EXPERIENCES OF REPRODUCTIVE COERCION AND ABUSE AMONG WOMEN: QUALITATIVE FINDINGS FROM THE THIRD AUSTRALIAN STUDY OF HEALTH AND RELATIONSHIPS

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Background:
We aimed to develop a deeper understanding of the lived experiences of women who have experienced reproductive coercion and abuse (RCA) and how it may vary across and within diverse communities, including its unique forms, underlying drivers and impacts, barriers and facilitators to support, and suggestions for services.

Methods:
This study was conducted as part of the Third Australian Study of Health and Relationships, a national population-based survey of 12,833 adults. In the survey, women were asked about partner interference with contraception, forced sterilisation or contraception, coerced abortion, and forced continuation of pregnancy. To gain deeper insight into experiences, qualitative interviews were subsequently undertaken with 19 women aged 20– 54 years old who reported having experienced RCA. Data were analysed thematically.

Results:
RCA was shaped by multiple sources of coercion, including intimate partners, family members, in-laws, and health professionals. Women described emotional manipulation, financial pressure, social judgement, and direct verbal pressure as coercive mechanisms influencing reproductive decision-making. These experiences often had long-term impacts on mental health, intimate relationships, and broader life trajectories. Structural factors, including access to medical information, healthcare and support services, cost, and societal stigma further constrained reproductive autonomy. Experiences of RCA, as well as access to support, varied by social position, with cultural background and financial resources shaping both vulnerability and help-seeking pathways. Within this broader context, women also identified barriers within healthcare systems, including limited awareness of RCA among healthcare professionals and fragmented or inconsistent medical advice regarding reproductive options and referral pathways, which further hindered access to appropriate support.

Conclusion:
RCA is embedded within both interpersonal and structural contexts. Responses should be accessible, trauma-informed, culturally responsive, and attentive to the social conditions that shape reproductive decision-making. Findings also point to

implications for government, healthcare, and education sectors, including the need for greater professional awareness and clearer referral pathways.

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