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Typology, Risk, and Protective Factors of Reproductive Coercion: A Narrative Literature Review of Studies from the US, Canada, Australia, and Europe

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ABSTRACT

Introduction: Reproductive coercion refers to attempts to control reproductive choices, often exerted by an intimate partner or a family member. Introduced by Miller et al. (2010), this concept highlights the link between reproductive coercion and unintended pregnancies, as well as its impact on sexual and reproductive autonomy. Although frequently associated with intimate partner violence, some research emphasizes its occurrence outside of this context.

Objectives: Reproductive coercion, defined as acts that directly interfere with contraception and compromise women's reproductive autonomy, was first formally described in 2010. Since then, numerous studies have examined its prevalence, forms, and consequences for reproductive health, primarily it to intimate partner violence and domestic violence. This study aims to update the current understanding of CR, including its occurrence beyond the context of intimate partner violence.

Method: A strategic literature search was conducted using ScienceDirect, PsycINFO, Scopus and PubMed to identify published articles that used reproductive coercion and related terms as keywords. A total of 68 articles met the inclusion criteria, addressing the prevalence, forms, contexts, risk factors, and existing intervention strategies related to reproductive coercion.

Results: The findings reveal that while reproductive coercion often occurs within intimate partner relationships, it can also involve family members or structural factors. Common tactics include contraception sabotage, pressure to pursue unwanted pregnancies, and coercion in pregnancy-related decision-making, often accompanied by violence or psychological manipulation. Prevalence rates vary widely and are often imprecise, with higher rates observed in the presence of intimate partner violence. Identified risk factors include gender inequality, socio-economic disadvantage, and minority status. However, protective factors remain underexplored. Current prevention strategies focus on healthcare-based screening and public awareness campaigns, although their effectiveness remains limited.

Conclusions: This review highlights the need for further research into reproductive coercion across diverse populations, the role of perpetrators, and cases occurring outside of intimate partner violence contexts, to better inform prevention and intervention efforts.

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Reproductive coercion; intimate partner violence; contraception; reproductive health; reproductive autonomy

Introduction

Reproductive coercion is a term introduced by Miller and colleagues in 2010 to describe "male partners' attempts to control women's reproductive choices" (p. 2) (Miller et al., 2016). Victims of reproductive coercion may include both adolescents and adults, across heterosexual and bisexual populations, and regardless of whether they have had a history of intimate partner violence (Kovar, 2018). One of the earliest studies, conducted by Miller and Silverman (2010), highlighted a strong association between unintended pregnancies and violence perpetrated by male partners, particularly in the form of reproductive coercion.

Reproductive coercion represents a major barrier to sexual autonomy and poses a serious risk to sexual and reproductive health. These barriers may include precarious socio-economic conditions, lack of social support, the prevalence of patriarchal norms, experiences of violence, as well as restrictive legislative and political

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frameworks (Grace & Miller, 2023; Warling et al., 2023). This form of coercion is often perpetrated by individuals close to the victim, such as a partner or a family member, with whom the victim has or had an intimate relationship.

Within the field of sexual and reproductive health research, reproductive coercion has gained growing attention from the scientific community. Numerous studies have sought to understand its forms, contextual factors, and associated risk factors. Although this scientific interest is relatively recent, a number of systematic reviews and literature analyses have already been conducted (Grace & Anderson, 2018; Lévesque & Rousseau, 2016).

However, existing literature, as represented in these reviews, primarily focuses on reproductive coercion within the context of intimate partner violence (Grace & Anderson, 2018; Grace & Fleming, 2016; Lévesque & Rousseau, 2016), even though reproductive coercion can also occur in relationships without violence. Some researchers, such as Grace and Fleming (2016), argue that while perpetrators may not always be intimate partners—potentially including family members of the partner or the victim—reproductive coercion should still be considered a subset of intimate partner violence. Others, like Rowlands and Walker (2019), emphasize the need to distinguish between intimate partner violence and reproductive coercion, noting their overlap yet highlighting their distinct characteristics.

However, the existing literature primarily focuses on reproductive coercion within the context of intimate partner violence (Grace & Anderson, 2018; Grace & Fleming, 2016; Lévesque & Rousseau, 2016), despite evidence that reproductive coercion can occur independently of overt violence. Some researchers, such as Grace and Fleming (2016), argue that while perpetrators may not always be intimate partners—potentially including family members or partner or the victim—reproductive coercion should still be considered a subset of intimate partner violence. In contrast, researchers like Rowlands and Walker (2019) advocate for distinguishing reproductive coercion from intimate partner violence, emphasizing that while the two may overlap, they have distinct characteristics and dynamics.

Additionally, the numerous studies and research conducted to date on reproductive coercion have primarily been carried out in the United States, Canada, and Australia. Additional studies from other regions of the world, particularly low- and middle-income countries, also exist. However, these geographical limitations may lead to a culturally and sociodemographically biased understanding of how reproductive coercion is experienced and the factors that contribute to it. Furthermore, despite the growing number of studies on this issue, empirical studies evaluating the effectiveness of reproductive coercion prevention or intervention programs remain scarce.

The systematic reviews analyzed in this article highlight several important limitations. First, most of the research focuses on a relatively short time frame, often limited to the past ten years, and excludes publications written in languages other than English. This limits the diversity of perspectives and excludes cultural contexts that are essential to fully understanding the scope of the phenomenon (Grace & Anderson, 2018; Grace & Fleming, 2016). Furthermore, since the studies originate from countries with highly diverse social, legal, and cultural contexts, it becomes difficult to compare the findings and draw generalizable conclusions. Certain extreme situations, such as sexual violence committed in wartime contexts, are not addressed. The field of reproductive coercion remains in its early stages. Existing research tends to focus primarily on men as perpetrators, which limits consideration of other forms or actors involved. There is also ongoing confusion between reproductive coercion and other forms of violence, such as intimate partner or sexual violence, which complicates analysis. Lévesque and Rousseau (2016) emphasize the lack of reliable data on its prevalence, risk factors, and concrete manifestations.

This narrative literature analysis aims to build upon existing research by summarizing findings from prior literature reviews and integrating studies conducted outside the United States. It also explores the possibility of reproductive coercion as a phenomenon distinct from intimate partner violence and highlights opportunities for both primary and secondary prevention, while

examining its occurrence, typology, and associated risk and protective factors.

Method

To identify relevant publications on reproductive coercion, a bibliographic search was conducted across four databases: ScienceDirect, PsycINFO, Scopus, and PubMed. The following keywords were used: "reproductive coercion", "contraceptive sabotage", "contraceptive coercion", "condom sabotage", "pregnancy-related coercion", "pregnancy pressure", "sexual and reproductive coercion", "reproductive coercion and abuse", "reproductive autonomy and decision making", "coercion and unintended pregnancy".

The inclusion criteria for articles were as follows: (1) published in English or French; (2) published after 2015; (3) originating from the United States, Canada, Australia, or Europe; and (4) presenting either quantitative or qualitative data, including systematic reviews. Selected articles addressed definitions, characteristics, prevalence, risk and protective factors, as well as prevention and intervention strategies related to reproductive coercion. To ensure the quality of the included studies, only articles published in peer-reviewed journals and presenting a clearly detailed methodology were selected. Articles not published in English or French, or published before 2016, were excluded. Additionally, studies conducted in Africa, Antarctica, Asia, or South America were not retained. Articles that did not focus primarily on the characteristics, definitions, prevalence, risk and protective factors, or prevention and intervention strategies concerning reproductive coercion were also excluded. As such, all articles focusing predominantly on consequences, healthcare professionals, or other topics not directly aligned with the analytical framework were omitted from the study.

Following the application of the established keywords, a total of 364 articles were identified. The titles and abstracts of these articles were initially screened, after which the inclusion and exclusion criteria were applied. At the end of this stage, 162 articles were retained. After the removal of 95 duplicates, 67 articles remained. A third search was then conducted by reviewing the reference lists of the selected articles to identify any additional relevant studies. This process yielded two more sources, bringing the final total to 68 articles included in the study (Figure 1).

Data extraction from the 68 selected articles was conducted using a two-step approach. First, data from literature reviews published since 2016 were synthesized. Second, data was extracted from primary studies by examining prevalence rates, typologies, potential risk and protective factors, as well as reported primary or secondary prevention measures in each of the selected articles. For additional details on the included studies, see Table 1.

Results

Reproductive coercion tactics

To expand on the findings of previously reviewed articles and enhance understanding on the prevalence and manifestations of reproductive coercion, we extracted data from the primary studies included in this narrative review. Consistent with Lévesque and Rousseau (2016), the majority of the articles identified three main tactics of reproductive coercion: contraceptive sabotage, pregnancy pressures, and coercion during pregnancy.

**Contraceptive sabotage* refers to the deliberate interference with a woman's contraceptive method. This includes behaviors such as hiding, tampering with, or destroying birth control pills; damaging or puncturing condoms; removing a condom during intercourse; failing to remove a condom as agreed; or extracting the vaginal ring, patch, or IUD. Perpetrators may use physical violence, threats, accusations, or psychological pressure to manipulate the victim. In some cases, the partner may also restrict or block access to healthcare, or refuse to pay for contraception. A particularly notable form of contraceptive sabotage is known as "stealthing", which involves the non-consensual removal of a condom during sexual intercourse. Although the intent is often motivated by a desire for increased pleasure or sensation, this practice jeopardizes the sexual and reproductive health of the female partner.

