ask women to attend in person to enhance safeguarding.

The flexibility to be able to switch between telemedical and in person appointments is important and needs to be properly funded. In addition, ensuring that women can choose between medical or surgical abortion, without having a delay or needing to travel, would enhance women's ability to choose the safest option for their circumstances.

It is important not to make assumptions or judgements about contraceptive use or non-use, even if this results in more than one abortion. Some women coerced into not using contraception may be helped by less visible methods, such as injections or implants. As menstruation may be monitored by perpetrators of abuse, they may not be suitable for all.

The general pressure on healthcare staff in services that lack resources and are pressured for time, in addition to overstretched specialist services that healthcare professionals usually refer women onto for support, make the environment for safeguarding much more difficult.

Recommendations

1. The issue of RCA should be included in safeguarding training for all those working in reproductive healthcare settings, and awareness raised more generally across the healthcare sector.
2. Pathways of referral to specialist services are established in each local area for those at risk of RCA, ensuring wherever possible that they are suitable for additional vulnerabilities (e.g. young person's service).
3. Screening for RCA is incorporated into existing screening protocols, depending on the appropriateness of this in particular settings, and/or staff encouraged to use their professional curiosity where there may be issues of concern.
4. Maternity services are organised to ensure that women are routinely screened for RCA sufficiently early in pregnancy to allow referral to abortion services if required. They also need to ensure that women are seen alone during antenatal care on a regular basis. Sending a partner to sit outside the consultation room for a few minutes is unlikely to provide a meaningful opportunity for safeguarding.
5. Abortion care needs to be funded so it can be flexible both in terms of offering telemedical and in person appointments, and offering a choice between medical or surgical abortion without delays or a need to travel. This would maximise the opportunities for women at risk of RCA to choose the safest option for them.
6. Policies and practices that make stigmatised assumptions about issues such as the non-use of contraception, number of abortions, or 'late booking' into maternity services need to be challenged. In particular, policies that target specific groups of women for long-acting reversable contraception (LARC) need to be avoided as this is a form of institutional reproductive coercion.
7. More research is needed to ascertain the prevalence of RCA, especially in minority groups. It would also be useful to investigate which safeguarding interventions increase disclosure in different settings.

Understanding Reproductive Coercion and Abuse in Abortion, Contraception and Maternity Care Settings

Background

Reproductive coercion and abuse (RCA) has been recognised as attempts or actual control of pregnancy through interference, abuse, threats and assaults. Although governments, institutions, and policies can exert considerable RCA (for example, through forced sterilization of marginalised groups), the focus here is RCA as a specific form of interpersonal violence (IPV). RCA involves a collection of behaviours that reduce or prevent autonomous decision-making in reproductive health, including sabotaging or denying access to birth control, pressure or coercion to become pregnant, continue a pregnancy, or to have a termination. It goes beyond disagreement between parties, and is associated with the exercise of power and control over another, and is often a feature of other forms of IPV such as domestic abuse or child sexual exploitation (CSE).

Reproductive coercion and abuse involves a collection of behaviours that reduce or prevent autonomous decision-making in reproductive health.

This can be interpersonal through the exercise of power and control. Institutionalised RCA can also occur through law, policy and practice by governments or organisations.

This report arises from a qualitative research project that aimed to increase safeguarding policy and practice for RCA in abortion, contraception, and maternity care. It comprised a narrative review of academic and grey literature from countries with comparable healthcare systems, and qualitative interviews and workshops with 25 healthcare professionals (HCP) and 13 experts in specialist services working with survivors of abuse (SSE). Participants in the research were asked to reflect on their experiences in other reproductive healthcare settings and organisations as well as their current position, enabling a broader view to be incorporated in the research (more details about the methods are in Appendix 1).

The study showed normative cultural understandings play an important role in shaping both individual experiences and institutional practices for safeguarding around RCA. In particular, essentialist biological understandings of women, men, and heterosexuality, in which pregnancy and parenthood is seen as natural and normative for most women but undesirable in others, shapes understanding and practices around the issues. Although actions such as deception can be used to force fatherhood, the outcome is different due to the embodied impact of pregnancy, abortion, and most methods of contraception. Moreover, the cultural expectations of parenting remain highly gendered, with women still expected to provide the majority of care, and women are judged more harshly should they not perform 'good motherhood'.[1] Consequently, the focus here is on women at risk from RCA, and the role of reproductive and sexual health services in being able to provide support.

It is recognised that trans and non-binary people can become pregnant, and many face institutional RCA. For example, there are regional variations in NHS funding for fertility preservation procedures such as egg and sperm collection and storage for people undergoing medical transition. Very little is known about interpersonal RCA experienced by trans and non-binary people and, as this project was unable to fill this gap, this report does not cover them. This is an area that future research will need to examine, including considering safeguarding policy and practice in fertility services.

This research was carried across the UK. It is important to remember that there are national, regional, and clinical differences in the organisation and delivery of healthcare services. In some areas, women can self-refer to maternity services and abortion services, whereas in others, a referral may need to be through their GP. Women may have maternity care provided in the community or they may need to travel to attend hospital settings. The number and timing of routine appointments can also vary from place to place. Contraceptive services are also provided in different places including integrated sexual health services, specialist services for vulnerable populations, GP practices, maternity, and abortion services. In Scotland, reproductive and abortion services are provided by the NHS directly, whereas in England, services are frequently contracted out rather than run directly by the NHS. Where reproductive services are contracted out, integrated care boards (ICB) can include conditions and targets that shape the delivery of the service in different areas. Variations in settings and services have implications for safeguarding practices. For example, different maternity services will undertake routine screening for domestic abuse at different gestational points. Consequently, whilst not all of the issues mentioned in this report apply to all settings, they are nevertheless still important considerations in the commissioning, organisation and delivery of reproductive healthcare.

Normative cultural understandings about pregnancy, women and motherhood shape policy and practice in reproductive healthcare settings and this has implications for safeguarding around RCA.

Most of the report sets out generic issues for HCP and organisations to consider, including defining RCA, awareness amongst women and HCP, and screening and disclosure. It will also address two specific areas: the lack of safeguarding for RCA in maternity care and the introduction of telemedical abortion services.

Of the three reproductive healthcare areas investigated within this project, maternity care was the least likely to have adequate safeguarding in place for RCA. As will be shown later, this largely stems from assumptions about the desirability of pregnancy to women and the move to increase the involvement of birth partners in antenatal care. In contrast, whilst the second area, telemedical abortion care has often been the subject of specific policy and political concern, both telemedical and face-to-face abortion services had better policy and practice in place for safeguarding for RCA. Finally, the report will set out some additional issues that could be considered to improve safeguarding and safety planning with women.

