

# 'I had no control over my body': Women's experiences of reproductive coercion in Aotearoa New Zealand

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## ABSTRACT

**INTRODUCTION:** Reproductive coercion broadly describes behaviour intended to undermine the reproductive autonomy of a victim through pregnancy coercion, contraceptive sabotage, and controlling pregnancy outcomes. This research sought to understand the experiences of victims of reproductive coercion in Aotearoa New Zealand.

**METHODS:** Participants shared their experiences of reproductive coercion from an intimate partner through an online survey that was distributed via social media and posters that were put up primarily in Family Planning clinics across the country. Five participants subsequently participated in in-depth interviews.

**FINDINGS:** Participants (mostly women) in this research experienced high rates of controlled access to contraceptives (83.8%), contraceptive sabotage (58.6%), and pregnancy coercion (64%) by an intimate partner. Furthermore, 40.5% of participants who had ever been pregnant had experienced a partner attempting to prevent them from accessing an abortion, and over 30% were subjected to a partner's attempts to force an induced abortion or miscarriage. Many also expanded on their partners' coercion regarding reproductive decisions, and abuse during, and after, labour and birth. However, they were rarely asked about reproductive coercion and abuse by health care or social service practitioners.

**CONCLUSIONS:** Reproductive coercion is a phenomenon that is globally under-researched. Emerging evidence suggests this is a highly gendered issue, and that there needs to be greater focus on promoting how we can improve and protect women's reproductive autonomy. Findings from this research indicate the need to incorporate discussions about reproductive autonomy and coercion in screening for intimate partner violence.

**KEYWORDS:** Reproductive coercion; intimate partner violence; coercive control

## Introduction

Reproductive coercion describes behaviour from one person intended to undermine and exploit the reproductive autonomy of another, most commonly within the context of an intimate or sexual relationship, although it can also happen in other

contexts such as within family relationships. Conversely, reproductive autonomy describes someone's capacity to make free, voluntary and informed decisions related to their sexual and reproductive health, wellbeing and future (Moore, Frohwirth, & Miller, 2010). While US-based studies

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have estimated that the prevalence rates of reproductive coercion range from 15% to 25% depending on the vulnerability of the population (Black et al., 2011; Miller et al., 2010; Park, Nordstrom, Weber, & Irwin, 2016), this has yet to be explored in a New Zealand context. Accordingly, this research sought to understand the experiences of individuals in New Zealand who have experienced reproductive coercion by an intimate partner.

The National Collective of Independent Women's Refuges (NCIWR) surveyed 162 respondents, with a final sample size of 111 participants (50 respondents did not complete the survey, and one respondent did not consent to participate), and the first author carried out in-depth interviews with five women who had experienced reproductive coercion by an intimate partner. In this article, we present the findings of this research across three temporal phases of reproductive coercion, and discuss the gendered nature of reproductive coercion and implications for service providers.

## Background

Reproductive coercion is a form of intimate partner violence (IPV) that often occurs alongside other forms of IPV, such as sexual and psychological abuse (Clark, Allen, Goyal, Raker, & Gottlieb, 2014; Miller et al., 2010; Park et al., 2016). IPV essentially describes the use of coercive control, or the process by which perpetrators (those who use coercive control) undermine the liberty, equality and autonomy of their partners through a range of tactics (Stark, 2009). Such tactics may include social and physical isolation, surveillance, intimidation, and threats to their partner's physical, sexual, emotional, and/or psychological safety and dignity, depending on what type of threat they observe to be the most effective means to circumscribe agency, enforce compliance, and restrict resistance in their partner (Stark, 2009). The use of coercive control in relationships is a particularly male form of

domination, and is tied to gender inequality between men and women more generally:

...coercive control takes the enforcement of gender stereotypes as its specific aim, the degradation of femininity as a major means, and reinforces sexual inequality in society as a whole in ways that constrain women's opportunities to "do" femininity. (Stark, 2009, p. 1511)

As with the use of coercive control generally, emerging evidence of reproductive coercion suggests it is a gendered phenomenon, meaning that, while there may be outlier cases where women perpetrate reproductive coercion towards their male partners, or it is perpetrated in same-sex relationships or by family members, reproductive coercion is primarily perpetrated as a tactic of coercive control and domination by men towards their female partners (current, ex, or desired) (Park et al., 2016). Generally, men's use of coercive control can lead to women's decreased fertility control, for example in relation to condom negotiation (Martin et al., 1999; Plichta & Abraham, 1996; Wingwood & DiClemente, 1997) and contraceptive use (Bawah, Akweongo, Simmons, & Phillips, 1999; Biddlecom & Fapohunda, 1998; Pallitto & O'Campo, 2005). Furthermore, women who are victims of IPV have been evidenced to experience generally poorer sexual health (Coker, 2007; García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005). However, further research is needed to understand LGBTQI+ people's experiences of reproductive coercion in their intimate relationships, as well as reproductive coercion in family relationships.