**Pregnancy pressures* involves coercing a partner into becoming pregnant against her will,

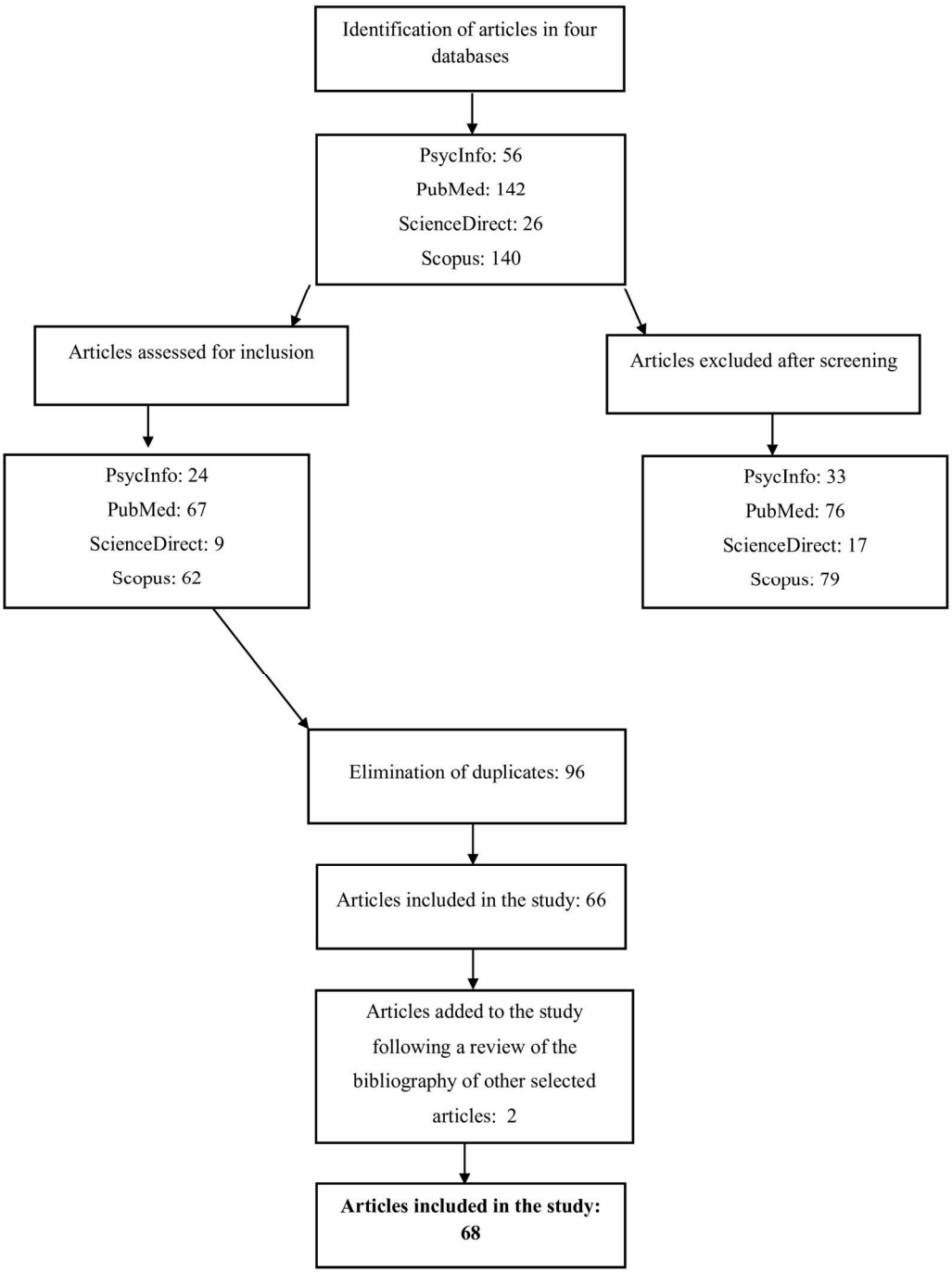

Figure 1. The PRISMA flowchart of the search process.

disregarding her reproductive desires or intentions. This may entail pressuring the victim to discontinue contraceptive use and using threats—such as those of divorce, infidelity, or abandonment—should pregnancy not occur.

* *Coercion during pregnancy* refers to controlling behaviors that occur when a woman refuses to comply with her partner's demands and wishes regarding a pregnancy. This may include threats or violence to force a woman to either carry a pregnancy to term or terminate it against her will. In some cases, physical violence is used to prevent access to abortion services.

Context of reproductive coercion

While reproductive coercion often occurs within an intimate relationship between two partners and is typically perpetrated by the intimate partner themselves, it is not exclusive to them.

Table 1. Overview and details of studies included in the review.

Literature Reviews					
Authors	Years	Country	Objectives	Type of review	Key findings
Grace & Fleming	2016	Bangladesh, China, Côte d'Ivoire, India, Jordan, USA	To provide an update on the state of knowledge regarding RC and its specific behaviors in an international context.	Systematic review of 10 studies	RC is defined as a subcategory of IPV. No studies exist outside the US, and it remains poorly understood in international contexts. Further research is essential to expand knowledge around protective factors, interventions, and coping strategies used by victims. Additionally, there is a need to better understand the causality and timing of events in the lives of these women victims.
Lévesque & Rousseau	2016	Canada	To identify factors associated with RC, manifestations of the problem, its main risk factors, and measurement tools for diagnosis.	Systematic review of 54 studies	The prevalence of RC was found to range between 9% and 25%, depending on the measurement tools and populations surveyed. There is a lack of studies in French and a lack of validated tools in that language.
Park et al.	2016	USA	Review of the Literature on RC and its impacts on the reproductive health of Women, Men, Adolescents, and the LGBTQ+ Community.	Narrative review	RC is widespread among heterosexual adolescents and adults, as well as in heterosexual and homosexual relationships. It occurs in people with and without a history of physical or sexual abuse. The mental and reproductive health implications are severe for those who experience it. Health care providers should be sensitized to RC. The use of safety cards has been shown to improve women's safety behavior.
Kovar	2018	USA	Review of studies dealing with RC and interventions that could be used by nurses in clinical settings.	Narrative review	The prevalence of RC was estimated at 8-16% of cases and was found in both adolescents and adults, among heterosexual and bisexual populations, and in individuals with and without a history of IPV. There was a strong association between IPV, STIs, and unintended pregnancies. Women presenting to a reproductive and/or contraceptive clinic for pregnancy or STD tests offer an opportunity for RC screening. Education by a health professional and the use of safety cards can help address this form of violence.
Fay & Yee	2018	USA	Review the existing knowledge about RC, suggest avenues for future study, and provide guidance to health care providers.	Narrative review	RC remains poorly studied and misunderstood. Future studies are needed to understand the association between RC and health impacts. Women who experience RC face similar risks as IPV victims, including violence during pregnancy and poor birth outcomes.
Grace & Anderson	2018	USA	Study the prevalence and correlates of RC in the US, the strategies that women use to maintain their reproductive autonomy when they experience RC, and interventions that can be effective in reducing RC.	Systematic review of 27 studies	RC particularly affects women who are IPV victims, single, African-American, multiracial, and of lower socio-economic status. The literature indicates that women affected by IPV often seek specific health care. Future research should examine co-occurrence with other phenomena like IPV or unintended pregnancy, as well as the timing and causality of events in victimized women's lives. The coping strategies they employ and the clinical interventions provided by health care professionals also need further documentation.
Jargin	2018	USA	Examines the relationship between alcohol use and sexual and RC.	4 case studies and a mini review	Excessive alcohol consumption is a risk factor for refusing to use condoms in intimate relationships as well as for other risky sexual behaviors.
Rowlands & Walker	2019	UK	Examine the manifestations, means, and effects of RC.	Narrative review	RC can be exercised by an intimate partner or family member but can also be structural. Reproductive control and IPV share important similarities but overlap semantically. Almost a quarter of women attending sexual and reproductive health services face this issue, and health professionals should be made aware of it.
Dejoy	2019	USA	Explore the role of reproductive health care centers in coercive reproductive health care policies.	Narrative review	Public policies that restrict access to contraception or abortion represent RC at a structural level. They negatively affect the mental health and economic well-being of those most at risk, particularly those experiencing RC from an abusive partner and those denied access to reproductive health services. Reproductive health care facilities sit at the intersection of interpersonal and structural RC.
Carter et al.	2021	Australia	Explain what RC and abuse are. Examine what RC and abuse entail, who they affect, and how they impact those individuals. Identify potential strategies to combat these issues and improve the identification and response.	Literature Review	RC is often associated with heterosexual women as victims and male partners as perpetrators, due to the gendered nature of reproduction and violence. The definition of RC and its various forms are not yet universally agreed upon. Australian data indicates that RC disproportionately affects young women, those with disabilities, individuals in financial hardship, or those in abusive relationships. The prevalence of RC ranges from 2.3% to 10%, depending on the study. Clinician involvement is central to the

(*continued*)

Table 1. Continued.