Defining reproductive coercion and abuse

Currently there is no standard definition of RCA, either nationally or internationally. In the UK, the Home Office defines domestic abuse as 'incidents of controlling, coercive or threatening behaviour, violence or abuse.[2] Within this, coercive behaviour is defined as acts intended to humiliate, intimidate, harm, punish or frighten a victim and controlling behaviour is considered to be acts that make a person subordinate, dependent, and which regulates everyday behaviour. Although at this point in time there is no specific legal definition of RCA in either guidance or case law, it is likely that domestic abuse offences could be used to prosecute perpetrators for many forms of RCA. In addition, some forms of RCA may also be sexual offences. Some deceptions about contraception, for example removing a condom without consent during intercourse (known as stealthing), are recognised as sexual violence.[3]

In the academic literature, definitions of RCA vary, and the lack of an agreed definition can mean that comparisons across different research studies, especially about the prevalence of abuse, are difficult. In Australia, Tarzia and Hegarty argue that an important part of the definition of RCA should be that that there is an *intention* to prevent, promote or control pregnancy *in the victim*.[4] A focus on intention means that RCA can be clearly distinguished from other forms of IPV, which may be useful when safety planning. For example, a perpetrator of repeated rape within a relationship may be indifferent to contraception use, whereas if pregnancy is an intention, they will exert control over this. However, as research with perpetrators has shown that denying intent is a strategy used by perpetrators of domestic abuse to minimise their responsibility,[5] a focus on intent within a definition may be problematic for raising awareness more generally. Moreover, victims and survivors of RCA may not necessarily always know the perpetrators motivations, only their actions.

Although there is still some variation in definition, in terms of safeguarding policy and practice what is of central importance is for HCP to focus on service users' experiences and any support needed following behaviour by perpetrators. Hence the definition developed and used in this study focuses on how the behaviours are experienced:

> Reproductive coercion and abuse are an actual or attempted pattern of behaviours that are experienced as aiming to reduce individual autonomy over reproductive decision-making through coercive or controlling behaviour, deception, manipulation, threats, violence, or other forms of abuse. This includes regulating everyday behaviour in relation to the prevention or promotion of pregnancy, and access to reproductive healthcare services.

RCA often occurs within a broader pattern of abuse where men seek to exercise power and control over the life of a partner. Research has shown that by enforcing pregnancy, men are able to cement ties to the women they are abusing.[6] Within the evidence on domestic abuse more generally, it is clear that the family courts in the UK have a strong emphasis on maintaining contact with fathers, and domestic abuse does little to change this. Perpetrators of violence use contact with children as a way to continue to exert control over women after relationships have ended.[7,8]

Enforced pregnancy is a way to increase power and control making more it difficult to leave an abusive relationship.

In these circumstances, having an abortion can be an important safety strategy.

Moreover, having a child can increase the financial dependency of women on men. While financial abuse can occur in any relationship, it is heightened for some, for example migrant women who may not have access to alternative forms of welfare support under the terms of their visa.[9]

Perpetrators of RCA can also include other family members, where power, control or force is used over reproductive decision-making.[10] Although RCA commonly occurs in the context of other forms of IPV, it can occur on its own and this may be particularly the case where there are familial expectations around reproduction. Whilst some pressures, such as having a son, are associated with particular cultural norms,[11] it is important to recognise that all communities have norms about family life and that pro-natalism is common in many societies, although the pressure will vary.[12]

Types of reproductive coercion and abuse

There are a variety of actions that constitute RCA and it can be helpful to divide them into pregnancy-promoting and pregnancy-preventing RCA. There is some evidence that pregnancy-promoting RCA is more common than pregnancy-preventing RCA.[13] Existing evidence shows that domestic abuse often commences or escalates during pregnancy, which underpins policies to routinely screen for abuse during pregnancy.[14] However, whilst there are a variety of screening tools and practices in use for screening for domestic abuse and other forms of IPV such as CSE, to date there is very little focus on pregnancy as an *outcome* of abuse. This is an oversight that needs addressing.

Pregnancy-promoting RCA from partners include behaviours such as stealthing, contraceptive pills being thrown away, intrauterine device (IUD) being removed, and lying about male infertility. Tactics to enforce continuing a pregnancy can also include the prevention or monitoring of HCP appointments to block any discussion of abusive behaviours or abortion. Perpetrators can also publicly announce a pregnancy to family and friends, so a termination would expose a woman to potentially difficult conversations or abortion stigma.

RCA can include gaslighting, interference with appointments with healthcare services, and restricting travel to appointments as well as more direct control over use/non-use of contraception and threats and violence over pregnancy decision-making.

Pregnancy-preventing RCA can include excessive monitoring of pill usage and pressure to accept a contraceptive implant or undergo sterilization. Coercion, threats and violence can take place to force women to have an abortion. Some perpetrators will enact physical assaults to try to induce a miscarriage including administration of abortion medication without consent.

In both cases, RCA can involve excessive pressure, gaslighting, monitoring of behaviour, including appointments with HCP, and financial control, such as withholding money for travel. It is important to recognise that some perpetrators will use RCA to promote pregnancy, but once it has been confirmed, switch to coercing a termination.[15] More examples that participants in this research encountered will be given during the course of this report.

Awareness of RCA amongst victims and survivors

In many cases, women may not always initially identify the pattern of behaviour that they are experiencing as RCA.[6] Many are reluctant to see themselves as a victim. Where there are other forms of abuse, the particular controls over reproduction may not be their focus of concern, particularly in situations where physical abuse is used.[16] Heteronormative patterns of masculinity and femininity, which position men as 'naturally' dominant and in control mean that the move from non-abusive to abusive relationships can be gradual.[17] Emotional manipulation about giving or withholding love if the perpetrator's reproductive wishes are not followed is a common tactic to exert control, and build on the gendered responsibility that women have for ensuring successful heterosexual relationships.[18,19]

In families and communities where there are strong social norms around childbearing, such as the timing of birth after marriage or pressure to have a son, coercive practices may be experienced as a cultural norm rather than abuse, even when it involves fairly extreme actions.[20] Young people may also not see themselves as being exploited even if they are uncomfortable with the relationship that they are in.[21,22]

> *Some of the women that are not particularly in the groups that we would consider vulnerable, who have good jobs (…) their partners have said "oh you are getting older now, you need to start thinking about having a baby" (…) I think we miss those women (…) we do begin to see it on the wards when they are delivered, that sort of detachment. "And I never wanted a baby anyway."*
>
> *(Midwife)*

> *The girls who were at risk from gangs (…) the power and control dynamic was so strong that choosing their reproductive health and their rights just wasn't even a conscious decision.*
>
> *Once someone got pregnant (…) having a child was then the only option.*
>
> *(Safeguarding Lead)*

Many of these issues were recognised by the research participants who reported that some groups of women may be more vulnerable or less able to disclose RCA. This was particularly the case in some families, communities and groups where reproductive decision-making was not seen as belonging to women.

For example, young women who are at risk of gangs and groups are often subject to high levels of control, and they may not recognise they have a right to make their own decisions

For example, young women who are at risk of gangs and groups are often subject to high levels of control and may not recognise they have a right to make their own decisions. Extreme pressure or control can also exist in families who are not otherwise marginalised, including where RCA is the only form of abuse. An example of this is coercion or control by partners or families on some middle-class women to conceive during their thirties as they approach an age where fertility usually starts to decline.

