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Author/s:

Tarzia, L;Wellington, M;Marino, J;Hegarty, K

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# How do health practitioners in a large Australian public hospital identify and respond to reproductive abuse? A qualitative study

Laura Tarzia,<sup>1,2</sup> Molly Wellington,<sup>1</sup> Jennifer Marino,<sup>3</sup> Kelsey Hegarty<sup>1,2</sup>

**R**eproductive abuse is a form of violence against women that has only recently been identified in research, policy and practice.<sup>1</sup> Defined as a deliberate attempt to influence or interfere with a woman's reproductive autonomy and decision-making,<sup>2</sup> it is also known within the literature as 'reproductive coercion'.<sup>1</sup> Reproductive abuse typically takes one of three forms: the use of violence or coercion to force a woman to become pregnant against her will (pregnancy coercion); tampering with, or removing a woman's birth control (contraceptive sabotage); and attempting to control a pregnancy outcome (forcing a woman to terminate a wanted pregnancy, or to continue an unwanted one).<sup>1</sup> It is usually perpetrated by a male intimate partner or ex-partner, although other family members can also be perpetrators.<sup>3,4</sup> Although the term 'reproductive coercion' is more commonly used in the extant literature, we have argued that 'reproductive abuse' is a more appropriate term, since it highlights the intentionality of the behaviour and the mechanisms of fear, power and control that are central to this gendered form of violence.<sup>5</sup> There is a dearth of research, both in Australia and internationally, aiming to understand reproductive abuse. However, studies do suggest that it has strong associations with intimate partner violence (IPV) and unintended pregnancy.<sup>2,6</sup> There is also a strong case to be made for its relationship with intimate partner sexual violence, although this association has been largely

## Abstract

**Objective:** Reproductive abuse is defined as a deliberate attempt to control or interfere with a woman's reproductive choices. It is associated with a range of negative health outcomes and presents a hidden challenge for health practitioners. There is a dearth of research on reproductive abuse, particularly qualitative research. This study aims to address this gap by exploring how health practitioners in a large Australian public hospital identify and respond to reproductive abuse.

**Methods:** We conducted semi-structured interviews with n=17 health practitioners working across multiple disciplines within a large metropolitan public hospital in Victoria. Data were analysed thematically.

**Results:** Three themes were developed: Figuring out that something is wrong; Creating a safe space to work out what she wants; and Everyone needs to do their part.

**Conclusions:** Practitioners relied on intuition developed through experience to identify reproductive abuse. Once identified, most practitioners described a woman-led response promoting safety; however, there were inconsistencies in how this was enacted across different professions. Lack of clarity around the level of response required was also a barrier.

**Implications for public health:** Our findings highlight the pressing need for evidence-based guidelines for health practitioners and a 'best practice' model specific to reproductive abuse.

**Key words:** reproductive coercion, health practitioners, qualitative methods, violence against women

neglected within the literature. Reproductive abuse may also exist in relationships in which no other forms of violence are present.<sup>2,7</sup> This complexity makes it difficult to identify and measure reproductive abuse and may explain why few studies to date have examined its prevalence on a large scale. In the US, where the majority of reproductive abuse research has been conducted, prevalence rates have ranged between 8%<sup>8</sup> and 24%,<sup>9</sup> and the types of behaviours included in these studies has varied. In Australia, one cross-sectional study in a general practice population found that

around 10% of women had experienced a partner trying to force them to become pregnant or interfering with birth control,<sup>10</sup> although again this does not represent the full scope of reproductive abuse. There is also a lack of qualitative evidence – from women, men and practitioners – that could help to unpack and more clearly conceptualise reproductive abuse as a unique phenomenon.