Reproductive coercion may be seen as a further tactic of coercive control as the perpetrator attempts to limit the sexual and reproductive autonomy and equality of their partner (afforded by, for example, modern contraceptives). The particulars of masculine enactments of coercive control in the context of reproductive coercion have been considered across these three domains:

- Labour, or reifying women's domestic and childrearing duties;
- Power, or exercising authority and control over women's sexuality and reproductive capacity; and
- Cathexis, or men's commandeering of women's sexual, emotional and intimate experiences and enforcing childbearing (Connell, 1987; Moore et al., 2010).
- Injuring a woman to cause a miscarriage; and
- Threatening to end the relationship, or to harm the woman if she does not stop using contraception.

Moore et al. (2010) identify three temporal periods in which perpetrators' behaviours intended to control reproductive outcomes may occur: before sexual intercourse (e.g., controlled access to contraceptives and pregnancy coercion), during sexual intercourse (e.g., birth control sabotage), and post-conception (e.g., controlling pregnancy outcomes). In these three temporal phases, the perpetrator intentionally attempts to impede their partner's reproductive autonomy to exert greater control over them (Moore et al., 2010).

The Family Planning New Zealand website (FPNZ, 2015) outlines some key identifying features of reproductive coercion that can occur before sexual intercourse, during sexual intercourse, and post-conception (Hathaway, Willis, Zimmer, & Silverman, 2005; Moore et al., 2010), including:

- Hiding or throwing away a woman's pills or pill packet;
- Breaking or making holes in condoms, refusing to use a condom, or taking a condom off during sex;
- Removing intrauterine devices (IUDs) or vaginal rings;
- Threatening behaviour that pressures a woman to become pregnant when she does not want to;
- Forcing a woman to abort or continue a pregnancy when she does not want to;

Perpetrators' attempts to undermine their partner's reproductive and sexual wellbeing and autonomy can involve overt instances or episodes of sexual violation (rape) and other forms of physical force (e.g., forced removal of IUDs, or physical violence during pregnancy), or more coercive, non-physical behaviours such as threatening to leave if their partner does not become pregnant or withholding money for contraceptives, or both (Moore et al., 2010).

Reproductive coercion also includes perpetrators' use of threatening behaviours intended to influence or control pregnancy outcomes or undermine contraceptive use (Blanc et al., 1996; Clark et al., 2008; Miller et al., 2007; Njovana & Watts, 1996; Watts & Mayhew, 2004; Wingood & DiClemente, 1997); forcing pregnancy then denying paternity (Moore et al., 2010); and attempting to control their partner's access to healthcare and support, for example antenatal care (Moore et al., 2010). Perpetrators may also attempt to control the outcome of the pregnancy by forcing their partner to have an abortion (Coggins & Bullock, 2003; Hathaway et al., 2005; Moore et al., 2010) or by somehow preventing them from accessing an abortion, such as by sabotaging clinic appointments (Moore et al., 2010).

The odds of unintended pregnancy increase almost two-fold where reproductive coercion and IPV are co-occurring (Miller et al., 2010), and, furthermore, research has evidenced that men's violence towards women can worsen during pregnancy or post-birth (Moore et al., 2010). Women who are abused during pregnancy may also be at greater risk of more severe abuse from their partners and femicide, with one case-controlled study of attempted and completed femicides across 10 cities in the US evidencing that, if

a woman is abused during pregnancy, the risk of her becoming a victim of attempted or completed femicide increases three-fold (McFarlane, Campbell, Sharps, & Watson, 2002). Moreover, some studies have shown that pregnancy outcomes for women whose partners are abusive, or for women who otherwise do not want or are unhappy about the pregnancy, are generally worse, including experiencing a higher proportion of miscarriage, stillbirth, pre-term labour, low birth weight and foetal injury, and other complications and adverse mental and physical health consequences for the mother (Bustan & Coker, 1994; Cokkinnides, Coker, Sanders, Addy, & Bethea, 1999; Campbell et al., 1999; Campbell & O'Campo, 2005; Fanslow, 2017; Janssen et al., 2003; McFarlane, Parker, & Soeken, 1996a, 1996b; Martin, English, Clark, Cilenti, & Kupper, 1996; Laukaran & van den Berg, 1980; Park et al., 2016).