Participants pointed out, as briefly mentioned earlier, how dependence on abusers can also be heightened where women have migrated, and they may be dependent on perpetrators financially and/or administratively in terms of visas. These women may also experience language barriers, including before they are able to access services. In some communities even general discussion of sex or reproductive health is taboo, and this can make it really difficult for women to recognise abusive situations. Women who have been trafficked are likely to face considerable barriers.

In addition to the issues faced by other vulnerable women, those who do not have the right to remain in the country are likely to be fearful that any disclosure could lead to being deported or detained. This situation is used by perpetrators, and if victims have often been isolated and/or manipulated for a long time, this may increase the level of fear of encounters with HCP and reduce the likelihood of disclosure.

Modern slavery victims can have been lied to for a long time and have a deep emotional connection to their exploiter. It can be difficult to overcome this in a short appointment.

Fear of detention or deportation can also reduce the trust in healthcare professionals.

(Expert in Modern Slavery)

Awareness of RCA amongst healthcare professionals

Whilst most of the participants in the research had not heard of the term RCA in relation to IPV, they had previously encountered situations where RCA was, or may have been, a factor. There were a number of key issues that were identified in terms of raising awareness, including recognising RCA where there is other abuse, lack of training, and organisation factors (which will be dealt with later).

It's often hidden, because I think it's not necessarily... while we talk about pregnancy as being a time that abusers choose to escalate. I don't think there is a lot of knowledge or understanding about the ways.

(Domestic abuse expert)

Many participants felt that other forms of abuse could overshadow RCA, and that this was a barrier to its identification. This was mentioned by both HCP and SSE. Most participants felt that RCA was a bigger issue than is currently recognised in the UK, and this was particularly the case where there is an ongoing pregnancy.

Whilst they reported that in their workplaces there had been a growing understanding of the impact of coercive control, and it was widely acknowledged that pregnancy was a key time that safeguarding may be needed, awareness of RCA specifically was reported as low. This is in line with evidence from other countries. For example, an Australian study found that although HCP heard accounts of RCA whilst safeguarding for IPV, it did not always receive the attention that it should.[23]

Similar to other research,[24,25] the HCP interviews identified a lack of specific training as a factor for the lack of awareness of RCA. None of the participants mentioned that that this had been covered in safeguarding training, even where there had been a focus on IPV. In particular, participants felt it was important to use the term RCA to help raise awareness of this type of abuse. They suggested that increased staff awareness would improve policy and practice around safeguarding.

> *The biggest thing is more from a clinical perspective or from a staff perspective is that it's a real blind spot and it's not included in a lot of… or it is included in training, but it's not (….), it's not named as its own thing to train people on.*
>
> *(Midwife)*

Where healthcare staff had experience of working in more than one setting, they reported that their policy and practice around safeguarding was enhanced when training was focused on the area in which they worked.

Consequently, whilst all healthcare staff mentioned a need for training around RCA specifically, they felt that this would gain more understanding if the training was rooted in the specific department or services that they were involved in providing, rather than having generic training across multiple departments or settings.

Some participants felt that it was important to have a clear definition of RCA, and this would increase safeguarding. For others, understanding different scenarios was more important than the definition. The key issue was not whether or not the account given fitted into a definition, but what support was needed going forward.

> *Whether or not a pregnancy has arisen from coercion, stealthing, or rape, the issue for us is the same. How can we support the woman in her reproductive decision? Does she want or need us to put her in touch with a support service? We shouldn't be focused on which box they might be in.*
>
> *(Doctor, Community Gynaecology)*

In a US study, training on RCA in a family planning service was reported to have raised awareness of how RCA was a barrier which prevented women accessing and using contraception.[25] Increasing awareness is important but may not lead to increased safeguarding. For example, another US study found that although the majority of staff surveyed in some domestic violence support organisations stated that they were comfortable discussing most aspects of RCA with service users, only a minority of them reported that they actually asked about RCA in practice.[26] Even when knowledgeable about RCA, only 26% discussed it when safety planning with women, and around a third of staff were uncomfortable discussing abortion as an option.[26] However, it was not clear in the research whether this was due to personal beliefs, particular organisational settings, or the wider cultural context of abortion stigma in the US.

Screening and encouraging disclosure

As research elsewhere has revealed, whilst many healthcare settings routinely screen for IPV, HCP reported that general screening did not necessarily reveal RCA.[27] Routine screening for RCA has been implemented in some healthcare settings in other countries, and there have been a small number of trials of interventions. Some validated screening tools that focus specifically on RCA or have an RCA component that have been developed for use in research and clinical practice. However, none of the validated screening tools reported in the literature currently cover the full range of RCA as most had been developed for particular settings, such as family planning clinics[28] or contraceptive and abortion services.[29] No studies could be found of RCA-specific screening in maternity services or when ascertaining if young people are at risk of CSE. This latter aspect is surprising as control and abuse has long been recognised as a factor in the lives of young mothers[30] and there is often a significant age difference between them and the fathers of their children.[31]

In the US, a clinical trial of routine screening and information provision in a family planning clinic consisted of discussion, a small take-away card for clinic users, and targeted advice for those disclosing RCA, for example, discussion of 'hidden' methods of contraception.[28] In the pilot study, there was a reduction in pregnancy coercion at follow up, and part of this reduction was due to women ending relationships. In a larger randomised controlled trial, the same intervention was found to reduce IPV in the group who reported multiple forms of RCA, but it did not have this impact on the wider sample.[32] It increased awareness of RCA but did not have a significant effect on the level of unintended pregnancy between the intervention and control arms. This latter element may have been affected by general increased access to long acting reversal contraception (LARC) during the period of study, which may have impacted on the study outcomes.[32] Similar studies have been carried out which have varied the way that screening is undertaken, and/or HCP messages are targeted with broadly similar outcomes.[33,34]

In this research, routine screening for IPV was reported as common in many reproductive healthcare settings. Participants mentioned that the type of service and perceived vulnerability of women shape the likelihood of disclosure of RCA. In abortion and contraception services, women may only have one appointment with a particular service, whereas in maternity care, normally there are a series of appointments. Many of the HCP mentioned that they used particular tools with young people that are designed to screen for child sexual exploitation. None of the tools currently used asked directly about RCA, although this does not prevent staff asking additional questions.

Whilst most of the participants mentioned that their healthcare service routinely screened all patients for abuse, or some groups of patients (like young people), none reported routinely asking about RCA.

Even if a pregnant patient disclosed abuse, and was referred for safeguarding, they were not routinely asked if the pregnancy was an outcome of the abuse.

Many of the professionals interviewed mentioned that whilst routine screening tools could help facilitate disclosure, they were limited in what could be achieved. Indeed, it was widely recognised that women needed to be ready to disclose, and that disclosure needed to be recognised as a process rather than event. For those in abusive relationships, disclosure is a process which starts with a recognition of the abuse that they are suffering, develops though stages where they consider seeking help, and will be made when they are feel that the outcome of disclosure will be beneficial to their circumstances. They need to feel that they have some level of control over the outcome of any disclosure, and anxiety about this can reduce the chance. This means that, as is widely recognised, whilst routine screening is important, it will never uncover all cases of abuse.