Literature Reviews					
Authors	Years	Country	Objectives	Type of review	Key findings
					screening for RC. Several challenges are faced by clinicians, which are also linked to the disclosure process.
Moulton et al.	2021	Australia	To explore women's experiences of RC and abuse on a global scale, aiming to enhance our understanding of how these phenomena manifest and are perceived across various sociocultural contexts.	Literature review	RC and abuse manifest through a range of behaviors, including control over pregnancy outcomes, pressure regarding pregnancy, and contraception sabotage. The reasons cited for RC and abuse are varied, including control over women, rigid gender roles, social inequalities, and familial pressure. Women's responses to RC and abuse include the use of hidden contraception and feelings of distress, anger, and trauma. The perpetration and experiences of RC and abuse are influenced by various factors, including son preference and social exclusion.
Tarzia & Hegarty	2021	Australia	To propose a new way of understanding RC that emphasizes the perpetrator's intent and the presence of fear and/or control.	Literature Review	There is a lack of conceptual clarity around RC, which presents a barrier to developing a strong evidence base. There is also a poor understanding of how RC intersects with other forms of violence (IPV, sexual violence). Definitions and measurements of RC are inconsistent in both research and healthcare practice. We believe that IPV and sexual violence are the mechanisms through which RC is perpetrated. RC cannot exist without another concurrent form of violence in a relationship. This finding has significant implications for research, policy, and healthcare practice, including for the screening and identification of women in reproductive healthcare settings.
Lowe	2022	UK	Explore situations where a partner intentionally uses power and control to prevent, promote, or control pregnancy in the victim.	Narrative review	Regulatory frameworks and cultural norms significantly influence perceptions of RC. Coercion to abort is more publicized than forced pregnancy, although evidence suggests the latter is more common.
Graham et al.	2023	Australia	How is RC defined across social, cultural, systemic, and structural dimensions? Do the definitions of RC take into account the conditions and contexts in which it occurs?	Literature Review	Most research defines RC at the interpersonal level, with only 8 articles partially addressing the sociocultural, systemic, and structural levels, and 4 articles fully incorporating these dimensions. Four main themes emerge in the definitions of RC: the individual exercise of external control over a woman's reproductive autonomy; systems and structures; social and cultural determinants; and the absence of external forces in achieving reproductive autonomy.
Warling et al.	2023	USA	Propose a framework to conceptualize RC in the United States as an integrated system of RC.	Narrative review	The integrated RC system operates on four socio-ecological levels: societal, institutional, interpersonal, and internalized. Clinicians play a major role and should use their influence to address RC at all socio-ecological levels.
Grace & Miller	2023	USA	Understand and explore emerging study areas related to RC, including associations with IPV, health effects of RC, and demographic/contextual factors associated with RC experiences.	Narrative review	Future research should further examine evolving interpretations of pregnancy intention in a context of reduced abortion access, RC among disabled individuals, and multiple levels of marginalization, including sexual and gender minorities; intersections of RC with economic abuse in the context of economic justice efforts; and community-centered intervention and prevention approaches.
Coleman et al.	2023	USA	Use Bronfenbrenner's model to organize the multi-level factors influencing RC and its impacts on individual health.	Narrative review	RC is pervasive, with considerable implications for mental and physical health. Interactive, multi-level processes lead to RC and modulate its impact on individual health outcomes. Dominant conceptualizations of RC often focus interventions on individual or interpersonal levels. Future research should build on the ecological model presented to identify and address structural factors playing a critical role in RC risk and its detrimental consequences for individuals.
Rowlands & Walker	2023	Australia	Examining Deliberate Attempts to Interfere with a Woman's Reproductive Autonomy in the Context of Intimate Partner or Family Relationships.	Narrative review	RC is a prevalent form of abusive behavior often linked to IPV. Recognizing and disclosing such coercion to professionals remains challenging. Contraceptive sabotage is a widespread manifestation of RC encompassing behaviors such as refusing to use condoms or other contraceptive methods, tampering with condoms, non-consensual removal of intrauterine devices, or falsely claiming to have undergone a vasectomy. In certain cultural contexts, other family members may also engage in RC. Some women reclaim their autonomy by utilizing concealed contraceptive methods.

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Primary studies					
Authors	Years	Country	Objectives	Population	Key findings
Grace	2016	USA	Case study of a woman experiencing RC	1 case study	Midwives and other health care providers can play a key role in addressing RC.
Phillips et al.	2016	USA	Understand how RC affects women in a primary care population.	97 women who sought care at a family practice clinic in the Bronx	24% of participants reported experiencing at least one form of RC, often linked to other forms of control and violence. Risk factors included lack of personal safety, history of transactional sex for money, and history of sex for shelter. The link between RC and unwanted pregnancy was unclear. Health care providers are advised to discuss contraceptive sabotage and pregnancy coercion with their patients.
Miller et al.	2016	USA	Evaluate the effectiveness of an RC intervention program conducted in family planning clinics	25 family planning clinics in 17 groups, with a total of 4,009 women aged 16-29 years.	The program significantly increased participants' awareness of partner violence resources, their self-efficacy in harm reduction behaviors, and the use and sharing of a domestic violence hotline number. It did not significantly reduce RC or partner violence overall, but it did reduce RC among women who had experienced multiple forms of abuse a year later.
Alexander et al.	2016	USA	Examine the prevalence of RC, sexual risk behaviors, and mental health symptoms in women who have sex with both men and women, compared to those who have sex only with men.	149 women, 42 of whom reported sex with both men and women, and 107 who reported sex only with men.	Women who had sex with both men and women were less likely to frequently use condoms during vaginal sex. These women were also more likely to trade sex for resources and exhibit symptoms of post-traumatic stress disorder. They reported more experiences of RC and higher rates of physical and sexual IPV compared to those who only had sex with men.
Liu et al.	2016	USA	Describe the degree of perceived fertility control and the associated likelihood of unintended pregnancy and poor pregnancy outcomes among women who have experienced IPV.	282 female IPV victims who sought help for the first time from a shelter or district attorney's office.	In abusive relationships, 29% of women reported at least one unwanted pregnancy due to their abusers' refusal to use contraception, while 14.3% were prevented from using birth control themselves. Abuse-related miscarriages were 28 times more likely when abusers did not use contraception, and preterm births were 8 times more common in cases of abuse linked to contraception use. These findings demonstrate that women in violent relationships face reduced fertility control, higher rates of unintended pregnancies, and increased risks of poor pregnancy outcomes, including preterm births and miscarriages.
Holliday et al.	2017	USA	Explore racial/ethnic differences in RC, IPV, and unintended pregnancy.	1,234 patients aged 16-29 years recruited from five family planning clinics in the San Francisco area.	Black (37.1%) and multiracial (29.0%) women seeking care at family planning clinics were at a higher risk of both RC and unintended pregnancy. Multiracial women were almost twice as likely as white women to experience RC, but the impact of RC on the risk of unintended pregnancy was similar for both white and Black women.
Katz et al.	2017	USA	Examine the association between domestic violence, female students' sexual health, and RC coercion by male sexual partners.	223 sexually active female undergraduate students at a public liberal arts college in New York State.	Approximately 30% of participants reported experiencing RC, most commonly contraceptive interference. The association between RC and contraceptive use was not dependent on the occurrence of partner violence. Both RC and partner violence may reduce contraceptive use, but among women who experience both, RC is the primary predictor. No association was found between past experiences of RC, partner violence, and condom negotiation. Women who experienced RC also reported lower contraceptive and sexual self-efficacy than those who had not experienced RC.
Katz & Sutherland	2017	USA	Explore the existence of coexistence of contraceptive interference with IPV and find out whether past contraceptive interference is negatively associated with women's contraceptive outcomes.	146 sexually active undergraduate students who had ended a (hetero)sexual relationship of at least one month.	The study examined 146 undergraduate students who had recently ended a heterosexual relationship. Results showed strong links between contraceptive interference and various forms of IPV, such as psychological, physical, and sexual abuse. contraceptive interference l also lowered self-efficacy in condom negotiation, affecting long-term sexual health and autonomy. The primary motive for contraceptive interference was reported as the pursuit of sexual pleasure, highlighting manipulative relationship dynamics.

(*continued*)

Table 1. Continued.

Primary studies					
Authors	Years	Country	Objectives	Population	Key findings
McGirr et al.	2017	USA	Questioning how advocates for victims of domestic violence proactively or reactively deal with IPV and RC.	700 domestic violence advocates across the United States.	Discussions around RC generally provoke little discomfort, and only a few obstacles to addressing the issue are noted. However, discomfort and barriers tend to emerge when coercion is less frequent or not easily recognized. Consistent intervention in RC practices appears limited, highlighting the need for specific training and organizational support to better address this issue.
Northridge et al.	2017	USA	Assess the prevalence of RC among urban adolescent girls and examine links between RC and reproductive health risks.	149 sexually active girls aged 14-17 years living in a high-poverty community.	One in five girls reported experiencing RC. Those who reported RC were almost three times more likely to have contracted chlamydia and almost five times more likely to report physical IPV. They were also less able to recognize abusive behavior and communicate easily with their sexual partners.
Miller et al.	2017	USA	Evaluates an intervention addressing domestic violence and RC in a family planning clinic.	18 providers, 5 administrators, and 49 patients participated in semi-structured interviews.	The intervention increased healthcare providers' confidence in discussing IPV and RC. Asking patients to share educational information with other women facilitated conversations on these topics. The intervention also provided patients with important information, support, and the ability to help others.
Barber et al.	2018	USA	Explore the impact of IPV on pregnancy during the transition from childhood to adulthood.	867 young women in Michigan.	Threats and physical assaults were associated with higher pregnancy rates between the ages of 18 and 22, but only when the violence was recent. During periods of violence, victims perceived greater partner desire for pregnancy, engaged in more sexual activity, and used less contraception. Violent young men were more likely to want their partner to become pregnant, using verbal and physical aggression to avoid contraception, increasing the risk of pregnancy.
Holliday et al.	2018	USA	To qualitatively describe and compare the contexts of RC and unintended pregnancy risks among low-income Black and White women with histories of either.	44 low-income Black and White women aged 18 to 29.	Differences emerged between the reproductive experiences of Black and White women. For White women, maternal threats, including life-threatening violence and IPV associated with motherhood, were particularly influential. For Black women, pregnancy was significantly shaped by RC factors such as imminent incarceration, subfertility, and inconsistent condom use. Decisions regarding contraception were often male-dominated. Sexual abuse, including childhood sexual assault, was more prevalent in the sexual and reproductive health narratives of White women. For Black women, experiences of childhood neglect significantly impacted their pregnancy intentions and shaped behaviors associated with seeking love and emotional connection.
Zachor et al.	2018	USA	Evaluates the effect of communication skills training on the frequency of IPV and RC assessment.	679 participants from four family planning clinics.	Communication skills training, alongside standard IPV and RC training, significantly increased providers' communication about IPV and RC.
Alhusen et al.	2019	USA	To explore the perspectives of women with disabilities who had experienced unintended pregnancy due to RC.	9 women with disabilities participated in a study examining the facilitators and barriers associated with unintended pregnancies among women with disabilities.	Reversible contraception may increase the risk of unintended pregnancies among these women. Women with disabilities face a heightened risk of IPV. The resources needed to ensure their safety are often inadequate: healthcare professionals do not always provide appropriate responses to the situations encountered, and the healthcare system limits access to suitable services, further contributing to their vulnerability.

(*continued*)

Table 1. Continued.