Research suggests that reproductive abuse may be linked to a range of negative physical and mental health outcomes.<sup>1</sup> These

1 Department of General Practice, The University of Melbourne, Victoria

2. Centre for Family Violence Prevention, The Royal Women's Hospital, Victoria

3. Department of Obstetrics & Gynaecology, The University of Melbourne and the Royal Women's Hospital, Victoria

**Correspondence to:** Dr Laura Tarzia, Department of General Practice, The University of Melbourne, 200 Berkeley Street, Carlton, Victoria 3053; e-mail: laura.tarzia@unimelb.edu.au

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include sexually transmitted infections,<sup>11</sup> pelvic inflammatory disease,<sup>12</sup> pregnancy complications,<sup>7</sup> repeated or unsafe abortions<sup>7</sup> and mental health conditions such as post-traumatic stress disorder.<sup>13</sup> In addition, women may also experience health problems associated with co-occurring IPV and sexual violence. Consequently, it is not surprising that women who have experienced reproductive abuse are more likely to use health services than women who have not.<sup>14</sup> The critical role of health systems in responding to violence against women has been repeatedly acknowledged in the extant literature,<sup>15,16</sup> although little is known about the health system's response in the specific case of reproductive abuse.<sup>17</sup> Studies in the IPV context more broadly suggest that women trust health practitioners and are willing to disclose to them, providing they receive a non-judgemental, empathetic response.<sup>18</sup> A number of promising interventions in a range of settings<sup>19-21</sup> confirm that health practitioners can respond effectively to women experiencing IPV if they receive appropriate training and education. In the context of reproductive abuse, however, there is a lack of evidence (and none from Australia) to support 'best practice' responses. We know very little about whether – and how – health practitioners identify and respond to reproductive abuse, or what challenges they might experience in their work.

## Objective

In this article, we report on the findings from a qualitative study conducted with health practitioners working at a large public hospital in the state of Victoria, Australia. The study broadly aimed to explore how health practitioners understand and respond to reproductive abuse in their female patients. Elsewhere<sup>5</sup> we have described how the practitioners understood and conceptualised reproductive abuse. In this article, we aim to explore how they respond to it as part of their everyday practice, addressing a critical gap in the literature and taking a step towards building an evidence base to support best practice guidelines.

## Methods

### Study setting

The participating hospital is one of the largest providers of women's health services in Australia and it has a key focus on violence

against women. The study was conducted within the women's cancer and gynaecology branch, which covers women's health, sexual assault, pregnancy counselling, abortion and reproductive services. Our findings, therefore, primarily focus on reproductive abuse in the context of unplanned pregnancy, abortion and sexual assault. Antenatal services were not included in the study as they sit within a different department.

The hospital is one of the few public providers of both medical and surgical abortion services in Victoria; most terminations in the state are carried out by private clinics (medical and surgical) or general practitioners (medical only). At this hospital, women with a healthcare card (typically low-income earners or women experiencing other vulnerabilities) can access fee-free services. In the state of Victoria, medical abortion can be performed anytime up to nine weeks' gestation, and surgical abortion is legal before 24 weeks' gestation.<sup>22</sup>

### Participant recruitment

Once the study had been approved by the hospital's ethics committee and the director of the women's cancer and gynaecology section, we approached managers of the individual clinics. Managers either distributed the study expression of interest (EOI) forms directly to clinic staff or invited the researchers to attend team meetings to discuss the study and distribute EOI forms. Staff members who wished to participate contacted the researchers directly to receive more information and to arrange an interview time; their managers were not informed about who chose to take part.

### Data collection

Interested health practitioners were invited to participate in a semi-structured interview with Author 2, either on the phone or face-to-face at the hospital. Interviews took place between July and September 2017. The use of a semi-structured interview guide enabled a balance between obtaining detailed data around responses to reproductive abuse, while also containing the interview into a manageable timeframe. For the section of the interview that focused on responses to reproductive abuse, participants were asked questions such as: "Can you tell me about your personal experiences treating women who have disclosed, or whom you suspect, have experienced reproductive

coercion?"; and "How would you describe the best practice response to women experiencing reproductive coercion?" The term 'reproductive coercion' was used in the interview context to facilitate participant understanding. Our full interview guide is reported elsewhere.<sup>5</sup>

Interviews ranged in length from 13 minutes to one hour, with the average length being 35 minutes. All interviews were audio recorded and transcribed verbatim for analysis.