Healthcare providers reported that it was important to pay attention to signs and feelings of both the woman and anyone accompanying her, regardless of the answers to standardised screening questions.[23,35] Being attuned to behaviours, pauses in answers, or other signs can be important signals to ask further safeguarding questions. Whilst body language can be important to consider during face-to-face appointments, HCP also report the ability to recognise changes to tone of voice and language during telemedicine consultations and they did not feel that they were less able to safeguard during these consultations.[36,37]

> *[they can be] asked repeatedly the same questions (…) because staff are very conscientious about asking those questions. So we can do as much as we want, but actually if that person doesn't feel safe in their own headspace, even if you are offering them that platform (…) people won't disclose if they are not ready.*
>
> *(Safeguarding Lead)*

An important element as to whether or not a disclosure was likely to be made was the extent to which women have the perpetrator 'in their head'. In coercive and controlling relationships, the ongoing abuse means that everyday behaviour is often undertaken in line with the perpetrator's direction, whether or not they are present. As Stark has documented, in a situation of coercive control, it can take years after leaving a perpetrator for the routines and ways of thinking to change.[17] It is also important to recognise that whilst having the perpetrator 'in their head' is an outcome of control, compliance can be an important safety strategy whilst living in an abusive relationship.

This means that whilst it is important to ask questions about potential abuse, whether or not a disclosure is made will depend on factors beyond the healthcare setting. If someone is not ready to disclose, then they will not do so, regardless of the questions they are asked. This can also be an issue for young people who have reported some anxiety about safeguarding questions. In a telemedical sexual health service where screening questions were asked online, young people were anxious that 'ticking a box' would lead to actions that they could not control.[22] Explaining what would happen after a disclosure was considered to be really important by young people in the study.[22]

Moreover, as many of the specialist service experts pointed out, whilst it is still important to ask, the chances that women would disclose to a healthcare professional on the first encounter are low, as they often needed to develop confidence and trust in a healthcare professional or service before disclosure takes place. This is consistent with other research on abuse survivors which found women

may not disclose when asked directly, even if they understand that support would be available to them.[38]

In maternity care, disclosure of domestic abuse has been found to be less common at booking-in and postnatally than it is during appointments at other times, which suggests that factors outside of the appointments are influencing disclosure.[39] Nevertheless, even in settings where repeat appointments are rare, it is important to routinely ask, as individuals participants might be at a point where they are willing to disclose. It also helps build awareness that support is available in healthcare settings should people need it.

It can take time for women to disentangle their own thoughts about a pregnancy from their abusers.

Good access to 2nd trimester abortion is important to ensure that pathways of care remain open to them.

Another important issue is that staff had concerns about being able to help some women differentiate between their own thoughts and feelings, and those of the perpetrator. It is not uncommon in abortion or maternity settings for women to mention whether their partner's attitude to a pregnancy, including whether or not it should proceed, was different to theirs.

In these situations, where it has been articulated that they are under pressure from a partner to have a termination or proceed with a pregnancy, it can be difficult for HCP to get women to separate their own thoughts and feelings from those of the perpetrators. It may take time for women to disentangle their own decision from the overarching abuse.

Most of our clients who are being coerced to an abortion, want the abortion nevertheless. They don't like the situation, but they would choose to have it because that is the still the best option for them.

(Doctor, Sexual Health Services

This is made more difficult if abortion is being considered due to the availability and legal limits on 2nd trimester abortion. Overall, it is important to remember that just because a perpetrator is exercising RCA with the aim of getting a particular outcome, this does not mean that victims should be denied that care. Women may, for example, still decide for themselves to have an abortion, even if this is also what the perpetrator wants them to do. There are better ways to ask about RCA, and these include asking direct questions in a way that the person feels that HCP are interested, will believe what is said and can be trusted to present options in a non-judgemental way.[23,40] However, there is no specific question or set of questions that will always ensure that disclosure of RCA will be forthcoming. Moreover, although it is imperative to try to ensure that women have time with HCP without the presence of partners, family, or others, private spaces and sensitive questions may not always be enough to ensure reproductive decisions are not coerced.

Safeguarding concerns

All the participants were supportive of safeguarding and the need to ask questions in reproductive and sexual health services. However, some were also concerned that if women are repeatedly asked about their experiences, this could be problematic as it was asking them to routinely relate details about potentially traumatic experiences. This was of a particular concern if disclosure would not necessarily lead to any positive improvement in women's lives. Some participants described circumstances in which they had raised safeguarding concerns, and information had been shared with relevant organisations in line with organisational polices, but women seemingly remained without support.

Staff working in healthcare organisations often make referrals to other services following a disclosure, such as social services, charities and local refuge services. Healthcare participants recognised that many support services were underfunded and overstretched, and were not able to provide the level of support that they would have wanted to. Other research with midwives has also found concerns about encouraging disclosure of abuse without having appropriate resources available leading to an inadequate response.[35] Some participants felt despondent, and worried that they could be making things worse rather than the process being helpful. In addition, staff were well aware that women were often frightened of social service involvement as this carries a threat of child removal. This was felt to be a major barrier to women disclosing, and there was little that HCP could do to change this.

> *What I felt about that was that I think that we have got the children first guidelines, the guidance on protection of children, whereas I think that not enough is done to actually incorporate the women.*
>
> *(Nurse Practitioner)*

This is illustrative of another broad concern about the relationship between child and adult safeguarding in abortion and maternity care. Some of the HCP mentioned that, although women are the patient, they were not often positioned as a priority.

Instead, safeguarding policies and practice prioritise foetal/child protection and operate in a way that was not always helpful for women. For example, staff in some abortion services mentioned that when women were considering to be proceeding with the pregnancy, the level of support they could refer them to was higher than if they decided to have a termination. Having 'children first guidelines', as one participant described them, often seemed to undermine the principle that pregnancy does not invalidate the right of women to make decisions about their health, even if they are unwise.

For abortion care providers, another area of concern is that in some areas, services are required to notify appropriate agencies about all ongoing pregnancies. Antenatal care is important in ensuring the best outcomes for pregnancy, but it is not mandatory; women are not obliged to seek care (assuming they have the capacity to make this decision). Whilst this policy might have good intentions, it treats women who had considered abortion differently from other women. Culturally, women who seek abortions are often seen as 'irresponsible', and this is linked to abortion stigma. The notification of ongoing pregnancies could be seen as drawing on this negative stereotype, and reducing autonomous decision-making about engagement with antenatal care. It also potentially puts women at risk as they are unable to ensure that communications with maternity services take

place when it is safer for them. It is an example of how the prioritisation of foetal welfare could increase the risks to women.

