

Experiences of reproductive coercion and abuse among women: Qualitative findings from the Third Australian Study of Health and Relationships

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Introduction & Background

What do we know?

Reproductive coercion and abuse (RCA) refers to behaviours that interfere with an individual's reproductive autonomy and decision-making.

RCA may include contraceptive sabotage, forced contraception and pregnancy coercion, with physical and psychological impacts.

Research has largely focused on RCA perpetrated by intimate partners and close family members. Increasing attention is now being paid to the role healthcare professionals (HCPs) may play in perpetrating or perpetuating RCA during clinical encounters.

What are we not sure about?

Healthcare settings have traditionally been viewed as places where people disclose RCA, rather than as environments in which RCA may occur.

In healthcare encounters, where is the boundary between routine directive clinical guidance and reproductive coercion—and can it be crossed even without overt violence?

What are women's experiences of encounters with HCPs regarding reproductive autonomy, and what do they believe could prevent RCA perpetrated or perpetuated by HCPs?

Aim

To understand how women with lived experience of RCA experience and navigate healthcare encounters, including where the healthcare encounter itself becomes a source of RCA

Methods

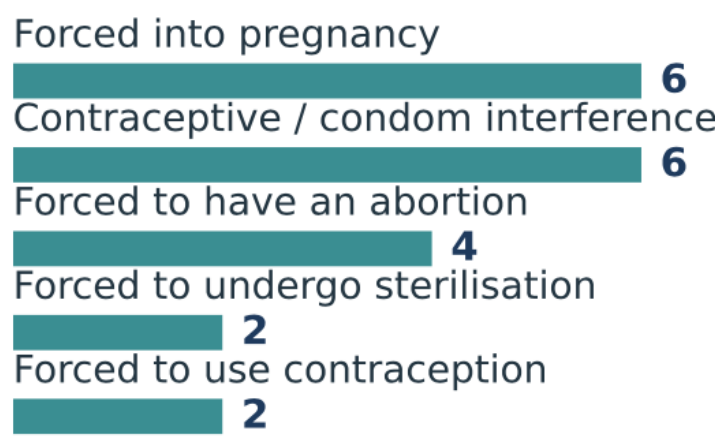
- Design: qualitative secondary analysis of 15 in-depth interviews from ASHR3 data.
- Eligibility: Biological women who had completed the ASHR3 survey, reported experiencing at least one form of RCA, and participated in a follow-up in depth qualitative interview.
- Analysis: reflexive thematic analysis, inductive coding and theme development.
- Rigour: reflexive journal; credibility, dependability, confirmability, transferability
- Ethics Approval: UNSW HREC (HC210682)

Participant Demographics

15 women with lived experience of RCA (N = 15)

AGE AT INTERVIEW		ETHNICITY	
20–30 years	2	Australian (non-Indigenous)	10
31–40 years	3	European	2
41–50 years	2	Hispanic	1
51–60 years	6	Māori	1
≥61 years	2	Nigerian	1
AGE AT TIME OF RCA		HEALTH & DISABILITY*	
≤18 years	4	Physical / medical condition	5
>18 years	11	Intellectual / cognitive condition	3
LIVING LOCATION		Mental illness	9
Urban or city	9		
Rural or regional	6		

Type of RCA*



Source of RCA*



Navy bar: healthcare professionals as a source of RCA

*Participants could report more than one category. All experiences occurred in Australia except one (France). Values are counts.

Results *Three themes across 15 women's accounts*

Theme 1: HCPs as a source of RCA

“It Was Delivered As an Ultimatum”

Care made conditional

“...the obstetrician had said unless I was prepared to have my tubes tied at the same time, he was refusing to do the Caesarean.”— Participant 11

Choices taken rather than made

“The doctor said there was only one option available, and it was like ‘here you go, here’s the option, see you later.’” — Participant 3

For the woman's own good

“The doctor said he knew having an abortion is the better for me because I will have a disabled son.” — Participant 16

Leaving no room to refuse

“Small town. There weren’t options to go see someone else. There was nothing you can do and no way you can go” — Participant 11

Theme 2: Navigating healthcare while managing RCA

“I Didn’t Know When and What to Ask”

Decisions made without deliberation

“Go on, take this one.” My doctor was lovely, but you were just a patient to him. —Participant 4

Why women remained silent

“I was an I didn’t know there was much of an option at the time “ — Participant 2

“I was an uneducated young person back then, and I listened to my doctors.’ — Participant 4

“I didn’t have a relationship with any of my doctors, and I could have said I had RCA. there was a degree of shame involved in revealing private life openly.” — Participant 7

Trust as both protection and vulnerability

“I did what the doctors said. In my mind, there was no other option. At the time I didn’t have a voice, and it was disrespectful to talk back to the doctors.” — Participant 8

“...there are lots of women out there who don't have support, and they trust the medical team, and they would go along with doctor’s advice.” — Participant 16

Theme 3: Lasting impact on trust in the healthcare system

“It Changed How I Trust Them”

Trust reshaped rather than simply lost

“Perhaps if I had said no, doctors would have offered a more in-depth discussion.” — Participant 3

Returning on different terms

“I start to ask any doctor I see lots of questions.” — Participant 16

“I am more active in my healthcare rather than accepting what they offer.” — Participant 11

What women said they needed

“Take time, explain carefully about all available options and respect the fact that patients may not know any information before they come.” — Participant 16

“Be not judgemental... and don’t take the option out of their hands.” — Participant 8

“It’s the whole public system... it’s hard to build relationship with doctors... [it’s] not helpful in discussing such personal topic like RCA.” — Participant 11

Discussion & Implications

A blurred boundary:

Participants described a difficult-to-locate boundary between directive clinical care and reproductive coercion. In accounts of RCA within healthcare encounters, essential care was made conditional, decisions were presented as already determined, and refusal carried consequences women felt unable or unwilling to absorb.

Unfavourable experience:

Across all 15 accounts, consultations were often structured around a single recommended option, with limited discussion of alternatives or support for deliberation, even when women had actively sought care to exercise reproductive autonomy and support from intimate partner initiated RCA.

Trust was recalibrated:

Participants did not describe a straightforward loss of trust. They continued to engage with healthcare on different terms, using strategies developed through previous experiences to protect their autonomy in subsequent encounters.

Implications:

Future research should examine healthcare encounters as a primary focus of RCA. Policy and practice should reduce reliance on individual HCPs by embedding RCA knowledge in professional training, improving access to services and community support, and expanding reproductive health education and decision-support resources

Conclusion

Healthcare settings are not only places where RCA can be identified and addressed. They can also become sites where RCA is perpetrated or perpetuated and reproductive autonomy is constrained. Women recalibrated their engagement with healthcare to protect themselves. Their accounts point to the need for change at both individual and system levels.