### Data analysis

We chose thematic analysis as our method as it provides greater freedom to explore new ideas and concepts within the data.<sup>23</sup> We used a step-by-step inductive coding process as outlined by Braun and Clarke.<sup>24</sup> Author 1 immersed herself in the data by reading and re-reading the transcripts and taking notes. Initial descriptive codes were then generated focusing on the health practitioners' responses. These were then grouped to form interpretative codes representing deeper layers of meaning within the data. Lastly, these interpretative codes were grouped together to form common themes across the dataset. At this point, cross-coding of selected transcripts was undertaken by other members of the research team (Authors 2 and 4) to maximise rigour before development of the final coding framework. NVivo 11<sup>25</sup> was used to facilitate these processes.

### Ethical considerations

The study was approved by the hospital's Human Research Ethics Committee (HREC) as a Quality Assurance activity per National Health and Medical Research Council guidelines.<sup>26</sup> We did not offer any incentives to health practitioners. Managers were not informed about staff participation. Prior to commencing all interviews, informed consent was obtained from participants in writing via a consent form and plain language statement.

## Results

Seventeen health practitioners took part in this study. All were women, reflecting the staff profile of the hospital. Participants included social workers, doctors, nurses, midwives and counsellors. All had at least five years' experience in their respective fields (most had between 10 and 20 years' experience). Through our analysis, three main themes were developed that describe how health

practitioners responded to reproductive abuse: Figuring out that something is wrong; Creating a safe space to work out what she wants; and Everyone needs to do their part. These are outlined in detail below.

### Figuring out that something is wrong

Many of the health practitioners outlined a primarily intuitive process for determining whether a woman might be experiencing reproductive abuse. Described in ways such as “listening to your gut” or “getting a feeling”, this intuition could strike practitioners at various points along the woman’s help-seeking trajectory, including during an initial phone consultation, when making an appointment or during the consultation itself.

*You just get a general sense that something is just not quite right.* (Participant 10, Social worker)

*You can tell that there’s something there if they pause ... when someone pauses when you ask that question [about violence], you go, ‘This is now going to be a long consultation.’* (Participant 13, Doctor)

*It’s that stuff about picking up on the vibes really.* (Participant 14, Nurse)

Often, it was the behaviour of a woman’s male partner, or hers towards him, that alerted health practitioners to something being amiss in the relationship. Many women presented for consultations at the hospital with a partner or made an initial telephone contact with the partner in the room.

*The guy answers the questions, or the woman often won’t make eye contact, or looks away when you’re asking her questions. Or hesitates and allows the partner to answer.* (Participant 3, Midwife)

*On the phone, quite often women – especially if you’re aware a male has rung in on their behalf – quite often they’ll have the phone on loudspeaker and you can tell, it echoes ... It’s hard to describe it, but you can pick up in their tone or in their responses, whether there seems to be some sort of threat.* (Participant 10, Social worker)

For the social workers who provided pregnancy counselling, determining whether a woman’s decision to terminate a pregnancy was made autonomously was of paramount importance. Being alert to any potential uncertainty around these decisions, as well as noticing any interference from a partner or other family member, was a key part of the initial intake process and consultation.

*We would ask: ‘Are you clear in your decision? Have you had any difficulties in your decision? How have you come to this decision? Did you make this decision on your own or in consultation with other people? Who are you pregnant to? What’s your relationship with them like? Do you feel safe in that relationship?’ Often these kinds of questions will illuminate if there are issues.* (Participant 16, Social worker)

*We do always try and ask, ‘What’s brought you to that decision? Who’s the man involved? What’s your relationship like?’ Throughout those kinds of conversations, it can become clear that, actually, ‘I don’t want to do this [have an abortion] but I feel like I have no choice because he wants me to.’* (Participant 15, Social worker)

The majority of the practitioners interviewed, in all disciplines, felt that this level of intuition and insight was only able to be achieved through years of experience.

