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One in four women at sexual health clinics reports coercion over their reproductive lives

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As many as one in four women attending sexual and reproductive healthcare services say they are not allowed to take control of their own reproductive lives, reveals a review of the available evidence, published today in *BMJ Sexual & Reproductive Health*.

As well as not being able to actively choose whether to use contraceptives, or start or continue with a pregnancy, this 'reproductive control' also takes the form of 'contraceptive sabotage', which includes covert removal of a condom during sex, so invalidating consent, the research shows.

The concept of reproductive coercion-control over women's reproductive autonomy by others-was first described in 2010.

The study authors wanted to update the available evidence to 2017, and to widen the spectrum of activities involved, to include family pressure and criminal behaviour, such as sex trafficking and exploitation.

They therefore searched relevant databases of medical and social sciences research, looking at women's experiences of interference with their reproductive autonomy.

They found that the practice is common, with as many as one in four women attending sexual and reproductive healthcare clinics reporting coercion over their reproductive lives.

Younger women, and in the US, black and racial minority women, seem to be particularly vulnerable, the research indicates.

And in some cultures, the wider family, and older female relatives in particular, may have control over reproductive decision-making that is endorsed by society.

Reproductive control covers a wide range of behaviours, from persuasion through emotional blackmail, to threatened or actual infidelity and physical violence. It is predominantly perpetrated by male partners, but also by the wider family and criminal gangs, the evidence shows.

It includes not being allowed to make decisions about becoming pregnant and continuing or terminating a pregnancy, and contraceptive sabotage. This last interacts and overlaps with sexual coercion and violence, and effectively invalidates consent, say the study authors.

Examples of contraceptive sabotage include a male partner lying about having had 'the snip' (vasectomy); refusal to permit the use of contraceptives; forceful removal of contraceptive devices; failure to practise withdrawal during sex; piercing condoms or other barrier methods; and throwing away/hiding contraceptive pills.

And it includes 'stealthing,' whereby a condom is covertly removed during sex, and at the other end of the spectrum, spiking food and drink with agents known to induce abortion.

The negative consequences are many: undermining responsibility for contraceptive use; unintended or unwanted pregnancy; a higher risk of abortion; higher rates of testing for sexually transmitted infections and pregnancy and requests for emergency contraception.

Women may themselves respond by lying about their use of contraception, pregnancy testing, etc, and risk harm if they try to negotiate contraceptive use in a violent relationship.

But they may not always be aware that they are being subjected to reproductive control, especially if this isn't accompanied by physical or sexual violence, say the study authors.

"The degree of control that a male partner can have will vary from mild to extreme. Milder amounts of control may not be perceived by the victim as unhealthy or abusive. Women in a long term relationship may become inured to significant levels of reproductive control," they write.

Healthcare professionals have a key role in picking up and preventing this form of abusive behaviour, they say, and call for more international research to help guide this.

"In particular, more research is needed on the non-physical elements of abusive relationships and how coercive control can be resisted," they suggest.

More information: *BMJ Sexual & Reproductive Health*, srh.bmj.com/lookup/doi/10.1136/bmjsrh-2018-200156

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