Safeguarding for RCA in maternity settings

Participants reported that polices were in place to routinely screen for domestic abuse in maternity settings, but it was notable that there was very little attention or awareness of the need to safeguard for RCA. Moreover, even when staff were aware that RCA might be an issue, the organisation of maternity services generally did not facilitate appropriate times and spaces to enable disclosure to take place. There were two key reasons for this: first, general assumptions that pregnancy is a normal path for women and second, the routine inclusion of birth partners into maternity appointments which prevents disclosure from taking place.

Assumptions about motherhood being natural for women, combined with the routine inclusion of birth partners in antenatal care means that maternity services have little or no safeguarding for RCA.

Many of the participants pointed out that, although there could be a range of emotional reactions to pregnancy, it was assumed to be the normal life-course event for women.

Whilst some HCP reported being trained to not specifically say 'congratulations' in recognition that some women might be feeling ambivalent or worried rather than happy, assumptions were made that women had chosen to continue the pregnancy unless they specifically mentioned abortion.

This is in sharp contrast to when women attend an abortion service where they are routinely asked if they are sure about the decision to end a pregnancy. Some midwives who had worked in both maternity and abortion care reported that it was only when they started work in abortion services that they recognise that they had never been encouraged to think about routinely checking whether or not proceeding with the pregnancy was what women desired.

You don't want to be like Debbie Downer and someone comes in and, "I'm so delighted! I'm pregnant, hooray! I've been trying for two years…"you know, and then be like, "Well, is this really what you want?"

(Doctor, GP)

Even maternity care staff who were aware of RCA felt it would be very difficult to routinely ask questions about how certain the pregnancy was. It is clear that they believed that this, and therefore safeguarding for RCA, would potentially position HCP as emotionally inappropriate if it was adopted into maternity care, especially as some women may have had a difficult fertility journey towards pregnancy. Some of the reservations expressed were similar to those encountered when routine screening for domestic abuse was introduced into maternity services, yet the evidence has shown this is acceptable to women.[14] Moreover, continuing to make normative assumptions about women and motherhood which position continuing pregnancy as the routine option is a major gap in

safeguarding in the context of evidence that forced pregnancy is more likely than coerced abortion.[13]

Many of the participants who worked in maternity care commented on the difficulties posed by the move to include birth partners, generally men, more in pregnancy care. In some organisations, there were guidelines that stated that partners should be involved as much as possible, posing difficulties in ensuring that effective safeguarding for women took place. Although there was usually one appointment and/or consultation where partners were asked not to attend to allow routine screening for domestic abuse, in many cases this was ineffective, not least because they were often still on the premises or would be present in later appointments. This was felt to be a tokenistic gesture which, it was felt, did not create a meaningful environment in which to screen for RCA or other forms of abuse.

And I've seen it before in practice, where a midwife has turned around and said, "Oh, that partner is so lovely, he's so involved. He's gone to every appointment; he's always holding her hand. He's always got his arm around her or he's always there". And I think, [laughter] that sounds lovely, but is it lovely? Is he holding her hand and squeezing it very hard when you're asking a question? (…) these people are very clever, they're manipulators.

(Midwife)

Importantly, many of those interviewed reported that the routine screening that did take place was often in the 2nd trimester, sometimes as late as 20-24 weeks. This means that, even if it was disclosed that a pregnancy was forced, it was often very difficult or too late to refer for an abortion.

In one example, the first occasion that a woman was seen alone by maternity care staff was in the post-natal ward, where she disclosed that she had not wanted to proceed with the pregnancy. It is imperative that policy and practice in maternity care enables screening for RCA takes place early enough for women to be able to make decisions about their current pregnancy.

Many HCP reported that it was difficult to insist that male partners left the room in order to enable them to speak to women alone, and in some extreme cases men even accompanied their female partners into the toilet. Speaking for women and dominating the time for questions has also an issue in maternity care settings. Men could use the guidance on partner inclusion to challenge staff who tried to prioritise women in appointments.

Routine screening for RCA in maternity care must take place early enough to be able to refer to women to abortion services if they would prefer this.

It is also imperative that women are seen on regular occasions on their own. One appointment, or just sending birth partners out the room for a few minutes is unlikely to be enough to facilitate disclosure.

Whilst staff recognised these as red flags, and escalated safeguarding concerns, participants often felt that there was a limit to how far they could challenge men that appeared to be controlling without potentially increasing the risks to women when they left the healthcare service with the perpetrator. Moreover, it was reported by some that they felt that not all maternity staff were

sufficiently aware of how coercive control could present, and that they assumed that significant involvement by men was always a good sign, rather than potentially a way that men could exert control over their partners. In Australia, women who had experienced RCA believed that many HCP misrecognised coercive control and instead applauded the overt displays of 'proud fatherhood' made by male perpetrators.[41]

A small number of participants commented specifically how much the changes to maternity care during the Covid19 pandemic increased the opportunity to safeguard women. As the infection control measures imposed restricted women from being accompanied on most occasions, midwives were able to not only ask safeguarding questions on a single occasion, but throughout their care. Participants mentioned that disclosures of abuse increased, but then decreased when partners started to be able to attend again. Excluding partners during the pandemic was not without risks. In some cases there were altercations with hospital staff, and/or men resorted to kicking or punching doors when they were excluded from the premises.

Safeguarding in abortion care

Unlike maternity services, there is a strong emphasis in abortion care on ensuring that women are making autonomous decisions. The issue of safeguarding in telemedicine abortion care came under particular scrutiny during the debates about the continuation of the 'pills-by-post' services, not least due to the activities of anti-abortion activists, combined with the general stigmatisation of abortion which positions it as an option that needs to be justified or excused. Three main issues that surround telemedical services are covered here: issues surrounding access to abortion services; privacy and security during telemedicine consultations; and how telemedicine impacts on communication between HCP and women seeking abortions.

Abortion services have a strong emphasis on ensuring that women were sure about their abortion decision and this created opportunities for disclosure of RCA.

The introduction of early telemedical abortion services (pills by post) increased assess for many living in abusive situations.

Ensuring good local availability of surgical abortion would be helpful to ensure that women living with abuse can chose the procedure that will be safest for them.

It is generally agreed that telemedicine had the facility of potentially making access to abortion easier. It reduces the need to travel to a clinic, which can be a particular difficulty for those living with RCA who might have their activities monitored, or who are unable to access money for travel.

Even participants who had reservations about telemedical services recognised this. The introduction of telemedicine during the pandemic coincided with reports of an increase in domestic abuse, restricted access to contraception, and an increased demand for abortion services.

This complex picture means that whilst HCP reported that there had been an increase in the number of safeguarding disclosures since telemedicine was introduced, it is difficult to quantify the specific impact. However, the evidence suggests that telemedicine does not appear to be a substantial barrier to disclosing RCA or other abuse.

Many HCP stressed that having flexibility over the abortion pathway was crucial to enable safeguarding. All of the services were set up so that women who started on the telemedicine pathway could be brought into clinic if safeguarding (or other issues) were reported. Although access to medical abortion was generally good, for some women, being able to access surgical abortion is needed or would be preferable for safeguarding reasons.