### Method

This research was conducted by the National Collective of Independent Women's Refuges (NCIWR), and employed mixed methods, namely an online survey hosted by SurveyMonkey that collected quantitative and qualitative information, followed by five in-depth interviews conducted either face-to-face or via phone or Skype. This research was reviewed and accepted internally by NCIWR and externally by others in the sexual and reproductive health field (practitioners, researchers, and educators) before distribution. This review process included a thorough analysis and discussion of the recruitment and informed consent processes, the wording and ordering of the questions, distress protocols, and confidentiality.

Data collection was conducted over several months in mid-2018 and involved two key stages of recruitment. Firstly, an online survey was sent out via social media channels, principally the Women's Refuge New Zealand Facebook page where it was then shared to other Facebook groups (such as

affiliated Refuges' and Family Planning New Zealand's pages). Furthermore, 50 posters for participant recruitment were put up on the inside of toilet cubicles in Family Planning clinics ( $n = 40$ ) around the country and in the Wellington Sexual Health Service clinic ( $n = 10$ ) in central Wellington with tear-off tabs containing the URL address for the online survey. As Sexton, Miller, and Dietsch (2011, pp. 158–159) point out: "In cases where the population of interest is unknown or cannot be quantified, nonprobability sampling methods [...] may be necessary." Thus, the purposive sampling of participants via these Facebook groups and sexual and reproductive health (SRH) clinics was considered appropriate given the links between SRH needs, intimate partner violence, and reproductive coercion, as described above, and given the lack of data to date on the issue of reproductive coercion in New Zealand.

The post on Facebook and the poster both outlined the research and asked potential participants if they had experienced behaviours indicative of reproductive coercion by a partner, for example: "Has a partner ever tried to tamper with your contraceptives, such as throwing away your contraceptive pill or poking holes in condoms?" People who identified that a partner had used these behaviours could then select or enter the URL address for the survey. The five interviewees were recruited via the online survey by these participants leaving their contact details at the end of the survey with the explicit purpose of the principal researcher contacting them for an interview. The interviews were intended to gain a more in-depth account of women's experiences of reproductive coercion in the context of their relationship with a partner (current or former) through an in-depth interview.

Given the widespread use and access to the internet, online surveys are a convenient and cost-effective way to reach a wide range of people (Bouchard, 2016; Neville, Adams, & Cook, 2015). Some research

also suggests the anonymity of the online platform can yield greater numbers of disclosures on sensitive topics (Bouchard, 2016; Kays, Keith, & Broughal, 2013; Neville et al., 2015). However, online surveys also have limitations, notably the lack of interviewer–interviewee rapport that develops in face-to-face interviews, as well as the ability for the interviewer to assess and mitigate the discomfort and distress of the interviewee, and difficulties regarding participant authenticity (Bouchard, 2016; Neville et al., 2015). We attempted to address these limitations by presenting an initial page to participants outlining the topics the survey would cover and intended research outputs, as well as a consent process, and strategies and support options if participants experience distress (Bouchard, 2016). Participants were also reminded at the start of each set of questions that they could discontinue at any point, and were provided strategies and support networks if they were feeling distressed, before clicking to reveal the next series of questions.

Building trust and a sense of comfort was also attempted through the phrasing of the questions, such as, “Would you feel comfortable sharing some examples of how your partner controlled your access to contraceptives? You can describe your experiences in the box below.” This phrasing of questions, with the comfort of the participant in sharing their experiences at the centre, was intended to generate an open space for participants to anonymously describe their experiences. While participants were given only one opportunity to input their responses, participants were also able to answer questions in their own time, allowing time to reflect and take breaks from their participation, and this can be important for participants who are considering experiences that are rarely, if ever, discussed (Neville et al., 2015). Participants were also given the option of contacting the principal researcher if they had further questions or concerns, as well as to participate in an in-depth interview. Furthermore, only completed answers are included in this analysis to

minimise the potential of people entering the survey for purposes other than to share their lived experiences of reproductive coercion, such as out of curiosity.

The survey explored experiences and the dynamics of reproductive coercion amongst participants over the age of 16, regardless of their gender and sexuality and the gender of their partner. For each type of behaviour (controlled access to contraceptives, contraceptive sabotage, pregnancy coercion, intentional exposure to STIs/HIV, and controlled pregnancy outcomes) participants were asked, with examples of each behaviour, whether they had experienced this from an intimate partner, where they could select *Yes*, *No*, or *Prefer not to answer*. Following this, participants were invited to share their experiences of their partner’s behaviour in a text box provided. Survey participants were also asked about experiences seeking support and health care, and about their partner’s behaviour during and after their pregnancy (i.e., post-birth, miscarriage or induced abortion).