Primary studies					
Authors	Years	Country	Objectives	Population	Key findings
Alexander et al.	2019	USA	To examine the links between RC, mental health among Black adolescent and young adult women, and how exposure to RC interacts with physical and sexual IPV, thereby affecting symptoms of depression and post-traumatic stress disorder.	The study involved 188 Black women aged 18 to 25 years.	The prevalence of RC (37.8%) and IPV (48.9%) was significant within this sample. Approximately 10% of the women surveyed reported experiencing RC without IPV, while 38% indicated facing both forms of violence simultaneously. Depressive symptoms (69%) and PTSD symptoms (47.1%) were more common among women who had experienced RC compared to those who had not. The findings suggest that RC and IPV each have distinct impacts on mental health challenges within this specific group, emphasizing the need for targeted interventions and measures to address both types of violence.
Hill et al. (a)	2019	USA	Studies the occurrence of RC and relationship abuse among young women.	550 sexually active high school girls	12% of participating high school girls reported recent RC, and 17% reported physical or sexual abuse in a relationship with another adolescent. Physical or sexual violence was associated with a higher likelihood of seeking testing or treatment for STIs. Women reporting both relationship violence and RC were more likely to have an older partner, multiple recent sexual partners, and to use only one hormonal contraceptive.
Hill et al. (b)	2019	USA	Evaluates the effectiveness of an interactive application facilitating discussions between patients and providers about IPV, RC, a wallet-sized educational card, and sexually transmitted infections.	240 participants recruited from four clinics in Western Pennsylvania.	There was no statistically significant difference in the disclosure of IPV and RC between an intervention involving a personalized script for caregivers and a condition where an app with psycho-educational messages was provided to patients in addition to the script.
Samankasikorn et al.	2019	USA	Investigates the prevalence, relationships, and influences of male partner RC with IPV and unintended pregnancy.	20,252 women who gave birth between 2012 and 2015 and completed the PRAMS survey within nine months of delivery.	Approximately 2.7% of participants reported physical IPV, and 1.1% reported RC. Younger age, a history of IPV, low socioeconomic status, being single, and being Black or Hispanic were cited as risk factors. This study also highlighted associations between RC, IPV, and unintended pregnancies, emphasizing the importance of screening for IPV and RC to prevent and reduce unintended pregnancies.
Lévesque & Rousseau	2019	Canada	A qualitative study examining issues related to the recognition of RC.	21 young women in Quebec	RC can be difficult to recognize due to its various forms and the emotional attachment to the perpetrator. Non-consensual condom removal is the most easily identifiable behavior, while pressure or coercion to get pregnant is less recognizable. Recognition is easier in casual, non-committed relationships. Protective factors include education on the topic, confiding in friends, or finding a new partner who respects reproductive rights.
Willie et al.	2019	USA	To examine the associations between IPV and RC in young couples over time.	296 pregnant teenagers and young couples recruited from obstetrics, gynecology, and ultrasound clinics.	There are clear associations between IPV victimization and RC victimization among young pregnant and parenting couples. Couples experiencing RC were at greater risk of IPV within the following six months. Young women and men who had experienced IPV before the birth of their baby were more likely to feel pressured into having a child with their current partner. Those who had previously been victims of IPV in a prior relationship were at higher risk of experiencing IPV again with their current partner. Perpetrators of RC were more likely to experience psychological IPV and to coerce their partner into pregnancy if they had experienced RC in a prior relationship.

(*continued*)

Table 1. Continued.

Primary studies					
Authors	Years	Country	Objectives	Population	Key findings
Perry et al.	2020	USA	To describe contraceptive needs, explore associations between contraceptive use, IPV, RC, and unintended pregnancy, and assess the acceptability of receiving contraceptive care in a Syringe Exchange Program.	96 women of childbearing age participating in an SEP in Santa Ana, USA.	The majority of respondents had used methamphetamines and/or heroin. Sixty-two percent reported experiencing IPV or RC within the last three months. Half of the participants reported a history of unwanted pregnancy. No significant association was found between IPV, RC, contraceptive use, and unwanted pregnancy. The study suggests that referral to contraceptive care and the direct provision of contraceptive methods within SEPs could help address these contraceptive needs.
Fay & Yee	2020	USA	To compare birth outcomes between women who experienced RC during their last pregnancy and those who did not.	202 women recruited from obstetrics and gynecology practices.	8.6% of participants reported experiencing RC. Women with a history of RC were often younger, still in school, more likely to report IPV, and more likely to suffer from anemia or anxiety. They were less likely to be married to the baby's father and more likely to have been unwilling to become pregnant. Apart from lower birth weights, no other significant differences in birth outcomes were observed.
Grace et al.	2020	USA	To examine the correlates of RC in a sample of university women involved in abusive relationships.	354 higher education students who reported experiencing IPV.	24.3% of the sample reported experiencing RC. Factors associated with RC included non-white race, relationship instability, missing classes due to relationship problems, IPV severity ($p < 0.001$), technology abuse, traumatic brain injury-related events, and depression. The authors concluded that RC is also a predictor of depression.
PettyJohn et al.	2021	USA	To explore the prevalence of RC among adolescent girls currently or previously involved in the US foster care system.	Young African-American women (67.4%) and women from the LGBTQ+ community (46.6%).	30.1% of participants reported a history of RC. A significant prevalence of IPV, lifetime pregnancy, and unwanted pregnancy was found. There was a clear association between RC and IPV. Girls with a history of RC were more likely to use alcohol or drugs before sex and to engage in sexual relationships with partners who were five or more years older.
Swan et al.	2021	USA	To examine the relationship between RC and interpersonal violence among college students.	644 American students (mixed and cisgender) who had at least one sexual partner.	67.05% of participants reported experiencing interpersonal violence at least once, with 39.91% reporting multiple forms of violence. RC was reported by 11% of the sample. Young age and female gender were identified as risk factors for RC. RC also affected men, with 6.15% of male students reporting it. There was a clear association between RC and psychological violence by a partner. When controlling for demographic factors, RC was associated with a greater risk of polyvictimization and interpersonal violence, except for physical violence.
Bagwell-Gray et al.	2021	USA	To explore patterns of RC and pregnancy avoidance (PA) among women recruited from domestic violence shelters in the southwestern United States.	661 women recruited from domestic violence shelters.	Nearly one-third of the women reported RC, and nearly one-quarter reported engaging in pregnancy avoidance strategies. There was a clear association between IPV and RC. Risk factors for RC included young age and African American or Latino background. No association was found between RC and education, income, or marital status. However, there was an association between RC and pregnancy avoidance, both of which were linked to an increased risk of homicide.
Basile et al.	2021	USA	To assess the national prevalence of RC as well as its prevalence by gender and ethnicity.	A total of 22,590 women and 18,584 men participated in the National Intimate Partner and Sexual Violence Survey (NISVS) in 2010, 2011, and 2012.	In the United States, 9.7% of men and 8.4% of women have reported experiencing RC at some point in their lives. Men were more likely to report that their partner wanted to become pregnant when they did not, while women were more likely to report their partner's refusal to use a condom. The prevalence of RC was higher among non-Hispanic Black individuals, whereas Hispanic individuals exhibited a higher prevalence of condom refusal. Although RC can occur independently of IPV, this independence was less common among racial or ethnic minority communities.

(*continued*)

Table 1. Continued.

Primary studies					
Authors	Years	Country	Objectives	Population	Key findings
Addington	2022	USA	To compare the experience of RC in young adult men and women.	1,078 men and 1,026 women recruited via the National Intimate Partner and Sexual Violence Survey (NISVS).	Both young adult men and women experienced IPV and RC, though young women were more likely to experience RC. RC often occurred alongside psychological aggression.
Skracic et al.	2021	USA	Study and examine an association between IP and the level of contraceptive efficacy.	240 women of childbearing age were recruited from health care facilities in Delaware.	Among the women studied, 13.9% reported experiencing verbal RC and 16.1% behavioral RC. Women who experienced behavioral RC were more likely to use highly effective contraceptive methods, while those who experienced verbal RC tended to use moderately effective methods. Women affected by RC may be interested in risk reduction strategies involving highly effective methods.
Tarzia et al.	2021	Australia	Addressing the lack of qualitative research on experiences of RC and abuse, particularly among women from ethnic minority groups.	Thirty-eight staff members across six services participated in one of six focus groups.	The findings reveal a complex interplay between RC and abuse, domestic and sexual violence, and suggest that community attitudes toward women's roles in sex and reproduction, alongside structural risk factors, may further complicate this dynamic for women from ethnic minority backgrounds. It is crucial for service providers supporting ethnic minority women—particularly in prenatal and abortion care—to be aware of RC and abuse. Similarly, policies related to access to financial support for ethnic minority women should acknowledge the pivotal role such support can play in either facilitating or preventing abuse.
Willie et al.	2021	USA	Explore associations between birth control sabotage, a form of RC, and sexual risk among women attending family planning health centers.	675 women who attended family planning clinics in Connecticut	A study of 675 women at family planning clinics in Connecticut found that 16.4% had experienced contraceptive sabotage, which was associated with increased sexual risk.
Wellington et al.	2021	Australia	To explore the barriers to addressing RC and abuse in primary care settings.	24 primary care clinicians from various clinical backgrounds across Australia.	The analysis identified three key themes: a lack of clinician awareness on the issue; a lack of confidence in providing appropriate responses; and a lack of services to refer patients to. There is a gap between referral services and primary care. The absence of abortion services has a significant impact on women experiencing RC and abuse. Clinicians expressed concerns about the lack of equipment, training, and structures to which they can refer victims.
Grace et al. (a)	2022	USA	Describe the reproductive health status and needs of IPV survivors receiving housing support. Explore factors influencing their experience RC.	70 women with IPV experience who are enrolled in housing programs in the Baltimore metropolitan area.	In the past three months, 16.4% of women seeking shelter due to IPV had experienced RC. Most of these women did not wish to become pregnant, yet many were either not using any form of contraception or were relying on ineffective methods. RC was linked to the frequency and severity of IPV, post-traumatic stress disorder (PTSD), having fewer children, and not sharing children with their abusive partner. Financial instability may also be a contributing factor in these situations.
Muñoz et al.	2022	USA	Examine the lifetime prevalence of RC and its relationship to forms of IPV, as well as differences in prevalence between racial and ethnic groups in a diverse community sample of young adult women.	A community sample of 370 young adult women.	Victims of RC are more likely to face other forms of physical and sexual IPV. The risk of RC is higher among Black/African American and Latino/Hispanic populations, with a particularly high prevalence among Hispanic individuals. Further research is needed to explore culturally specific risk factors and protective measures.

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Table 1. Continued.