*I think that it is a skill that practitioners learn ... I pay a great deal of attention ... If you’d asked me this question 18 years ago, I would not have been as good.* (Participant 1, Doctor)

*I think also you just get better at these things over time, non-verbal things – which sounds silly [when you’re talking about a conversation] over the phone, but you can, you can hear non-verbal hints.* (Participant 8, Social worker)

*I think you kind of learn it on the job a bit. I know I’ve sat in on workshops and learnt, but actually probably learnt more by experience.* (Participant 9, Nurse)

### Creating a safe space to work out what she wants

Participants emphasised the importance of creating an environment within the patient encounter where women felt safe and supported. Practical aspects for some practitioners included ensuring that women were always seen or spoken to on their own, without a partner or family member present, even if they were accompanied to the consultation:

*Very often in our service, someone will try and call on someone else’s behalf and try and make an appointment [for an abortion], but we do not do that, we need to speak to the person who wants to make the appointment. Sometimes that’s quite well meaning, sometimes it’s just that it’s a friend or a relative and the person’s distressed or embarrassed ... But we just don’t, that’s our blanket thing,*

*we don’t even make appointments if a doctor calls ... we need to speak directly with the person.* (Participant 8, Social worker)

*Even if someone has brought [a woman] in, we greet them at the waiting area and we always say, ‘Look, we need to talk to her and this is our policy. This is just what we do with everyone’. We always meet with women on their own, just so that they have that opportunity to have that safe, confidential space.* (Participant 15, Social worker)

In terms of practitioners’ interactions with women they suspected of experiencing reproductive abuse, a range of strategies were used to promote a sense of safety. Most were focused on trust-building and non-judgemental communication, emphasising privacy and confidentiality.

*People will disclose ... if they feel like you’re open and you’re not judging them and you’re interested in what they’ve got to say and you’re there to support them and they feel safe ... And if they feel like you might be able to help them, that’s the other thing. It’s all of those things combined.* (Participant 1, Doctor)

*If you demonstrate that you’ll make the time and demonstrate that you’ll ... that you actually do want to listen and you’re real about that, and you work really hard to make things safe for people, then they’re more likely to disclose.* (Participant 5, Counsellor)

*Letting them know, I guess, that this is a part of the work that we do and this is a safe space. We would talk to them about confidentiality – that we want to respect their privacy and their confidentiality.* (Participant 15, Social worker)

Participants felt they had a key role to play in both naming the violence and helping women to feel that they were not alone in experiencing it.

*I try and normalise it [reproductive abuse] and let them know that it happens more than they’d think. In the same way that I normalise abortion, because reproductive [abuse] does happen a lot.* (Participant 8, Social worker)

*We need to be able to say what it is ... Yes, this is violence, it’s not okay, it’s not your fault, it’s never your fault. And we need to actually work on not blaming women.* (Participant 5, Counsellor)

The majority of the health practitioners also emphasised the importance of being woman-led and woman-focused in their approach to responding to reproductive abuse. At all times, the woman’s decisions about whether

to terminate or keep a pregnancy, whether to stay or leave an abusive relationship, or what type of strategies she might use to protect herself in the future, were prioritised.

*We're not dictating which way they're going to go. If they decide they want to continue the pregnancy, well, you know, that's fine with us. If you want an abortion that's fine too.* (Participant 9, Nurse)

*We've just got to be careful of not, you know, over compensating and then stepping in for there to be some systems abuse as well. Women are experts in their own lives ... they will feel free to discuss that with you if you ask in an appropriate way.* (Participant 7, Social worker)

*We're not here to be the Spanish inquisition. You have to be supportive and this has to be their safe place, they have to feel safe to tell us about [reproductive abuse] ... It's about giving them alternatives and saying, "What would you like to do about it? How can we help?"* (Participant 12, Doctor)

### Everybody needs to do their part

This theme emphasised the importance of the whole-of-organisation approach to addressing reproductive abuse. Participants mentioned issues such as time management and the need for reflective practice to be able to do their work effectively. More specifically, several participants felt strongly that multidisciplinary collaboration across the hospital was essential to providing an effective response, given that reproductive abuse incorporates both medical and psychosocial elements. Clear communication and a willingness to work together to support shared patients were key ways that this collaboration was enacted.

*I guess [it's important] for the doctors to know that they can have that support from us, as social workers, to be able to spend more time with a woman. So they might work on the clinical issues that are relevant, whereas we can spend more time looking at other psychosocial issues.* (Participant 16, Social worker)

*The doctor might see a partner in the room who's not particularly helpful, and say, "Look I'm just worried about this, can you come up and you know, screen this woman separately?" So sometimes it [disclosure] doesn't happen here [in the social work department], it happens when they get to clinic, and then sometimes it doesn't happen until they get to the day surgery unit, where they're saying, "This isn't even my decision*

*and I don't want to do this!"* (Participant 7, Social worker]

Making and enacting collaborative plans was seen as a key way to support women experiencing reproductive abuse. In some cases, this involved organised deception towards a coercive partner or family member in order to uphold a woman's decisions regarding a pregnancy, while also keeping her safe.