This research has some limitations; namely, it targeted individuals who are active on Facebook, understand how to use computers and basic online survey software, identify themselves as victim/survivors of reproductive coercion, and follow the pages on Facebook that shared the survey link, such as Women’s Refuge or Family Planning New Zealand, or attend Family Planning or Wellington Sexual Health Service clinics. This research presents the experiences of a purposive sample of individuals to prompt further investigation, and to begin to establish an awareness of people’s experiences of reproductive coercion in Aotearoa New Zealand.

The data from the survey and interviews were categorised into the three temporal phases of reproductive coercion identified in Moore et al. (2010), namely participants’ experiences of reproductive coercion before sexual intercourse, during sexual intercourse, and post-conception. To the temporal

category, 'during sexual intercourse', we added a sub-category on participants' experiences of a partner intentionally exposing them to a sexually transmitted infection (STI), based on the data. Furthermore, we added additional categories on participants' experiences during labour and delivery, post-partum, and their experiences seeking help, which participants were asked to describe in the survey. We then analysed participants' experiences at each phase, considering emerging and recurring patterns in participants' descriptions of their experiences, as well as in their accounts of the perpetrators' attempts to control or undermine their reproductive autonomy (Connell, 1987; Moore et al., 2010).

### Findings

This research involved a comprehensive survey of 162 respondents' experiences of reproductive coercion, with a final sample size of 111 participants (50 did not complete the survey, and one person did not consent to participate), followed by five in-depth interviews with the principal researcher. The majority (73%) of participants identified as Pākehā/NZ European, followed by those who identified as Māori (11.7%), and the vast majority of survey participants identified as women (97.3%; the remainder identified as either non-binary (1.8%) or Takatāpui (0.9%)).

The findings of this research span the three temporal phases identified earlier, exploring research participants' experiences of reproductive coercion by a partner before sexual intercourse, during sexual intercourse, and post-conception. This research also gathered participants' experiences of their partners' behaviour during labour and delivery, and post-partum. Participants' accounts of their partners' reproductive coercion are analysed from the lens of the enactment of masculine power across the three domains identified (labour, power, and cathexis) (Connell, 1987; Moore et al., 2010). We found that this analytical framework assisted in explaining the data

from this research given the vast majority of participants in this study identified as women and experienced reproductive coercion from a male partner.

### *Experiences of reproductive coercion pre-sexual intercourse*

The first temporal phase of reproductive coercion identified earlier is pre-sexual intercourse, including pregnancy pressure, controlled access to contraceptives, and some instances of contraceptive sabotage. All of these experiences of reproductive coercion pre-sexual intercourse were captured in this research.

The majority of research participants (83.8%) had experienced a partner attempting to control their access to contraceptives. These experiences ranged from participants' partners inhibiting their ability to access transport to attend clinic appointments, body shaming them (e.g., telling them they will become fat if they take contraceptives), controlling finances to prevent them from being able to pay for appointments and prescriptions, and outright refusal to use contraceptives, such as refusal to use condoms.

My pills would randomly go missing, something would "happen" to the car or just some excuse to why we couldn't get to the doctor's for IUD etc. (Survey respondent, Pākehā/NZ European woman, 1–2 children, age group 36–45)

[He] refused condoms and would not allow me to go on the pill or jab because he said I would get fat. (Survey respondent, Pākehā/NZ European woman, nulliparous, age group 26–35)

He would throw away my pills and if I tried to make a doctor's appointment, he would come. Only once did I ever make it there alone and got the jab, but he caught on quick to what I had done and [I] was never allowed to go again by myself. (Survey respondent, Pākehā/

NZ European woman, 3–4 children, age group 26–35)

[He] got mad, told me I was selfish and called me names when I told him I had a prescription for the pill. (Survey respondent, Pākehā/NZ European woman, 3–4 children, age group 16–25)

When I tried to obtain the morning after pill, he would distract me and occupy my time or threaten suicide to make it harder to get it in time. (Survey respondent, Māori woman, 1–2 children, age group 36–45)

Just under 60% of participants experienced their partner tampering with or sabotaging their method of contraceptives, and some of those experiences were in the temporal phase prior to sexual intercourse, for example disposing of, or destroying, contraceptives.