Primary studies					
Authors	Years	Country	Objectives	Population	Key findings
Grace et al. (b)	2022	USA	Examining the prevalence and use of RC and healthcare-seeking behaviors among students.	2,291 students of all genders who visited health and counseling centers at higher education institutions participated in the study.	Among female participants, 3.1% reported experiencing RC in the previous four months. RC is associated with older age, younger age at first sexual encounter, Black/African American race, behavioral bisexuality, a higher number of lifetime sexual partners, and confirmed pregnancy. Sexually transmitted infections, recent drug use or smoking, the need for specialized healthcare equipment, poor academic performance, and all categories of violence were associated with RC experiences among women.
Sheeran et al.	2022	Australia	The study aims to examine the frequency of reported abuse or RC among individuals seeking pregnancy counseling, analyze the prevalence of different forms of RC, and identify variations based on various demographic factors.	5,107 clients seeking psychological support related to pregnancy between January 2018 and December 2020.	RC was identified in 15.4% of clients, with similar proportions reported for coercion toward pregnancy (6%) and coercion toward preventing pregnancy or abortion (7.5%). Additionally, 1.9% experienced concurrent coercion both toward pregnancy and abortion. No significant differences were observed based on age or membership in migrant or refugee groups. However, individuals identifying as Aboriginal and/or Torres Strait Islander were significantly more likely to experience coercion aimed at promoting pregnancy.
Galrao et al.	2022	Australia	To examine the implementation and evaluation of a screening program for IPV and RC in an urban clinic specializing in sexual and reproductive health.	Questionnaires were completed during the waiting period before consultations. Inclusion criteria for the study were identifying as a woman and being 16 years of age or older..	The prevalence rate of over 17% is comparable to other Australian studies, demonstrating the effectiveness of the program in identifying these forms of violence. Additionally, a large proportion of patients who disclosed violence for the first time did so after being directly questioned, confirming that screening facilitates disclosure. The program also led to a significant increase in the number of domestic violence counseling appointments, with 16 times more appointments than the previous year. This highlights the importance of making such services accessible, particularly through emergency appointments. Screening was highly accepted by patients, and both the reception and clinical staff became increasingly supportive of the screening process, growing more confident in assisting patients who had been exposed to IPV and/or RC.
Price et al.	2022	Australia	To examine the prevalence and associations of RC in Queensland.	3,117 women from Queensland who contacted a pregnancy counseling and support hotline regarding an unplanned pregnancy.	RC is common and often linked to IPV. However, it can also occur independently. Young women (aged 16–29), Aboriginal and Torres Strait Islander women, and women from culturally and linguistically diverse (CALD) backgrounds are particularly vulnerable. Women experiencing RC face an increased risk of mental health issues, especially when it co-occurs with domestic violence. Affected women tend to access pregnancy-related services later, increasing the risks and costs associated with late-term terminations.
Suha et al.	2022	Australia	To explore cases of RC as described by women who participated in a broader qualitative study on violence against immigrant and refugee women in southern Australia..	13 women from 7 different countries	The cases described various forms of RC, including violence during pregnancy aimed at inducing a miscarriage, forced abortion, contraception sabotage, and forced pregnancy. In addition to intimate partners, some women described multiple perpetrators who were complicit in their experiences of RC, particularly regarding the control of their access to healthcare services and their interactions with those services. Further research is needed to address gaps in prevention and advocacy for victims of domestic violence within refugee and migrant communities. There is also a need to investigate how multiple perpetrators of RC can impact the consent processes for women who already face significant barriers to healthcare.

(*continued*)

Table 1. Continued.

Primary studies					
Authors	Years	Country	Objectives	Population	Key findings
Hayes et al.	2023	USA	Understand RC experienced by college students who have been sexually active in the past year..	1,515 sexually active college students.	Exclusive relationships were associated with a lower risk of RC, while prior victimization, including psychological and sexual violence, was linked to a higher risk. The study supports other research showing that RC is intertwined with other forms of victimization, highlighting the need for multifaceted prevention strategies.
Lévesque et al.	2023	Canada	Determine the prevalence of RC behaviors in a Canadian community sample and explore associated factors.	427 participants aged 18 to 55.	63.9% of participants reported experiencing at least one form of RC in their lifetime. Contraceptive sabotage was the most common form (62.8%). Among pregnant participants, 9.8% reported controlling the outcome of their pregnancy. Results also indicate that IPV increases the likelihood of contraceptive sabotage. Low education and IPV increase the risk of pregnancy outcome control.
Lévesque et al.	2023	Canada	To examine the practices, challenges, and facilitators faced by healthcare professionals in addressing RC. To assist in the development of informational and awareness tools tailored to their specific needs.	Discussions were conducted with 31 healthcare professionals working in six distinct professional settings.	Participants emphasized the use of intervention strategies centered on compassion and active listening, focusing on identifying signs of RC and fostering a safe environment for disclosure. Practices also included harm reduction strategies and efficient referral processes. Barriers to effective care included time constraints, unsuitable work environments, and a lack of training. Participants emphasized the importance of having straightforward practice guidelines and patient education tools to support their initiatives.
Cheng et al.	2023	Australia	To examine healthcare professionals' perspectives and experiences regarding RC screening.	an online survey and interviews were conducted to explore their understanding of RC and their views and experiences related to its screening.	Healthcare professionals considered RC screening to be relevant and important within family planning services. Key barriers to RC screening and responding to disclosures included time constraints and limited appropriate referral pathways. Ongoing education and training, along with resources such as a decision-support tool on RC screening and management, as well as effective multidisciplinary collaboration, were identified as strategies to improve the screening program.
Swan et al.	2023	USA	To address gaps in knowledge regarding RC among sexual minorities and explore its impact on behavioral health.	The study was conducted with 387 university students aged 18 to 24 in the southeastern United States.	Sexual attraction emerged as a significant risk factor. Students with multisexual attractions had higher rates of RC. RC was associated with poorer behavioral health outcomes. Notably, RC was significantly linked to behavioral health indicators among participants attracted exclusively to men and those attracted to multiple genders. However, no significant associations were found for participants attracted exclusively to women.
Amos et al.	2023	USA	Examine the prevalence of RC among postpartum women with disabilities.	3,117 respondents with available data on disability status and RC experiences. These women, from Massachusetts, had given birth between 2018 and 2020.	1.9% of respondents reported experiencing RC. 1.7% of non-disabled respondents reported RC, compared to 6.2% among respondents with at least one disability. Disability, age, education, relationship status, income, and race were all significantly associated with RC.
Hubel et al.	2023	USA	Examine the associations between reports of condom sabotage and indicators of sexual risk among university students.	466 students who completed an online cross-sectional survey	Students who reported experiencing condom sabotage were significantly more likely to be single, to have had multiple sexual partners, and to have been treated for a sexually transmitted infection in the past 12 months.

(*continued*)

Table 1. Continued.

Primary studies					
Authors	Years	Country	Objectives	Population	Key findings
Humphreys & Sheeran	2024	Australia	To explore the experiences of RC among community-based victims/survivors, their responses to RC, and the perceived motivations behind it.	101 women victims/ survivors of RC who completed an online questionnaire.	Intimate partners, family members, friends, cultural or religious leaders, and healthcare professionals have been identified as perpetrators of RC and abuse. Victims' and survivors' experiences of RC are diverse, encompassing a range of tactics aimed at both preventing and promoting pregnancy The experiences of victims/survivors of RC were heterogeneous, incorporating a range of RC tactics aimed at both preventing and promoting pregnancy. Women's responses to RC depended on how it was experienced; victims/ survivors were more likely to reaffirm their control when the RC was verbal rather than physical. Control was the primary motivation for RC, followed by contextual factors, drug use, and religion/culture.
Taylor et al.	2024	USA	Assess prevalence rates of two specific forms of RC, pregnancy-related coercion and condom manipulation, in an ethnically and racially diverse sample of young women.	143 adult women with prior sexual experience, recruited from two U.S. universities.	16.1% of the sample had experienced RC. 6.3% reported condom manipulation experiences during their lifetime. The most common form of RC experienced by participants was partner encouragement not to use contraception. Better relationship health knowledge can serve as a protective factor against pregnancy-related coercion and condom manipulation. Improved decision-making skills and relationship confidence may also protect against condom manipulation.
Miller et al.	2024	USA	To study the phenomenon, prevalence, risk factors, and impacts of RCon the physical and mental health of young adults. The aim is also to identify prevention strategies and interventions tailored to clinical and social contexts.	Adolescents aged 12–20 years with histories of intimate relationship abuse, RC, or related adversities. Examples include a 2007 interview study with 53 adolescent girls aged 15–20 and subsequent studies involving diverse adolescent groups.	RC is a significant form of gender-based violence affecting adolescents, often linked to IPV. It includes behaviors like sabotaging contraception, coercing pregnancy, and controlling pregnancy outcomes, with a prevalence of 12–19% in clinical adolescent samples. RC is strongly associated with poor mental health outcomes, including depression, anxiety, and suicidal ideation, as well as increased risks of mistimed pregnancies, STIs, and economic abuse. Marginalized groups, such as multisexual and gender-diverse youth, face heightened risks. Effective interventions, such as CUES and ARCHES, focus on harm reduction, education, and promoting reproductive autonomy in clinical and community settings.
Lévesque et al.	2024	Canada	Identify patterns of recognition and formal and informal disclosure of CR experiences.	Community sample of 317 participants	This study identifies three groups of recognition and disclosure of RC. (1) High recognition and high disclosure with a strong impact of disability and intimate partner violence; (2) Low recognition, high disclosure, characterized by ambivalence in identifying violence; (3) Hesitant recognition, no disclosure, hindered by a lack of social support. Disclosure helps reduce guilt and improves understanding of RC. Individuals exposed to high reproductive control and severe psychological consequences are more likely to recognize and share their experience.

Several studies have documented instances where reproductive coercion is perpetrated by individuals outside the immediate romantic relationship. These may include the partner's family members (e.g., in-laws), the victim's own relatives, friends, cultural or religious leaders, and even healthcare professionals (Carter et al., 2021; Grace, 2016; Humphreys & Sheeran, 2024; Lowe, 2023; Moulton et al., 2021; Rowlands & Walker, 2019, 2023). Grace and Miller (2023) identify three levels at which reproductive coercion operates: interpersonal, community, and institutional.

