

# Safeguarding for reproductive coercion and abuse

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During the debates around whether or not telemedical abortion could continue in the UK permanently, concerns were raised that this would increase the risk of coerced abortions. These concerns, often promoted by anti-abortion organisations,<sup>1 2</sup> help draw attention to two linked issues. First, there has long been awareness about some of the risks of reproductive coercion and abuse (RCA), but the issue in the UK has not been widely explored. Second, the continuing stigmatisation of abortion leads to differential understanding and regulatory control from other reproductive healthcare services, such as maternity care.

Currently, there is no singular definition of RCA in widespread use.<sup>3</sup> It is used in relation to issues such as state or institutional policies, such as the forced sterilisation of marginalised people, as well as situations of intimate partner violence.<sup>4</sup> Here we focus on the latter, and specifically are interested in situations where the perpetrator *intentionally* uses power and control to prevent, promote or control pregnancy in the victim.<sup>3</sup> RCA operates through abuse, coercive control, threats, and violence. As well as RCA from partners, perpetrators can include other family members, who use power, control or force to influence reproductive decision-making.<sup>5</sup> While RCA commonly occurs in the context of other forms of interpersonal violence, it can occur on its own, and this may be particularly the case where there are familial expectations around reproduction.

There are a variety of actions that constitute RCA, and it is useful to divide them into pregnancy promoting and pregnancy preventing methods of control.<sup>3</sup> Pregnancy promoting behaviours include throwing away contraceptive pills, intrauterine devices being forcibly removed, and lying about male infertility. Pregnancy preventing RCA can include excessive monitoring of pill usage, abortion coercion, and pressure to accept a contraceptive implant or undergo sterilisation.<sup>6</sup> As a form of coercive control, RCA can include the micromanagement of

everyday aspects of reproductive healthcare, including interactions with healthcare professionals.<sup>7</sup> Importantly, a systematic review found it is more common for there to be RCA to continue a pregnancy than abortion coercion.<sup>8</sup> This raises questions as to why abortion is often the focus of concerns around RCA, with less attention paid towards safeguarding for RCA in maternity services. This is most likely due to cultural understandings about childbearing.

Despite growing acceptance of diversity in family life, heteronormative understandings about families are still prominent cultural values.<sup>9</sup> This includes cultural expectations that generally women should want to have children, be the primary caretakers, and are subject to greater judgement should they not perform to 'good motherhood' expectations.<sup>9</sup> While there are cultural variations in 'good motherhood' expectations, pronatalism is still common across different ethnic and national communities.<sup>10</sup> It is not uncommon for women to be asked to justify or explain the absence of children, whereas families with children are rarely asked why they chose to have them. These factors shape policy, practice and law surrounding abortion.

The paternalistic 1967 Abortion Act was designed to give doctors control over access to abortion. The debates at the time clearly frame motherhood as the normal pathway for pregnancy, with abortion as a necessary exception in specific circumstances. Even today, this framing continues as while all medical interventions require informed consent, there is enhanced emphasis on abortion service providers to check women's decision-making. For example, embedded in standard operating procedures is an instruction for abortion service providers to provide access to counselling, yet there is no similar requirement for maternity services. In other words, the regulatory framework assumes that those booking into maternity services are unlikely to need decision-making support, whereas this cannot be assumed about those presenting to abortion



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services. Yet, uncertainty and ambiguous feelings towards pregnancy are fairly common, and not confined to those considering abortion.<sup>9</sup> Moreover, the surrounding legal framework still codifies medical paternalism through requiring two doctors to certify that one of the grounds for abortion is met, rather than just requiring informed consent from patients in line with other healthcare services.

The policy concerns over RCA and telemedicine abortion are a further illustration of abortion exceptionalism. Despite healthcare professionals reporting that they are able to recognise behavioural indicators such as changes to tone of voice and language during telemedicine consultations,<sup>11</sup> and an increase in safeguarding disclosures in British abortion settings when the telemedical service was introduced,<sup>12 13</sup> many policymakers have raised objections to continuing the service because of concerns that safeguarding responsibilities would not be as effective during virtual consultations. This was particularly the case for telemedicine for young people, despite evidence that the move to online sexual health services, which in some cases pre-dated COVID-19, had also increased safeguarding disclosures.<sup>12 14</sup> Moreover, these concerns are based on a false assumption that the right physical setting for a consultation is the key to ensuring safeguarding disclosures, despite the evidence that disclosure will not happen until abuse victims are ready to do so, even if they are asked direct questions and are aware of the support available to them.<sup>15</sup> Perpetrators do not have to be present to exert coercive control.

RCA is a serious and significant issue and all reproductive healthcare settings, including maternity services, need to have safeguarding processes and procedures that facilitate disclosure and offer appropriate support. Providing information and screening helps raise awareness of interpersonal violence, including RCA, and ensures that healthcare settings are seen as places where disclosure can take place. However, disclosure of abuse is a process rather than an event, and it will only happen when people are ready to seek support. The framing of abortion as a decision that needs scrupulous checking arises from cultural understandings about women and motherhood. This means that abortion coercion is given a higher profile than forced pregnancy, even though the evidence suggests the latter is more common.<sup>8</sup>

It is important that there is more research and awareness of RCA to ensure that reproductive healthcare settings can improve safeguarding. However, focusing solely on abortion, and telemedicine in particular, shows a lack of understanding of the evidence and reinforces the stigmatisation of abortion.

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