However, the availability of surgical abortion is variable, and many women face having to wait or travel to be able to access the procedure. In order to increase safeguarding for RCA, there needs to be better access to surgical abortion reducing delays and increasing the number of locations were this service can be accessed.

Many of the concerns about telemedicine stem from worries about privacy and that it may increase the likelihood of coerced abortion. During telemedical consultations, although healthcare staff can ask if someone is on their own, there are no guarantees that this is actually the case. The health professionals interviewed all mentioned that they are alert to this possible scenario, and paid attention to what might be happening in the background. Where staff had safeguarding or other concerns they would ask women to attend an in person appointment. But the research participants also pointed out that, rather than always being a potential privacy risk, telemedicine means that women can be certain that they in a space where they are comfortable to talk. Moreover, the understanding that face-to-face appointments will always be better in terms of safeguarding, ignores evidence that victims/survivors need to consider the perpetrator's potential reaction at all times. The control extends beyond any physical presence or technological control. To facilitate disclosure, women need to be in an environment that feels safe for them, for some this will be at home, whereas for others it will be in a clinic setting. Having services close to home where women can choose either pathway initially, as well as the flexibility to move between pathways is likely to optimise safeguarding opportunities, but is likely to increase the costs of services.

The majority of participants who were involved in telemedical appointments felt that they were not a barrier to communication. It was notable that the majority of participants who expressed reservations, were either not regularly offering telemedical consultations, or in some cases had never done so. A number of participants mentioned that many women talked more during telemedical appointments about the issues leading up to an abortion decision.

> *I think the combination and the fluidity of both that we use in abortion care is a real positive, actually. I think it's really helpful for people, and I think that we can see that in the rise of safeguarding disclosures that we're getting now, since telemedicine came into place. I think you really are seeing that; that that combination approach is helpful for people.*
>
> *(Safeguarding Lead)*

Some felt that this was because they had not had to travel and, at home, they were in a more comfortable environment. A few people mentioned that patients used emojis such as an angry, happy or crying face during webchats and this also increased communication about how they were feeling. The sharing of emotional states beyond words, could be of particular benefit for those who find it difficult to talk about the issues that they are facing.

Overall, being in a familiar environment, and not feeling like they were going to be trapped into a course of action that they had little or no control over were considered to be important elements in increasing RCA disclosures. This may not be the case for everyone, as some people may have

concerns about privacy or, particularly for video calls, find telemedical appointments as invasive These contrasting possibilities is a reminder that the best way to enhancing disclosure and support for RCA is to ensure that patients have the option of choosing the best type of consultation for them, as well as sufficient flexibility within abortion care services to allow for people to change the pathway that they are on when seeking care.

Organisation and policy issues

A number of other organisational and policy factors were mentioned by HCP that had an impact on their ability to provide consultations in a way that would help facilitate disclosure of RCA. A key factor was that many NHS staff drew attention to issues such as a lack of time, resources and an exhausted workforce. There was huge pressure to get through appointments as quickly as possible, but this was often accompanied by a growing list of topics that were supposed to be discussed. Healthcare staff felt rushed and were acutely aware that this had an impact on the quality of conversations that took place. Many interviewees felt that it was also likely to be the case that because taking extra time would often mean staff working late or missing breaks, unless there was a clear disclosure, some of their colleagues may be tempted to not persevere with trying to encourage women to disclose to them.

In addition, it is important that systems are set up to facilitate improved access to services for people who may not have regular phone access. Those working in specialist services suggested that having direct lines for professionals supporting women in specialist services would be extremely useful, and would help build support around women.

> *With the pressure to see more patients quicker (…) we need time to talk about it properly (…) some people don't want to raise these issues in a quick consultation. Some people feel they are not the person to actually deal with this, [better to be] someone who has a longer relationship with patients like GPs.*
>
> *(Doctor, Sexual Health)*

Participants working for non-profit abortion care providers mentioned that underfunding by commissioners was a barrier to improving services. They pointed out that whilst there was always a strong emphasis on safeguarding, not all areas were willing to invest in sufficient funding. This negative situation was then compounded by some commissioners, and others, who exhibited bias against non-profit organisations, making stigmatised assumptions that the care they provided needed to be more closely monitored and/or was inferior to NHS providers. Whilst poor levels of care need to be identified and dealt with in any service, the growing list of scandals in NHS maternity services alone is evidence that the type of provider does not guarantee good care.

> *Abortion stigma produces negative stereotypes about women who have abortions. This can undermine the ability of services to safeguard women.*

Another issue raised by participants is stigmatised assumptions made about certain patients. For example, having more than one abortion, or presenting later to maternity care are particularly stigmatised. In both of these situations, RCA could be a factor.

Women may be unable to insist on regular contraceptive use, and to assume 'irresponsibility' fails to consider this. Whilst ensuring all women have good access to contraception is important, policies which focus on reducing the number of second or subsequent abortions by encouraging the use of LARCs can be detrimental to some victims. It is an example of institutionalised RCA, and could increase the risks to women, particularly if the method promoted has an impact on menstrual cycles as these may be monitored by perpetrators.

Less stigmatisation for 'late bookers' for maternity services is also important. It is important to remember that not all women have regular periods, particularly if they are living in a stressful situation or are using medication or substances that have a significant impact on body sensations or menstruation. Moreover, in situations of pregnancy promoting RCA, women may be prevented from consulting with HCP until it is too late to access abortion. Whilst many women in this position will need safeguarding, it is important not to make assumptions about why late presentation has happened, and to remember that, during pregnancy, women are the patients that need safeguarding, rather than seeing them mainly as just a potential risk to the foetus.

In terms of abortion care, some participants felt that decriminalisation would be helpful. For some, the need to elicit reasons that meet the legal criteria, shaped the consultation process through having to be framed around justification, and this undermined their ability to safeguard women. For others, whilst decriminalisation may not directly help to increase disclosure of abuse, it would contribute to reducing the stigmatisation of abortion more generally, and that was of value in reshaping an understanding of services and service users.

Key issues and future research

This research has examined policy and practice surrounding the identification and support for RCA in England, Scotland and Wales in abortion, contraception and maternity services. It found that whilst most professionals interviewed had encountered examples of RCA, this was not an area that had received much attention.

Of the three areas investigated, abortion care was more likely to have policy and practices that would facilitate disclosure of RCA. This was due to the routine questioning about abortion decision-making, including being alert to the possibility of abortion coercion. Sustaining access to telemedicine while also improving access to surgical abortion, so women can choose the best abortion method for them without concerns about delays or needing to travel further, would also increase the safety of those at risk of RCA. Currently, the legal framework means that women need a justifiable reason to have an abortion, and whilst exploring this in consultations opens up space for conversations about RCA it is possible that concerns about being 'allowed' an abortion may prevent some people from disclosing. The decriminalisation of abortion could alleviate this issue. Ending practices such as information sharing with maternity services for those who have not proceeded with an abortion unless there are particular issues of vulnerability or capacity would also improve women's safety.