When reproductive coercion is perpetrated by extended family, it may take the form of pressure to use – or refrain from – contraceptives, or more extreme actions such as forced abortions or coerced sterilization. Alhusen et al. (2020) found that reversible contraceptive methods may increase the risk of unintended pregnancies among women with disabilities. These findings

are corroborated by a 2023 study indicating that women living with disabilities are particularly vulnerable to reproductive coercion (Amos et al., 2023). In the context of immigration, Suha et al. (2022) noted that violence during pregnancy, intended to induce miscarriage, may stem from family-driven beliefs and values. This suggests that reproductive coercion can transcend intimate relationships and be rooted in broader familial and cultural expectations.

Men and individuals in same-sex relationships can also be affected by reproductive coercion (Grace & Anderson, 2018). *The National Intimate Partner and Sexual Violence Survey* (NISVS), published by the Centers for Disease Control and Prevention in 2011, revealed that 10.4% of men had experienced some form of reproductive coercion, including 8.7% who reported pregnancy pressure or contraceptive sabotage attempts (Grace & Anderson, 2018; Kovar, 2018). Other studies in the United States corroborate these findings. For example, Basile et al. (2021) reported that 9.7% of men had experienced reproductive coercion at some point in their lives (Basile et al., 2021). A recent study conducted among students revealed that 6.15% of male students had been affected by reproductive coercion (Swan et al., 2021). Similarly, in a study involving 296 partnered men, Willie et al. (2019) found that 11% of participants had experienced reproductive coercion from the mother of their child, and 16% from a previous partner. Finally, Addington (2021) found that among a sample of 1,078 men and 1,026 women, 3.2% of men had experienced reproductive coercion compared to 6.5% of women.

Additionally, research conducted in the United States indicates a higher risk of reproductive coercion among women sexual or gender minority identities (Kovar, 2018; Lévesque & Rousseau, 2016; Taylor et al., 2024) and among women who have sex with both men and women (Park et al., 2016). In same-sex relationships, lesbian women who identify as more feminine have reported experiencing reproductive coercion from other lesbian women who identify as more masculine. The latter seem to be the primary decision-makers regarding pregnancy, planning, and monitoring of the pregnancy (Kovar, 2018). Swan et al. (2023) conducted a study on young heterosexual adults from sexual minority groups, highlighting higher rates of reproductive coercion within these groups, particularly among multisexual individuals and those of Latinx origin. Their results indicate sexual minorities are 1.8 times more likely to experience reproductive coercion than their heterosexual peers, Latinx students face a fourfold higher risk, and multisexual individuals are three times more likely to be affected compared to monosexual individuals (Swan et al., 2023). These findings are reinforced by Taylor et al. (2024), who, in a sample of college students, found that individuals attracted to multiple genders face a significantly greater risk of reproductive coercion.

In non-Western societies, the experience of reproductive coercion may be shaped differently by cultural and state-imposed norms, policies, and laws (Carter et al., 2021; Dejoy, 2019; Rowlands & Walker, 2019; Tarzia et al., 2022). Reproductive coercion may also be structural, arising from institutional constraints such as governmental restrictions on access to contraception or abortion services (Dejoy, 2019). According to Graham et al. (2023), dominant societal ideologies shape institutional frameworks, which in turn influence policies and services related to reproductive rights.

Some researchers also point to a commercial dimension of reproductive coercion, noting the influence of economic and marketing pressures particularly in the context of fertility treatments (Grace & Miller, 2023, Graham et al., 2023).

Prevalence of reproductive coercion

As indicated by published systematic reviews, the reported prevalence rates of reproductive coercion vary considerably. According to Lévesque and Rousseau (2016), the prevalence of reproductive coercion ranges from 9% to 16% in the absence of intimate partner violence, increasing to 25% when intimate partner violence is present. Similarly, multiple studies have reported prevalence rates between 8% and 16% (Grace, 2016; Kovar, 2018). Data from the National Intimate Partner and Sexual Violence Survey (NISVS) indicate that 8.4% of women in the United States would have experienced reproductive coercion (Basile et al., 2021). Fay and Yee (2020) found

that 8.6% of a sample of 202 women reported experiencing reproductive coercion during their most recent pregnancy.

Grace and Anderson (2018) identified prevalence rates ranging from 5% to 13% among women attending family planning services. They detailed the forms of reproductive coercion: These authors further detailed the forms of reproductive coercion: 7% to 11% reported contraceptive sabotage, 1% to 19% experienced pregnancy coercion, 0.1% to 4% were subjected to abortion coercion, and approximately 8% faced coercion to continue a pregnancy. Another recent 2024 study involving 317 cisgender heterosexual participants revealed that, among those who had experienced reproductive coercion at least once, 83.3% reported contraceptive sabotage, 17.7% reported pregnancy coercion, and 12.6% reported pregnancy control (Lévesque et al., 2025). Additionally, research conducted by Willie et al. (2021) found that among 675 women attending family planning clinics, 16.4% had been victims of contraceptive sabotage. A recent 2023 study conducted in Canada revealed that nearly 62.8% of participants reported experiencing contraceptive sabotage, including instances of stealthing (Lévesque et al., 2023). According to Lowe (2023), existing research indicates that reproductive coercion aimed at continuing a pregnancy is more prevalent than coercion to terminate a pregnancy, largely explained by cultural norms surrounding motherhood.

In 2021, an Australian study reported a prevalence of reproductive coercion ranging from 8% to 30% (Tarzia et al., 2022). The authors attribute these variations in prevalence to the ambiguity surrounding the intent behind acts of reproductive coercion, highlighting the particular case of non-consensual condom removal.

Prevalence estimates can also vary by age: a study of 550 sexually active adolescent girls found that 12% had experienced reproductive coercion, and 17% had suffered physical or sexual abuse in intimate relationships. In a study involving girls aged 14 to 17, 29 out of 149 participants reported exposure to reproductive coercion (Northridge et al., 2017).

Studies in the United States indicate higher prevalence of reproductive coercion among women who experience intimate partner violence. For example, a study of women aged 18 to 44 attending an urban obstetrics and gynecology clinic found that nearly one-third of those who had experienced intimate partner violence also reported reproductive coercion in their relationship (Park et al., 2016). A recent study of New York college students found that 50% of women who had experienced reproductive coercion also reported partner violence (Katz et al., 2017), and a study of 660 women from domestic violence shelters revealed that nearly one-third had experienced reproductive coercion (Bagwell-Gray et al., 2021). Other research suggests that women experiencing intimate partner violence are eight times more likely to experience reproductive coercion than those who do not (Samankasikorn et al., 2019). However, coercive control can also occur in the absence of intimate partner violence. According to Skracic et al. (2021), 13.9% of these women reported verbal coercive control, while 16.1% reported behavioral coercive control. Another study by Alexander et al. (2021) found that about 10% of 118 young Black women reported experiencing reproductive coercion without an unplanned pregnancy.

It is evident that prevalence rates vary significantly, and as such, the estimates presented above should be interpreted with caution. Indeed, the different methodologies used to estimate prevalence vary from one study to another. Furthermore, since reproductive coercion is often included in studies addressing domestic violence or intimate partner violence, it is challenging to understand the underlying mechanisms of reproductive coercion, as well as its specific characteristics and consequences (Holliday et al. 2018). In this regard, Grace (2016) suggests that reproductive coercion be considered as a distinct phenomenon while acknowledging its connections to intimate partner violence. Additionally, several authors have questioned the temporal relationship between reproductive coercion and intimate partner violence – whether reproductive coercion precedes, follows, or occurs concurrently with intimate partner violence (Grace & Fleming, 2016; Lévesque & Rousseau, 2016).

Risk and protective factors for reproductive coercion

The factors listed below should be read and understood in light of the fact that the studies referenced were conducted in the United States, Canada, and Australia, within political, socio-cultural, and economic contexts specific to each of these countries.

Individual risk factors

Adolescence and early adulthood are predominant risk factors for reproductive coercion (Bagwell-Gray et al., 2021; Carter et al., 2021; Grace & Anderson, 2018; Katz et al., 2017; Hayes et al., 2023; Lévesque & Rousseau, 2016; Miller et al., 2024; Northridge et al., 2017; Rowlands & Walker, 2019; Tarzia et al., 2022). Miller et al. (2024) indicate that adolescents, particularly those in abusive relationships or vulnerable situations, are especially affected by reproductive coercion. However, this form of violence is rarely reported, as victims are often deterred by fear and a lack of trust in adults (Miller et al., 2024). Building on the previously mentioned findings, Swan et al. (2021) indicate in their study on young women that undergraduate students are particularly at risk of reproductive coercion. Furthermore, a second study conducted in 2023 with a diverse sample of young women revealed that 11% had experienced reproductive coercion, with 10% reporting pregnancy-related pressures and only 3.3% reporting contraceptive sabotage (Hayes et al., 2023). However, Grace et al. (2023) report a lower prevalence of reproductive coercion among adolescents, estimating it at 3.1% in a sample of 2,221 individuals.

Despite varying results depending on the contexts and populations studied, many authors identify belonging to a minority or multiethnic group as a major risk factor (Dejoy, 2019; Lévesque & Rousseau, 2016; Grace et al., 2023; Grace & Anderson, 2018; Grace & Fleming, 2016; Hayes et al., 2023; Holliday et al., 2018; Price et al., 2022; Samankasikorn et al., 2019; Tarzia et al., 2022). Several studies highlight an increased risk among Black, African American, Hispanic women, or those from multicultural backgrounds. Bagwell-Gray et al. (2021), Fay & Yee (2018), and Muñoz et al. (2023) emphasize the specific vulnerability of these populations, linked to power dynamics, racism, and social discrimination.