He grabbed my pills and destroyed them all. I had condoms for us to use as well. He destroyed them all and said if I fell pregnant, I have no choice but to have the baby. He also stopped me from going to my appointment to get a new supply of pills and condoms. (Survey respondent, Māori woman, 5–6 children, age group 26–35)

I tried the pill but when he found them he got mad and put them down the sink. The time I put my foot down with condoms, he poked a needle through some and mixed them all up. Told me “good luck”. (Survey respondent, Māori woman, 3–4 children, age group 26–35)

Finally, participants’ partners’ attempts to coerce or pressure them into pregnancy (experienced by 64% of participants) also occurred before sexual intercourse, in the form of verbal threats, for example threats of harm towards themselves (such as suicide threats) or towards their partner, and other methods of emotional abuse and manipulation, such as name calling and accusations of infidelity.

He put tremendous pressure on me to have a child to him as my first [child] was not his. This involved coercion and threats to kill himself (and sometimes me with him). He claimed he didn’t feel like a man because he failed to impregnate me. Eventually I became pregnant even though I was emotionally and financially not ready. (Survey respondent, Māori woman, 1–2 children, age group 36–45)

Shortly before the end of the relationship, when he became convinced that I had had an abortion. I hadn’t. It kind of seemed similar to the ways that he would sometimes accuse me of cheating on him. So he was trying to guilt me into doing other things for him based on the fact that I had killed his child and “shouldn’t I be so ashamed of myself,” and “shouldn’t we have another baby to replace the one that you killed?” The crazy making around it was just unreal. (Interviewee, Pākehā/NZ European woman, 1–2 children, age group 36–45)

It was “God’s choice to open and close the womb”. If I wanted to use any contraceptives it was considered not trusting God. [He] also frowned on the idea of using any natural method like fertility awareness, and hated abstaining. (Survey respondent, Pākehā/NZ European woman, 6+ children, age group 36–45)

It was always a measure of how much I love him – that if I do, I would want to have a baby with him, if I said I didn’t want to or wasn’t ready it often turned violent because he believed I must be cheating or didn’t love him or didn’t want to be with him. (Survey respondent, Pākehā/NZ European woman, nulliparous, age group 26–35)

Strong themes of enactment of masculine power across the domains of labour, power, and cathexis were apparent in the behaviour of participants’ partners in this temporal phase (Connell, 1987; Moore et al., 2010).

Power and cathexis in particular were apparent, for example, some participants gave examples of their partners forcing pregnancy as a method of trapping them in the relationship and enforcing the role of motherhood.

Another key theme that emerged from participants' accounts of their partners' behaviour was the monitoring of their sexuality in order to coerce non-use of contraceptives. Specifically, many participants recalled their partners accusing them of infidelity if they were to use, or were found to be using, contraceptives.

My former partner refused to allow me to use contraceptives as he said this was only necessary if you are a prostitute [or] not able to stay in a monogamous relationship. On the occasion that I did sneak oral contraceptives, when he found them he threw them away saying if I am faithful then I won't get pregnant too fast. (Survey respondent, Pasifika woman, 5–6 children, age group 26–35)

[He] just wanted to use the pull-out method or if I had contraception, he would say I'm being a slut. (Survey respondent, Pākehā/NZ European woman, nulliparous, age group 26–35)

Such behaviour is both an example of perpetrators' attempts to exercise power and authority over their partner's sexual experiences and bodies, and of male appropriation of women's sexual experience in order to mandate childbearing (Connell, 1987; Moore et al., 2010). However, women's resistance to their partners' attempts to circumscribe their decisions regarding their sexual and reproductive health is also apparent in these accounts, for example in their attempt to use contraceptives covertly. The monitoring of their sexual and reproductive behaviours by their partners, however, meant these behaviours were often discovered, and for many this resulted in further threats from their partners towards their sexual, physical, psychological,

economic, and sometimes spiritual safety. Participants recalled their partners threatening to abandon them if they did not become pregnant, or threatening further isolation from their support networks. For one survey participant, threats included referencing religious beliefs, namely that contraceptive use is akin to showing distrust in God. There were also several accounts of participants' partners threatening suicide and/or to harm or kill them if they did not become pregnant. Furthermore, alongside fear, some perpetrators also incited guilt and shame in order to attempt to coerce their partner into pregnancy, including the example from an interviewee of her partner falsely accusing her of having had an abortion, with another pregnancy being her only option for atonement.