Practices in contraceptive services varied, depending on who was operating the service. Routine screening for child sexual exploitation in contraceptive provision meant that staff were alert to the possibility that young people could be victims of RCA, but potential contraceptive abuse was not routinely considered for older clients. It is also important that there are not policies or targets for

increasing contraception, particularly fitting LARCs, as these can be a form of institutional RCA. Being alert to RCA as potentially a cause of uncertainty or being uncomfortable with contraception is also important.

The service with the least safeguarding in place for RCA was maternity care, despite routine screening for domestic abuse being in place. This illustrates how it is important to draw attention to different forms of abuse, if safeguarding is to be enhanced. Moreover, normative assumptions about women, motherhood and pregnancy meant that, unless raised by the woman herself, assumptions were made that women would continue a pregnancy. Midwives who had worked in both maternity and abortion care pointed out that it was only after they started working in abortion services that they realised that this was a major gap in safeguarding. In many services, routine screening for domestic abuse often takes place in the 2nd trimester, making arranging an abortion, if that should be desired, more difficult. The routine inclusion of birth partners into maternity appointments is also problematic, and significantly reduced safeguarding opportunities. It also means that the ability of pregnant people to be sure of being able to discuss their healthcare needs in privacy has largely disappeared. A better balance needs to be sought, ensuring women are routinely seen alone on a number of occasions during antenatal care. As the evidence suggests that forced pregnancy is more common than coerced abortion, changes to maternity services are urgently needed.

There has been very little research into RCA in Britain, and there are a number of important areas that need further investigation:

1) Qualitative research is needed with survivors of RCA to increase understanding of their experiences and what changes to services could be made to support them better. This should include experiences of Trans and non-binary people.
2) Quantitative research could help establish the prevalence of RCA. This would be useful to ask in population surveys as well as within specific areas of research. As there is currently a lack of awareness of RCA, care needs to be taken about how questions are phrased. It can be especially difficult to disclose forced pregnancy after birth, as that could be interpreted as a lack of care for existing children.
3) Research is needed as to how to best adapt commonly used screening or risk assessment tools for issues such as for domestic abuse or child sexual exploitation.
4) Research is also needed into safeguarding policy, practice and experiences of RCA in fertility services.

Appendix 1: Methodology

This research was designed to investigate policy and practice around the identification and support for those living with RCA in abortion, contraception, and maternity services. There were three stages in the research design:

- A narrative review of academic and grey literature focusing on broadly comparable countries.
- Qualitative interviews with healthcare professionals and those working in specialist support services for survivors of abuse.
- Stakeholder workshops.

Narrative literature review

The literature review focused on countries with broadly comparable healthcare systems, which was defined as having countries that have high income, well developed healthcare systems generally available to the population, and legal access to abortion. The search used a range of electronic databases to identify academic and grey literature using a range of key words including 'reproductive coercion' and combinations of domestic abuse/sexual violence/rape/CSE/safeguarding AND pregnancy/maternity/abortion/contraception. The search included both academic and grey literature and backwards and forwards citation searching was used to identify additional publications. After the initial search, abstracts were screened and literature was included if the publication addressed issues of safeguarding policy and practice issues for abortion, contraception and maternity services.

There were a relatively large number of research studies that had sought to measure the prevalence of RCA in different healthcare services. Many of these used different definitions of RCA, making comparing them difficult. None of the prevalence studies found had focused on a UK population, and so they were largely excluded from the review, as unlikely to be able to add to our understanding of the issues in Britain due to demographic and cultural differences. The review found a number of key themes in the literature, and these were: debates over definition, awareness of RCA, facilitating and operational barriers to disclosure, and safety planning. These themes were used to develop the interview questions.

Qualitative research

In total, 38 participants were recruited for in-depth interview, 25 healthcare professionals (HCP) and 13 specialist services experts (SSE) from a variety of support organisations (see Table 1). The HCP were all currently working in abortion, contraception or maternity services, or had responsibility for safeguarding in one or more of those services. They were recruited through email distribution lists, social media advertising and snowball sampling. The sample was purposely chosen to achieve a balance of professional roles across the different services. As many of those working in abortion and maternity services also undertake contraceptive counselling, the number of professionals working in this area is higher than the other two services.

A number of the HCP held more than one role (e.g. working in both community midwifery and abortion services), and all of the participants were asked to relevant experience throughout their career. Participants were drawn from across the UK and included hospital based and primary care staff. It included HCP who work directly for the NHS as well as those working in other organisations that deliver NHS services.

Table 1: Primary professional role at the time of interview

Primary Professional Role	Main Current Responsibility			Total Number
	Abortion	Contraception	Maternity	
Doctor	5	7	4	9
Midwife	4	7	6	10
Nurse	1	3		4
Commissioning and other roles	2	1	1	2
Sub total	12	18	11	25
Specialist service experts				13
Total participants				38

The interviews with professionals working in specialist services were also purposively recruited to cover a broad range of areas of organisations and roles. These include domestic violence organisations, Independent Sexual Violence Advisors (ISVA), experts in child sexual exploitation, modern trafficking, honour-based crime and those who worked with vulnerable populations such as sex workers and drug and alcohol service users.

Some of the interviews were face-to-face and the others were conducted by video calling, at the preference of the person being interviewed. Most were individual interviews, but there were two that had more than one participant present, this was also at the interviewee's suggestion. When permission was granted, interviews were audio-recorded, with notes being taken in other cases. All of the audio-recordings from the interviews were fully transcribed.

Stakeholder workshops

During the project, three workshops were held, and attendees were given the opportunity to discuss and give their input around the major themes identified in the fieldwork at that point. Two of the workshops were held at specific professional events, and the third was publicly advertised though email and social media at each stage of the project. Notes from these events were added into the dataset, as well as being used to verify the interim findings and shape dissemination. Permission was obtained from the event participants for this.

Data analysis

The data from interviews and workshops were analysed together thematically using NVivo to assist in the process. As Braun and Clarke make clear, qualitative analysis is complex and messy, and setting out the stages of the process often hides this complexity.[42] The initial coding of the data was both inductive and deductive, using understandings from the literature and those that arose from the qualitative fieldwork, and this was later refined into descriptive codes, which described common themes and meanings. This was followed by arranging the codes into themes, through interrogation and reflection. Moving backwards and forwards between the themes, codes, and transcriptions ensured that the final analysis fully reflected the data.

The main limitation, common to many other research projects, is that the participants were a self-selecting sample. For the HCP in particular, this meant that most had a particular interest in safeguarding for abuse, and their knowledge and experience may not be representative of staff in general. Nevertheless their understanding and depth of insight added to the understanding of the issues. In addition, there is little or no research evidence on RCA in LGBTQI relationships and this project is also unable to contribute to an understanding of this. More research is needed to examine this issue in detail.

References

1. Lowe P (2016) *Reproductive health and maternal sacrifice: Women, choice and responsibility*. Basingstoke: Palgrave Macmillan.