A particularly concerning issue is that reproductive coercion also affects non-Hispanic Black men, who face a dual vulnerability (Basile et al., 2021). A study conducted with 354 American college students confirms that identifying as a non-white ethnic minority is a significant risk factor (Grace et al., 2020; Grace et al., 2023). Muñoz et al. (2023) report a particularly high prevalence among Hispanic participants, especially Latina women, who face specific pressures related to immigration status, machismo, and family-centered cultural norms. Some migrant women in the United States and Australia have even experienced reproductive coercion under the threat of deportation (Moulton et al., 2021). In Australia, Tarzia et al. (2022) also highlight how immigration status can become a tool for control and abuse.

Socioeconomic and community factors further intensify this vulnerability (Coleman et al., 2023; Tarzia et al., 2022). As noted by Coleman et al. (2023), African American and Latino populations are particularly affected by reproductive coercion due to structural racism, economic instability, and limited access to care, particularly in terms of contraception and abortion. Legal restrictions on abortion further exacerbate this situation. According to Moulton et al. (2021), social inequalities, such as partner incarceration, employment barriers, and housing instability, also contribute to the occurrence of reproductive coercion within African American communities.

Other studies present more ambivalent results (Basile et al., 2021; Lévesque & Rousseau, 2016; Grace & Anderson, 2018; Grace & Fleming, 2016). For example, a study conducted in the Bronx showed that identifying as "White" was more associated with reproductive coercion than not being White (Alexander et al., 2016), while others found no significant difference in the experience of reproductive coercion among Black, Hispanic, and White students (Park et al., 2016; Willie et al., 2019).

Regarding immigration status, some migrant women in the United States and Australia have

experienced reproductive coercion due to the threat of deportation if they did not comply with their partner's reproductive demands (Moulton et al., 2021). Also in Australia, Tarzia et al. (2022) highlight that immigration status can serve as a tool for control and abuse against women, thus representing a risk factor for reproductive coercion.

The literature mentions various risk factors associated with reproductive coercion. These factors include belonging to a sexual minority (Grace & Fleming, 2016), lack of health insurance (Grace & Anderson, 2018), undocumented status (Coleman et al., 2023; Dejoy, 2019), adherence to gender norms and roles, particularly the "biological imperative" for women to reproduce (Moulton et al., 2021; Tarzia et al., 2022), incarceration (Coleman et al., 2023), and housing instability (Coleman et al., 2023; Lévesque & Rousseau, 2016). Additionally, engaging in transactional sex (Phillips et al., 2016; Willie et al., 2021), contracting sexually transmitted infections (Willie et al., 2021; Grace et al., 2023), and experiencing depressive symptoms (Grace & Anderson, 2018; Grace et al., 2020) are also considered significant risk factors for reproductive coercion. Grace et al. (2023) add to this list poor academic performance and previous pregnancy history and early sexual initiation (Grace et al., 2023).

However, results concerning education and financial situation are ambivalent, making it uncertain whether these act as risk or protective factors (Grace & Anderson, 2018; Lévesque & Rousseau, 2016). Nevertheless, a disadvantaged socio-economic status seems to constitute a potential risk factor for reproductive coercion due to limited access to care and the constraints involved in continuing a pregnancy in a context of precarity (Alexander et al., 2016; Carter et al., 2021; Dejoy, 2019; Samankasikorn et al., 2019). Finally, dropping out of school for relational reasons may also increase the risk of reproductive coercion (Grace et al., 2020). However, at least one study did not find a link between reproductive coercion and variables such as age, relationship status, and possession of health insurance (Phillips et al., 2016). A second study conducted in Australia indicates no significant difference between age groups or individuals from migrant and refugee backgrounds, suggesting that reproductive coercion can affect any population (Sheeran et al., 2022).

Alcohol consumption is a particularly influential factor in the practice of stealthing (Jargin, 2018). It is also associated with an increased risk of not using condoms and other behaviors that disregard the consequences of unprotected sex. Similarly, drug use has also been identified as a risk factor for sexual coercion. Indeed, a study of 96 American women participating in a syringe exchange program (SEP) shows that 79% used methamphetamine, 74% used heroin, and 62% had experienced intimate partner violence or sexual coercion in the past three months (Perry et al., 2020). Furthermore, a more recent study highlights the prevalence of various victimization factors among young adults, such as drug and tobacco use, as well as the presence of health issues (Grace et al., 2023).

Finally, Petty-John et al. (2021) suggest that a history of foster care placement is also a risk factor for reproductive coercion. In their study of 136 adolescents placed in foster care, 30.1% had been victims of sexual violence (Petty-John et al., 2021). This was particularly true for women of color and those from the LGBTQ+ community (Petty-John et al., 2021).

Relational risk factors

Although reproductive coercion can manifest in the absence of intimate partner violence (Addington, 2021; Bagwell-Gray et al., 2021; Basile et al., 2021; Grace & Anderson, 2018; Grace & Fleming, 2016; Grace et al., 2023; Hayes et al., 2023; Lévesque & Rousseau, 2016; Price et al., 2022), being a victim of intimate partner violence is a significant and substantial risk factor for the occurrence of reproductive coercion. Willie et al. (2019) establish a dual association: first, between intimate partner violence and reproductive coercion among young couples expecting a baby and parents; and second, that women who experienced reproductive coercion were at higher risk of intimate partner violence within the six months following the event. The authors also found that a history of reproductive coercion among young women and men

increased the likelihood of experiencing reproductive coercion in a new relationship. While this data suggests that a history of sexual violence appears to be a risk factor for reproductive coercion (Grace & Anderson, 2018; Grace & Fleming, 2016; Katz et al., 2017; Lévesque & Rousseau, 2016; Willie et al., 2019), this association is not supported by a 2021 study which indicates that physical violence was also not associated with sexual violence (Swan et al., 2021).

According to Katz and Sutherland (2020), contraceptive interference is closely associated with various forms of intimate partner violence. Partners who engage in contraceptive interference are often also involved in acts of psychological abuse, severe physical violence, as well as attempted sexual assault or confirmed sexual assaults. Grace et al. (2023) particularly highlight the role of harassment and digital abuse in the exercise of reproductive coercion among young adults. Additionally, another study conducted in 2022 reveals that women engaged in abusive and violent relationships have reduced control over their fertility. They are more likely to experience unplanned pregnancies and to face pregnancy-related complications such as preterm births and miscarriages (Liu et al., 2016).

A study conducted reveals a link between housing search due to intimate partner violence and reproductive coercion. In this research, involving a sample of 70 women victims of intimate partner violence, 16.4% of those who had undertaken housing search due to intimate partner violence had experienced acts of reproductive coercion in the three months prior. Reproductive coercion was notably correlated with the frequency and severity of the violence suffered (Grace et al., 2023).

Being single or involved in non-committed or unstable relationships (Hayes et al., 2023; Hubel et al., 2025; Tarzia et al., 2022; Fay & Yee, 2018; Grace et al., 2020; Grace & Anderson, 2018; Grace & Fleming, 2016; Samankasikorn et al., 2019), women with older partners (Grace & Anderson, 2018), women engaging in bisexual behaviors (Grace et al., 2023) and women who have had multiple sexual partners whether within the past six months or over time (Willie et al., 2021; Hubel et al., 2025) are at greater risk of experiencing reproductive coercion. Adolescents exposed to both relationship violence and reproductive coercion are more likely to have an older partner. More generally, it has been reported that living in a gendered and socially normative context, with low gender parity, increases the risk of violence against women, including reproductive coercion and sexual violence (Lévesque & Rousseau, 2016; Grace & Anderson, 2018; Rowlands & Walker, 2019).

Regarding the perpetrators of reproductive coercion, it seems that young men who exhibit violent behaviors are more likely to want their partner to become pregnant (Barber et al., 2018). They resort to threats and physical aggression to impose their demands, particularly through sexual intercourse and contraceptive nonuse, thus increasing pregnancy rates.

Protective factors

While the risk factors for reproductive coercion are relatively well studied and documented, very few studies have explored protective factors against reproductive coercion. In the review by Lévesque and Rousseau (2016), no protective factors for reproductive coercion were reported. In contrast, Grace and Fleming (2016) mention that living in an environment with a high level of gender parity and attending urban clinics may serve as protective factors against reproductive coercion. Other factors that may facilitate women's recognition of an experience of reproductive coercion have also been identified, such as being informed about reproductive coercion, confiding in a friend or acquaintance, or having a partner who respects reproductive rights (Lévesque & Rousseau, 2019). Hayes et al. (2023), in their literature review, highlight that being in an exclusive relationship is associated with a decreased risk of reproductive coercion, making it a protective factor. However, overall, protective factors against reproductive coercion appear to be somewhat neglected in the literature.

Preventive interventions in reproductive coercion

Given the limited information available on protective factors against reproductive coercion, it is understandable that few studies have focused on

prevention and intervention strategies for this specific form of violence. Nevertheless, a 2016 study evaluated the effectiveness of an educational program called "Addressing Reproductive Coercion in Health Settings" (ARCHES). This program, implemented with healthcare professionals working in family planning centers, aimed to inform participants about available resources for addressing domestic violence, strengthen their self-efficacy in adopting risk-reduction behaviors, and encourage the use of a domestic violence helpline. Although the program did not directly lead to a reduction in reproductive coercion, it contributed to reducing reproductive coercion among women experiencing multiple forms of violence one year after the intervention (Miller et al., 2016).

Miller et al. (2024) report that both ARCHES and CUES (Confidentiality, Universal Education, Empowerment, and Support) are effective strategies for empowering youth, increasing awareness of available resources, and educating about healthy relationships to prevent abuse. These initiatives aim to promote responsible behaviors while enhancing prevention efforts. They also emphasize the importance of integrating reproductive coercion into comprehensive sexual education and reproductive health services.

Another study examined an intervention designed to reduce intimate partner violence and reproductive coercion in family planning centers by informing women about available resources and risk-reduction strategies (Miller et al., 2017). The intervention facilitated discussions on intimate partner violence and reproductive coercion in a trusting environment, allowed participants to better understand available services for interpersonal violence, and empowered them by reinforcing their ability to help other women.

In this context, Galrao et al. (2022) suggest that screening programs for intimate partner violence and reproductive coercion could be beneficial, particularly in facilitating disclosure. Their study also demonstrates that the program contributed to an increase in specialized consultations for intimate partner violence. The findings indicate that patients strongly prefer systematic screening as well as paper-based screening methods.