For some participants in this research, this experience of guilt had a more specific connection to the enforcement of gender roles, therefore relating to the exertion of masculine power in the domain of labour (Connell, 1987; Moore et al., 2010). Participants shared various experiences of their partners referencing their gendered obligations to the relationship, such as using childbearing as a measure of love and commitment, and referencing the 'barefoot and pregnant in the kitchen' gender ideal. Many participants also experienced their partners using particularly gendered put-downs in the context of their attempts to access contraceptives, or expressing their wish to prevent or delay childbearing, for example use of the words 'slut', 'selfish', 'fat', and 'unmotherly'. These insults make reference to gendered stereotypes of women as maternal, selfless, and endlessly sexually available and appealing to their male partners (but no one else), and are used here perhaps in an attempt to incite worthlessness and inadequacy in the female partner, and thus to attempt to control their sexual and reproductive outcomes (Martin et al., 1999; Wingwood & DiClemente, 1997).

Some participants made more general references to their partners making them

'feel bad' about using contraceptives. Others experienced their partners attempting to implicate them in the reproductive coercion and other assaults made against them. Examples of participants' experiences of being blamed as victims include a survey respondent (a rape survivor) who was told by her partner that no one else would want her as she is 'damaged goods'. Another participant described how her partner poked holes in some condoms and mixed them up with undamaged condoms and saying 'good luck', thereby putting the onus on her regarding whether or not a damaged condom would be used during sexual intercourse.

These final examples relate to the complex situation apparent in many participants' accounts of having almost sole responsibility for birth control, and consequently holding the blame for any unintended or adverse reproductive or sexual health outcomes (including by some professionals) yet, at the same time, having to manage their partner's multiple attempts to circumscribe their sexual and reproductive decision-making. This is consistent with prior research into reproductive decision-making within partnerships underpinned by coercive control (e.g., Coker, 2007; Palitto & O'Campo, 2005; Wingwood & DiClemente, 1997).

### ***Experiences of reproductive coercion during sexual intercourse***

Participants in this research shared experiences of reproductive coercion during sexual intercourse that broadly fall into categories of non-consensual condom removal, sexual and physical violence, and intentional exposure to STIs. As with the analysis of the above accounts, reproductive coercion during sexual intercourse can be analysed as enactments of male power in order to control women's sexual and reproductive outcomes, and their labour.

One notable theme that emerged from participants' accounts of their partners' behaviour was non-consensual condom

removal during sex, either overtly or covertly, which, while not asked about directly in the survey, was mentioned 47 times by participants.

We were having sex using a condom and I saw him throw the condom over the other side of the room during us being intimate. He didn't say anything about it, wouldn't stop having sex with me after he had taken the condom off, and he knew I wasn't on the pill at that time and that I didn't want to become pregnant. (Survey respondent, Pākehā/NZ European woman, nulliparous, age group 36–45)

Others also described their partner tampering with condoms, and for some their partners damaging of condoms was only discovered later, for example after they became pregnant. These instances are examples of sexual violation (rape) because of the lack of explicit, voluntary and informed consent (Clark et al., 2008; Miller et al., 2007).

Multiple participants in this research described these forms of sexual violation as intended by their partners to cause pregnancy, and several also described violent rape by their partners, often following their partners discarding or destroying their birth control.

I was raped repeatedly till I was pregnant. This happened with my second and third child and four miscarriages in between. (Survey respondent, Pākehā/NZ European woman, 3–4 children, age group 26–35)

He forced me to have sex almost every day to get me pregnant. I never wanted to get pregnant. But I felt I had no choice, or he'd hurt or come after me if I didn't comply. (Survey respondent, Māori woman, 5–6 children, age group 26–35)

These examples can be analysed in relation to cathexis, with the male perpetrators'

apparent appropriation of these participants' sexuality and reproductive potential for their own objectives (Connell, 1987; Moore et al., 2010).

Physical violence (or the threat of) can also be understood through a similar analysis of men's attempts to exert power or authority over women's bodies. Participants in this research described their partners' use of physical violence as a form of punishment in the context of them discovering their use of contraceptives (or sometimes even merely expressing their desire to use some form of contraception), or the violent removal of long-acting reversible contraceptives (LARCs), such as the intrauterine device (IUD).

I was 18 and my partner, 28, gave me the bash and strangled me till the blood vessels in my eyes burst because he found my contraceptive pills in my bag. (Survey respondent, Māori woman, 6+ children, age group 36–45)

He would throw away my birth control pills. I then, with help from my doctor, managed to secretly get an IUD which was fine for a while until he discovered it in which he then forcefully ripped it out of me. Once I fell pregnant, he then refused to let me have an abortion. (Survey respondent, Pākehā/NZ European woman, 1–2 children, age group 26–35)

My first love and father of my five children would beat me if I ever suggested using condoms, and beat me twice when I went on the depo [Depo Provera]. (Survey respondent, Māori woman, 5–6 children, age group 16–25)

In these situations, these female participants were attempting to assert or act according to their reproductive decisions and intentions. Their partners' behaviour in response to their attempted enactment of their reproductive autonomy reveals the extent of these partners' efforts to establish control

over their sexual and reproductive outcomes (Martin et al., 1999; Moore et al., 2010).