2. Home Office. (2013) *Information for local areas on the change to the definition of domestic violence and abuse*. Available from: https://www.gov.uk/government/publications/definition-of-domestic-violence-and-abuse-guide-for-local-areas [accessed 15/04/23].

3. Chesser B & Zahra A (2019) Stealthing: a criminal offence? *Current Issues in Criminal Justice* 31(2):217–35.

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

5. Kelly L & Westmorland N (2016) Naming and defining 'domestic violence': Lessons from research with violent men. *Feminist Review*;112(1):113–27.

6. Nikolajski C *et al*. (2015) Race and Reproductive Coercion: A Qualitative Assessment. *Women's Health Issues*;23(3):216–23.

7. Birchall J & Choudhry S (2021) 'I was punished for telling the truth': how allegations of parental alienation are used to silence, sideline and disempower survivors of domestic abuse in family law proceedings. *Journal of Gender-Based Violence*; 6(1):115-131.

8. Morrison F (2015) 'All Over Now?' The Ongoing Relational Consequences of Domestic Abuse through Children's Contact Arrangements. *Child Abuse Review*;24(4):274–84.

9. Tarzia L *et al*.(2022) Reproductive coercion and abuse against women from minority ethnic backgrounds: views of service providers in Australia. *Culture Health & Sexuality,*24:4, 466-481.

10. Price E *et al*.(2022) Experiences of reproductive coercion in Queensland women. *Journal of Interpersonal Violence*;37(5–6):NP2823–43.

11. Kumar S & Sinha N (2020) Preventing more "missing girls": A review of policies to tackle son preference. *The World Bank Research Observer*;35(1):87–121.

12. Shenkman G *et al*.(2021) Deciding to parent or remain childfree: Comparing sexual minority and heterosexual childless adults from Israel, Portugal, and the United Kingdom. *Journal of Family Psychology*; 35(6): 844–850.

13. Grace KT & Anderson JC (2018) Reproductive Coercion. *Trauma, Violence, & Abuse*;19(4):371–90.

14. Baird K *et al*. (2013) A five year follow-up study of the Bristol pregnancy domestic violence programme to promote routine enquiry. *Midwifery*;29(8):1003–10.

15. Hathaway JE *et al*. (2005) Impact of partner abuse on women's reproductive lives. *Journal of the American Medical Women's Association*;60(1):42–5.

16. Lévesque S *et al*. (2021) Influence of the relational context on reproductive coercion and the associated consequences. *Violence Against Women*;27(6–7):828–50.

17. Stark E. (2007) *Coercive Control: How men Trap Women in Personal Life*. Oxford: Oxford

University Press.

18. Umberson D *et al*. (2015) Intimacy and emotion work in lesbian, gay, and heterosexual relationships. *Journal of Marriage and Family*;77(2):542–56.

19. Lévesque S & Rousseau C (2021) Young women's acknowledgment of reproductive coercion: A qualitative analysis. *Journal of Interpersonal Violence* 2021;36(15–16).

20. Moulton JE *et al*. (2021) Women's perceptions and experiences of reproductive coercion and abuse: a qualitative evidence synthesis. *PLoS One*;16(12):e0261551.

21. Brady G & Lowe P (2020) 'Go on, Go on, Go on': Sexual Consent, Child Sexual Exploitation and Cups of Tea. *Children and Society*;34(1):78-92.

22. Sullivan V *et al*. (2020) How can we facilitate online disclosure of safeguarding concerns in under 18s to support transition from online to face-to-face care? *International Journal of STD & AIDS*;31(6):553–9.

23. Tarzia L *et al*. (2019) "A huge, hidden problem": Australian health practitioners' views and understandings of reproductive coercion. *Qualitative Health Research*;29(10):1395–407.

24. Burton CW & Carlyle KE (2021) Increasing Screening for Intimate Partner Violence and Reproductive Coercion: Understanding Provider Motivations. *Violence Against Women*;27(11):1913–29.

25. Miller E *et al*. (2017) Implementation of a Family Planning Clinic–Based Partner Violence and Reproductive Coercion Intervention: Provider and Patient Perspectives. *Perspectives on Sexual and Reproductive Health*;49(2):85–93.

26. McGirr SA *et al*. (2020) An examination of domestic violence advocates' responses to reproductive coercion. *Journal of Interpersonal Violence*;35(9–10):2082–106.

27. Wellington M *et al*. (2021) Barriers to responding to reproductive coercion and abuse among women presenting to Australian primary care. *BMC Health Services Research*;21(1):1–9.

28. Miller E *et al*. (2011) A family planning clinic partner violence intervention to reduce risk associated with reproductive coercion. *Contraception*;83(3):274–80.

29. Upadhyay UD *et al*. (2014) Development and validation of a reproductive autonomy scale. *Studies in Family Planning*;45(1):19–41.

30. Brown G *et al*. (2011) Young mothers' experiences of power, control and violence within intimate and familial relationships. *Child Care in Practice*;17(4):359–74.

31. Pearce J *et al*. (2002) *It's Someone Taking a Part of You: A Study of Young Women and Sexual Exploitation*. London: The National Children's Bureau.

32. Miller E *et al*. (2016) A family planning clinic-based intervention to address reproductive coercion: a cluster randomized controlled trial. *Contraception*;94(1):58–67.

33. Decker MR *et al*. (2017) Implementing trauma-informed partner violence assessment in family planning clinics. *Journal of Women's Health*;26(9):957–65.

34. Hill AL *et al*. (2021)Trauma-informed personalized scripts to address partner violence and reproductive coercion: follow-up findings from an implementation randomized controlled trial study. *Journal of Women's Health*;30(4):604–14.

35. Baird K *et al*. (2021) Red flags and gut feelings—Midwives' perceptions of domestic and family violence screening and detection in a maternity department. *Women and Birth* 34(5):e468–74.

36. Reynolds-Wright JJ *et al*. (2022) A qualitative study of abortion care providers' perspectives on telemedicine medical abortion provision in the context of COVID-19. *BMJ Sexual & Reproductive Health*;48:199-204.

37. Tarzia L *et al*. (2019) How do health practitioners in a large Australian public hospital identify and respond to reproductive abuse? A qualitative study. *Australian and New Zealand Journal of Public Health*;43(5):457–63.

38. Kekana LP *et al*. (2016) Should violence services be integrated within abortion care? A UK situation analysis. *Reproductive Health Matters*;24(47):104–17.

39. Keeling J & Mason T (2011) Postnatal disclosure of domestic violence: comparison with disclosure in the first trimester of pregnancy. *Journal of Clinical Nursing*;20(1-2):103–10.

40. Burry K *et al*. (2020) 'I had no control over my body': Women's experiences of reproductive coercion in Aotearoa New Zealand. *Aotearoa New Zealand Social Work*;32(1):17–31.

41. Buchanan F & Humphreys C (2021) Coercive control during pregnancy, birthing and postpartum: women's experiences and perspectives on health practitioners' responses. *Journal of Family Violence*;36(3):325–35.

42. Clarke V & Braun V (2021) *Thematic analysis: a practical guide*. London: SAGE Publications Ltd.