In terms of secondary prevention, the focus can be on improving healthcare providers' skills in identifying and addressing reproductive coercion (Miller et al., 2024; Rowlands & Walker, 2019; Zachor et al., 2018). An exploratory study conducted in four family planning clinics evaluated the effects of two training programs for healthcare professionals: one provided standard training on reproductive coercion and intimate partner violence, while the other focused on teaching communication techniques for addressing sensitive topics (Zachor et al., 2018). Both training formats increased and improved the quality of healthcare professionals' communication regarding reproductive coercion and intimate partner violence. Additionally, clinics that received standard training on reproductive coercion and intimate partner violence communicated more about these issues after the training (Zachor et al., 2018).

The safety card is often highlighted in the scientific literature for its effectiveness in reducing risks related to reproductive health and interpersonal violence. It is a small card with key information on risk-reduction strategies, safety planning, and resources for domestic violence, reproductive control, and sexual coercion. Healthcare professionals can quickly present this card in under a minute to raise awareness among their patients (Kovar, 2018). This tool helps patients identify links between coercive behaviors from their partners and potential reproductive health issues. A randomized controlled trial in family planning clinics demonstrated that using the safety card, combined with provider training, reduced the risk of forced pregnancies by 71%. Patients who used the safety card were also more likely to end a relationship they perceived as toxic or dangerous (Park et al., 2016).

A digital version of the safety card, integrated into an interactive app, combines activation messages for patients with scripts for healthcare providers. This approach aims to facilitate discussions between patients and providers on topics of domestic violence and reproductive control while reducing barriers to disclosing harmful partner behaviors. Hill et al. (2019) compared two versions of this intervention, known as TIPS (Trauma-Informed Personalized Scripts):

TIPS-Basic, which provides only scripts for providers, and TIPS-Plus, which also includes psycho-educational messages for patients. Although the evaluation confirmed the usefulness of the scripts for guiding discussions, no statistically significant difference was found between TIPS-Plus and TIPS-Basic in terms of disclosures of domestic violence or reproductive control. These results suggest that messages aimed at patients do not provide additional benefits in the intervention. In 2023, Lévesque et al. conducted a study on the practices of professionals in Quebec concerning reproductive coercion. The findings suggest that assessing women's safety, validating their emotions, and implementing risk-reduction methods were the primary intervention actions undertaken by professionals. Additionally, professionals referred victims to appropriate resources and sought to ensure follow-up despite constraints related to time, space, and a notable lack of training in the field (Lévesque et al.).

In 2017, McGirr et al. examined the practices of professionals working in the prevention of interpersonal violence and how they address reproductive coercion. It was found that these professionals faced few obstacles in initiating discussions on reproductive coercion, but the frequency of interventions was insufficient, highlighting the critical need for specialized training and organizational support to adequately address these issues.

Cheng et al. (2023) identified several barriers to professional intervention, primarily time constraints and limited care options. To address these challenges, the researchers proposed solutions such as continuous training modules, decision-support tools for screening and managing reproductive coercion, and enhanced multidisciplinary collaboration (Cheng et al., 2023). In Australia, Carter et al. (2021) report very similar barriers; findings that are also confirmed by Wellington et al. (2021), who further emphasize that gaps in available support services and the lack of context-specific guidelines constitute major barriers to addressing reproductive coercion.

Discussion

Reproductive coercion is a relatively common phenomenon, but research on the subject, particularly outside the United States, remains limited. This paper contributes to the existing literature on reproductive coercion by summarizing key information from existing reviews and adding findings from international research to better document the prevalence and presentation of the issue, identify potential risk and protective factors, and suggest possible interventions.

As highlighted in the literature, reproductive coercion typically occurs within intimate partner relationships, though it can also be perpetrated by family members or in-laws. It can also be structural, when national policies affect women's reproductive and sexual health. The three main tactics used in reproductive coercion are: sabotaging contraception (with stealthing as a specific form of sabotage), pressuring the partner to become pregnant against her wishes, and coercing a pregnant woman into following the partner's demands regarding pregnancy outcomes. In all these forms, the perpetrator may use physical violence, threats, accusations, or other forms of pressure to manipulate the victim.

Reproductive coercion predominantly affects young women and those with low socioeconomic status, although it can also impact men and people with same-sex orientations. Social contexts characterized by gender inequality, sexual minority status, and histories of substance abuse or foster care are considered risk factors for reproductive coercion. However, the role of education, financial status, or ethnicity as risk factors for reproductive coercion remains unclear and warrants further study.

Prevalence estimates of reproductive coercion vary significantly, ranging from 9% to 16% among women, with pressures to become pregnant being the most frequently reported form. However, these estimates should be viewed with caution, as there is considerable methodological variation in how prevalence is measured. It is also important to note that in non-Western cultures, women may experience reproductive coercion differently due to cultural norms, policies, and laws in place.

Prevalence increases dramatically, reaching up to 25% or more, when intimate partner violence is present. Women experiencing reproductive coercion are often subjected to concurrent

intimate partner violence, with some studies suggesting up to 50% of cases overlap. While the strong association between reproductive coercion and intimate partner violence indicates that intimate partner violence is a major risk factor for reproductive coercion, reproductive coercion can also occur without intimate partner violence. Additionally, most studies focusing on the overlap between reproductive coercion and physical/sexual intimate partner violence do not address the complex relationship between reproductive coercion and psychological violence.

While many of these risk factors are structural and not easily modifiable, they can be used to identify higher-risk groups and individuals, thus informing secondary prevention strategies. As suggested by several researchers, early detection of reproductive coercion should be integrated into health service policies in reproductive/contraceptive clinics and counseling services.

Healthcare professionals must be sensitized to the phenomenon of reproductive coercion, trained in diagnostic skills and communication to address sensitive topics, and equipped with screening tools like the "*Safety Card*." Specialized intimate partner violence and reproductive coercion services should be available, and detection methods can include asking specific questions about reproductive coercion, especially when women frequently present for emergency contraception, pregnancy tests, or STI screenings. However, few studies have assessed the effectiveness of these interventions.

In contrast to risk factors, protective factors have been scarcely addressed in the literature on reproductive coercion. As a result, effective primary prevention interventions have been limited. However, some researchers propose prevention strategies based on the idea that gender parity in relationships, social awareness of the issue, and access to social support may protect against reproductive coercion. These interventions include public awareness campaigns, education on harm-reduction strategies, encouraging open discussions about intimate partner violence and reproductive coercion in a trusted environment, and empowering women to help other women. The few intervention programs developed in this area have shown promising results.

This study is not without limitations. Despite efforts to broaden the scope and include research from outside the U.S., Europe, Australia and Canada, almost all the studies included in this analysis came from English-speaking countries. While this reflects the geographic reality of the research interest, a more comprehensive understanding of reproductive coercion would require more research in other parts of the world. A cross-cultural comparison could explore the structural, cultural, and socio-economic factors underlying reproductive coercion and the experiences of its victims. It would therefore be relevant for future research to specifically examine how reproductive coercion manifests in non-English-speaking contexts, in order to gain a more global and complete understanding of the phenomenon.

Furthermore, the lack of comparable empirical data prevented the possibility of a meta-analysis, limiting the study to a narrative review. Therefore, inconclusive or contradictory findings in the reproductive coercion literature could only be noted, rather than systematically addressed. Additional research is needed to obtain more accurate prevalence estimates of reproductive coercion (with and without intimate partner violence) and to clarify the role of ethnicity, relationship status, education, and financial situation as potential risk factors for reproductive coercion. It is also important to acknowledge that vulnerability factors may vary considerably depending on location and social context.

Finally, a critical appraisal of the quality of the studies was not conducted in this review, which represents a methodological limitation. The absence of an in-depth analysis may limit the interpretation of the findings, as some of the included studies may present methodological biases. Future research should incorporate a systematic assessment of study quality using validated tools such as AMSTAR 2 or STROBE.

Despite these limitations, the findings of this study provide an overview of the current state of knowledge regarding the prevalence of reproductive coercion, its forms, context, potential risk and protective factors, and intervention possibilities. This allows for practical recommendations, highlights gaps in current knowledge, and suggests areas for further research.

In terms of practice, our study emphasizes the importance of primary and secondary prevention of reproductive coercion, as underscored by other researchers. Specifically, it is necessary to raise awareness about reproductive coercion and educate the public on harm-reduction strategies, as well as to sensitize healthcare professionals, especially those working in reproductive and counseling clinics, to the issue. Providing them with appropriate screening tools, such as the "safety card," and training them in communication on sensitive topics is crucial.

For future research, it would be beneficial to better document the occurrence of reproductive coercion in the absence of intimate partner physical violence and identify underlying mechanisms, as well as risk and protective factors, while exploring prevention possibilities. Further studies on reproductive coercion in male victims and within LGBTQ+ populations are also needed to determine whether gender, gender identity, or sexual orientation serve as risk or protective factors for reproductive coercion and if the underlying mechanisms and consequences for male or LGBTQ+ victims are comparable to those observed in cisgender women. Additionally, reproductive coercion in new relationships and diverse marital configurations deserves increased attention.

It would be equally interesting and relevant to clarify the intentions of perpetrators of reproductive coercion in order to establish more precise prevalence rates and achieve a better understanding of the phenomenon. Nonconsensual condom removal exemplifies this issue. This behavior does not always primarily aim to induce pregnancy but rather constitutes a selfish act of prioritizing male pleasure at the expense of the partner's sexual and reproductive health. Overall, perpetrators' intentions do not always align with the actual consequences of their actions. Therefore, a deeper investigation into the motivations and intentions of perpetrators would enhance the understanding of reproductive coercion and better inform prevention efforts.

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I certify that I have used the free version and version 4 of ChatGPT to translate my original text, initially written in French, into academic English. I also used it to format the bibliography according to APA standards and, on rare occasions, to refine the writing style. It is, of course, certain that the content of this text originates entirely from myself, and ChatGPT has been used solely for purposes of form, not content.

Author contributions

CE performed the literature search, CE carried out the review, FA and SV were consulted on the data extraction and structure of the review and participated in writing the manuscript. All authors approved the final manuscript.

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