Finally, almost half (45%) of participants in this research had experienced a partner intentionally exposing them to an STI, namely, their partners had known about having an STI but had not disclosed this to them and had proceeded to have unprotected sex with them, or removed the condom without their consent.

He took off the condom part way through sex without me agreeing, and I later found out he had given me an STI. I had a clean STI check before this happened. I didn't know about the STI until I ended up in hospital with complications from it. (Survey respondent, Pākehā/NZ European woman, nulliparous, age group 36–45)

He had chlamydia (thanks to the numerous women he had cheated on me with) and found out from one of them but didn't tell me. Weeks later she contacted me herself to let me know. That infection has severely compromised my fertility and am now going through my 3rd round of IVF (with a different partner, my now husband) to try to have a baby. It feels like this has ruined my life. (Survey respondent, Pākehā/NZ European woman, nulliparous, age group 26–35)

The use and threat of sexual and physical violence, intentional exposure to STIs, and the non-consensual removal of condoms during sex is an enactment of male power, and may also have been an attempt by these participants' partners to exacerbate power inequalities and limit sexual and reproductive autonomy through the use of fear (Palitto & O'Campo, 2005).

In these examples from participants, sexual intercourse essentially becomes an experience where they are used as a means to their partners' sexual and reproductive ends via a range of behaviours intended to circumvent, undercut and directly contradict their thoughts, intentions and decisions

about their sexual and reproductive experiences and future.

### ***Experiences of reproductive coercion post-conception***

For participants who experienced pregnancy, many also experienced their partners' attempts to control the outcomes of their pregnancy. About two fifths (40.5%) of participants had experienced a partner preventing them from accessing an abortion, and just under one third experienced a partner attempting to induce miscarriage or force them to get an abortion.

Every time I tried to book an appointment [for an abortion] he would threaten me or make wild accusations that I only wanted to abort because I cheated. I never cheated on him. He threatened to stab me and the baby to death if I tried to abort. (Survey respondent, Māori woman, 5–6 children, age group 26–35)

[He] hid my keys to prevent me leaving the house and took my wallet so I had no way to pay for other travel and also called me a murderer. (Survey respondent, Pākehā/NZ European, non-binary, nulliparous, age group 26–35)

He told me that if I had an abortion that he would take me to court to get custody of my eldest child. He is a defence lawyer so I was worried he would definitely win. I felt I had no other choice. (Survey respondent, Pākehā/NZ European woman, 1–2 children, age group 26–35)

He would threaten me [that] if I kept the baby, he would kill me. He went around telling everyone the baby isn't his, he would elbow my lower stomach and hit it so I'd have a miscarriage. (Survey respondent, Pākehā/NZ European woman, pregnant at time of survey, age group 26–35)

My ex tampered with condoms then bullied me into terminating. (Survey

respondent, Pākehā/NZ European woman, 3–4 children, age group 26–35)

I was pushed when I was 12 weeks pregnant into the corner of a couch, when he was the one who convinced me to "not use protection" and "he wanted a baby". That day he said it was all a mistake, this baby is a mistake. (Survey respondent, Pasifika woman, 3–4 children, age group 26–35)

Participants also shared experiences of their partners attempting to exercise authority and control over their experiences during labour and delivery, and during their post-partum recovery (Connell, 1997). These experiences included participants' partners expressing jealousy over the attention they received during their labour and delivery, scolding them for overreacting, ignoring them, taking their pain medication, and attempting to redirect the attention onto themselves (one interviewee, for example, shared her experience of her partner preventing her from breastfeeding and kissing her infant). Furthermore, 64.2% of participants experienced their partners impeding their recovery from birth, miscarriage or induced abortion, often through rape, forced domestic labour, and neglect.