*A plan was created between the doctor, the patient ... and myself around how we could support her to continue the pregnancy ... She was planning to go home and tell her partner that she had taken the tablets for termination, and then about a week later, she was going to say to him that she didn't think it was working. We had also booked in what we called a 'review' appointment, but ultimately it was for her to be able to return to the hospital in about three weeks' time, to make sure she was still OK with her decision and make sure she was safe and go from there. The hope was that this would make her over the 12-week mark and she was fairly certain that once she made 12 weeks, even though her partner would not be happy, her father-in-law would be supportive and wouldn't allow a termination to occur.* (Participant 10, Social worker)

On the negative side, a range of issues were identified by participants that could impede effective multidisciplinary collaboration. Several felt that there was a lack of shared understanding across the different disciplines and departments in the hospital about how to define, identify and respond to reproductive abuse.

*There are some barriers in terms of ... there's perhaps not a shared understanding about what reproductive [abuse] or assault is.* (Participant 11, Nurse)

*I don't know if you'd find consistency between the different practitioners. Yeah, there would be different ways and means of approaching it [reproductive abuse].* (Participant 17, Doctor)

This lack of shared understanding was particularly evident in the context of the sexual assault service within the hospital. Practitioners working in the sexual assault service perceived that very few women were referred to them from elsewhere in the hospital, and that there was a lack of collaboration in cases of reproductive abuse.

*Given what we know about the statistics and given what we know about how much sexual assault is perpetrated within relationships,*

*and given a victim/survivor's capacity to make decisions freely about her reproductive rights – no. I don't think we get a lot of referrals from the [rest of the] hospital ... Surprisingly few, actually.* (Participant 6, Counsellor)

One practitioner suggested that this might be because women experiencing reproductive abuse were not ready to name their experiences using the terms 'sexual assault' or 'rape'.

*When we're talking about reproductive [abuse], sometimes it can be a step beyond what a woman is feeling comfortable to say, that ... this might be considered sexual assault ... They're not ready to hear that. That's too confronting. So to think about linking in with [the sexual assault service] is actually too much.* (Participant 15, Social worker)

Within the hospital there were also conflicting opinions about how far the health practitioner's role ought to extend in terms of supporting women. For some, identification and referral was perceived as sufficient:

*The best advice I could give would be to offer a referral to a social worker or counsellor, because often as a midwife we don't have the time or the skills to sit down and talk through something like that.* (Participant 3, Midwife)

*I'd generally call [social work support] – only because it's a really busy clinic, so we don't have time to be doing the counselling and it's not actually my role to be doing the counselling, but it's my role to pick up that this decision is not yet unanimous from the patient's perspective.* (Participant 17, Doctor)

For others, identifying reproductive abuse was not perceived as being an appropriate part of their work at all, even if a clear disclosure of violence would have been responded to as a part of routine practice:

*Women often don't identify it as coercion, and it's not up to me as a clinician to actually try and persuade them either way.* (Participant 11, Nurse)

*Somebody coming here [to the abortion clinic], my assumption is that they've made a decision that this is what they want to do. So I don't generally bring that up ... That's not a question I ask somebody at the time of it. I figure if somebody's here, I'm going to put in as little obstruction as I possibly can in their process.* (Participant 14, Nurse)

This view was contested by other participants, however, who felt that responding to reproductive abuse should be everyone's responsibility:

*I think everyone should be having the conversation ... everyone should be asking [about reproductive abuse], and asking explicitly, not just waiting for tears or bruises or someone being uncomfortable. (Participant 8, Social worker)*

For the majority of the social workers, a range of emotional and practical supports were highlighted as being part of a 'best practice' response. These included helping a woman to navigate the complex system of external IPV services and ensuring her safety. For doctors, responses mostly involved helping to arrange safe contraception to prevent future unwanted pregnancies:

*We actually sat together here last week after she'd attended her appointment [for termination], and we rang [domestic violence crisis service], and then we rang [another domestic violence family service] ... I just feel like it's so important that she has that support so that she can get through the aftermath of today and then think about how she's going to safely end her relationship. (Participant 16, Social worker)*

*You have to do lots of safety planning around, "well now you're going to have a continuing pregnancy, what's this going to mean, will it escalate the violence?" And do lots of stuff to make sure that person leaves the hospital with all the supports in place that they need, which can take hours of time. (Participant 7, Social worker)*

*You have to work out a way of organising contraception that he [abusive partner] doesn't know about ... You just cut the IUD strings really short. Or you use Depo Provera injections. (Participant 12, Doctor)*

## Conclusions

This study provides initial insight into the range of ways that health practitioners working in a large Australian public hospital with a focus on violence against women identify and respond to reproductive abuse, particularly in the context of unplanned pregnancy and abortion. With increasing recognition that interventions and responses to violence against women need to be tailored,<sup>27</sup> understanding how health practitioners address specific types of violence is critical. Currently, very little is known about what 'best practice' might look like in the context of reproductive abuse, despite global acknowledgement that women's reproductive autonomy is an important human rights issue.<sup>28</sup> Although

the American College of Obstetricians and Gynaecologists<sup>29</sup> and the US organisation Futures Without Violence<sup>30</sup> have developed some guidelines for clinicians, not all the recommendations are informed by robust evidence for effectiveness. Furthermore, it is unclear to what extent the guidelines might inform what actually happens in practice, particularly in the Australian context.

For the participants in our study, intuition and 'gut feelings' were central to identifying women experiencing reproductive abuse. The practitioners' intuitive approach appeared to be used both instead of and additional to routine screening, depending on which department the participant worked in. Some health practitioners did not have a policy of routine screening for reproductive abuse or other types of violence. Practitioners working in pre-abortion counselling, however, clearly stated that they asked all women presenting for a termination about safety and decisional conflict. This policy is in line with current recommendations around universal screening in high-risk settings, based on its effectiveness in the antenatal context.<sup>31</sup> As yet, however, we do not have an actual evidence base to support universal or routine screening in the abortion setting itself; consequently, it is unknown whether it is more effective than usual care or a 'case finding' approach when indicators are present. Indeed, several practitioners in our study mentioned that the intake screening questions did not always elicit a disclosure from women, necessitating an approach that aligned more with case-finding. More evidence is needed to understand how each of these methods works in the abortion setting and why, in order to inform best practice guidelines.<sup>32</sup>

Participants stated that the ability to pick up on subtle body language and conversational cues that might indicate the presence of reproductive abuse was something that came only from years of practical experience in the workplace. Yet, interventions in general practice<sup>19</sup> and maternal and child health<sup>20</sup> suggest that health practitioners can be upskilled in identifying and responding to violence. In Australia, however, learning how to identify and respond to interpersonal violence is not yet a part of standard clinical education in most professions, including for doctors and nurses.<sup>33</sup> Effective ways of imparting clinical knowledge to junior practitioners need to be explored, including observation and shadowing to give them

opportunities to see these skills in action. Cross-disciplinary training and shared education between psychosocial/counselling services and clinical services may also be helpful.<sup>34</sup>

Once reproductive abuse was identified in a patient, the participants emphasised the importance of creating a safe space that would facilitate women being open about their needs and wishes. For those working in the abortion context, a clearly defined policy around seeing a woman alone for a consultation ensured that she was able to speak freely without interference from a partner or other family member. Consistent with current recommendations for responding to violence against women more broadly,<sup>35</sup> nearly all the practitioners highlighted the use of non-judgemental communication, as well as a commitment to upholding women's autonomy, as key ways they could respond to reproductive abuse. At the same time, however, because women experiencing reproductive abuse were often making decisions about what to do about an unwanted pregnancy and birth control, in addition to whether to stay or leave a relationship, several practitioners mentioned that it could be challenging to keep their opinions to themselves, particularly when a woman was at risk of experiencing reproductive abuse again in the future. Furthermore, at times, the pursuit of a woman-led response presented an ethical dilemma for the participants. Several mentioned that they had engaged in deliberate deception of an abusive partner or other family member to keep a woman safe. While it is clear that the practitioners were prioritising the interests of the woman, the fact that deception was the only available option is unfortunate. The implications of this, as well as how practitioners navigate the parameters of these situations, merit further research so that a preferable alternative response can be developed.

The importance of a multidisciplinary response to reproductive abuse was highlighted by almost all the participants. Different health practitioners are co-located within the hospital setting, enabling women with complex needs – both medical and psychosocial – to have all their issues addressed within the one place. The practitioners in this study highlighted that good communication and a collaborative approach between departments and disciplines was essential to achieving this.

Despite this positive feedback, however, participants still identified barriers to the effective enactment of a multidisciplinary response, including the lack of a shared understanding around how to identify and respond to reproductive abuse. We have explored the diversity in staff understandings of reproductive abuse in more detail elsewhere,<sup>5</sup> highlighting that it was particularly pronounced between sexual assault services and social work or clinical staff. This was reflected in practice by the lack of referrals between the sexual assault service and other departments within the hospital. This lack of collaboration may also be due to the different paradigms informing practice.<sup>34</sup> Sexual assault services in Victoria are typically informed by a feminist model,<sup>36</sup> where women are encouraged to name their experiences as 'sexual assault' or 'rape'; this was perceived by other health practitioners as being too confronting for some women experiencing reproductive abuse. On the other hand, the sexual assault service perceived that this naming was essential to helping women to address the issue. Given these differing viewpoints, qualitative research with women who have lived experience is necessary to identify acceptable terminology and ways of engaging with sexual assault services.

The lack of shared understanding was not the only organisational issue identified by the participants. Notably, there was also inconsistency around what level of response ought to be provided, and whose role it should be. Some health practitioners working in the clinical disciplines believed that it was enough for them to identify women and refer them to social work without taking any further action themselves. The social workers, however, felt strongly that responding to reproductive abuse ought to be a shared responsibility across the hospital. They identified a range of ways in which health practitioners could assist women, including linking them with external specialist services and helping them to plan for safety. For doctors, facilitating safe methods of contraception was another key area in which they felt they could assist. Theories of organisational change, such as Normalisation Process Theory<sup>37</sup> suggest that a lack of clarity around 'who does the work' and 'what the work is' are critical barriers to implementing new ways of doing things in complex settings such as hospitals. The discrepancies noted here suggest that greater attention needs to

be paid to clarifying what best practice might look like, and who is responsible for it.

### Limitations

Although our study had many strengths, there were also some limitations. First, the recruitment of participants from a single public metropolitan hospital obviously affects how applicable the findings might be to a broader health context. The participating hospital, in many ways, represents the 'best case scenario', in terms of awareness about violence against women, resourcing, and the co-location of services at the one site. Second, it is unfortunate that only female participants were able to be recruited to the study. As stated earlier, this reflects the demographics of the staff working in this hospital, however, it would have been beneficial to obtain the views of male health practitioners to explore whether they differed in any way. It is also likely that the staff who chose to participate had a particular interest in the topic of reproductive abuse or violence against women, and this may have resulted in a more informed study sample than the average health practitioner. Third, the participating branch of the hospital did not include antenatal care; the views of practitioners are thus primarily focused on responding to patients in the context of abortion, unplanned pregnancy or sexual assault.

### Implications for public health

This study is one of the only qualitative studies on reproductive abuse conducted in Australia. It is also, to our knowledge, the first attempt globally to explore how health practitioners respond to reproductive abuse as part of everyday practice. Our findings highlight the pressing need for clear, evidence-based guidelines and training to be developed and implemented to address reproductive abuse in Australian health settings. These should include recommendations about effective identification methods, as well as how to respond after disclosure and appropriate referral pathways to further support. Lastly, it is critical that health practitioners understand to what extent responding to reproductive abuse is a part of their role, and how they can work collaboratively across disciplines to address this complex issue.<sup>15</sup> Although our study focused on the unplanned pregnancy, abortion and sexual assault contexts, many

of our findings are equally relevant to practitioners working in the antenatal and maternity settings. We recommend further research with women planning to continue a pregnancy after reproductive abuse in order to identify any points of difference.

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