[He] forced sex, made me tend to his every need, would wake me up if I was asleep, said things like "it shouldn't be that hard for me why am I finding it so hard?", would go out and leave me alone with the older kids and a new baby, didn't care that I had mastitis or was sick and wouldn't help me take care of the children. (Survey respondent, Pākehā/NZ European woman, 3–4 children, age group 26–35)

After my C-section, which had major complications, the day I got home I was told I was lazy and needed to clean the house and put washing away and sort the kids even though I was told to be in bed rest. (Survey respondent, Pākehā/NZ European woman, 5–6 children, age group 26–35)

I had c-sec with first. He left me at the hospital. I was expected to cook and clean straight after I got home (I opened the stitches and had to be restricted). He wouldn't take me to the doctor or allow me to contact midwife. It was a whole night before midwife came back to check on me, I have lasting nerve damage because of it. He raped me after each birth far too early after. With [the] second [child], I had very severe tearing, he broke several of the stitches. I still have pain during sex because of this. (Survey respondent, Pākehā/NZ European woman, 3–4 children, age group 26–35)

These accounts also represent perpetrators' attempts to exercise power over the labour domain of gender relations through, for example, forced sexual intercourse and forced domestic labour, which resulted in severe and chronic pain and scar tissue for some women (Connell, 1997).

### *Experiences seeking support*

This can be a major way that women are controlled by their partner, but one of the hardest to talk about. It can impact their whole lives. [...] I would have had more options to leave or seek help if I had not been constantly pregnant and breastfeeding. (Survey respondent, Pākehā/NZ European woman, 6+ children, age group 36–45)

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

Many participants experienced their partners controlling their access to pregnancy support, care and counselling, including partners cancelling appointments

and check-ups, controlling access to special diets and other recommendations from health professionals. This restricted access to support entails that any risks associated with their pregnancy may not have been identified, and access to health care support may have been delayed. This research also explored the experiences of participants who did access healthcare and other support, including whether they were provided the opportunity to disclose the abuse and reproductive coercion by their partner. Under one third (29.7%) of participants had experienced a professional specifically asking if they were being abused by their partner when seeking pregnancy or contraceptive support. Only 3.6% had experienced a professional specifically asking about whether they were experiencing reproductive coercion from a partner.

Participants noted that the opportunity to be asked sensitively and non-judgementally if they were being abused, without their partners present, was important. Timing was also highlighted as an important factor in participants' ability to disclose abuse, namely not asking abuse survivors if they were being abused if they were in a state of heightened stress and fear.

For some participants who were asked by a professional about abuse, they had not yet gained a perspective that their partners' behaviour was abusive, especially if their partner had not been physically violent. Importantly, this suggests that professionals' ability to provide more information and context around specific behaviours indicative of abuse and reproductive coercion may also enable disclosure. Providing accurate information and insight into reproductive coercion was also noted as important by participants, especially given that the vast majority did not seek support or advice from professionals for reproductive coercion.

Overall, participants' suggestions for how screening of both IPV and reproductive coercion could be approached, and how

disclosures could be responded to by professionals include:

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

These suggestions from participants indicate a need for professionals to ask about people's level of comfort in making decisions regarding their sexual and reproductive health and rights (SRHR), including contraception. Professionals may also attempt to gain a greater understanding

of SRHR more generally, including access to abortion care and different contraceptive options, and foster greater collaboration and referral pathways to SRHR specialists.

## Conclusion

This research was the first to explore the issue of reproductive coercion in Aotearoa New Zealand with a targeted sample of individuals who self-identified as having experienced it, thus these findings are not representative of the New Zealand population generally. The findings discussed above of 111 survey participants and five interviewees revealed that over 80% of participants had experienced a partner controlling access to contraceptives, over 60% experienced a partner coercing or pressuring them into pregnancy, and just under 60% experienced a partner tampering with contraceptive methods.

These three types of behaviours were key features of reproductive coercion identified in the literature, alongside some research looking into abortion control and coercion by intimate partners which was also experienced by participants in this research. Many women in this research experienced a partner controlling their access to an induced abortion (40.5%), and over 30% of participants in this research experienced a partner intentionally trying to bring about a miscarriage or force them to get an induced abortion. Furthermore, close to half experienced a partner intentionally exposing them to an STI, and many experienced a partner controlling or preventing their access to pregnancy care and support. Many women in this study also experienced a partner using coercive and abusive behaviours during labour and delivery, and post-partum recovery.

These findings reveal that reproductive coercion as a tactic of intimate partner violence and coercive control warrants further investigation amongst the general population, as well as targeted groups, such as LGBTQI+ individuals. The findings of

this research, given respondents largely identified as women who had been abused by their male partners, also suggest that there are particularly gendered power dynamics integral to this phenomenon. These gendered power dynamics are linked to the enforcement of gender roles, stereotypes, and sexual mores that are ultimately used by perpetrators in an attempt to circumscribe women's reproductive autonomy. Generally, professionals, including those in social support and healthcare sectors, and their clients would benefit from a greater understanding of the dynamics and impacts of reproductive coercion to enable better responses to victims, and to prioritise their sexual and reproductive health, wellbeing and autonomy.

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