Health Professionals' Knowledge of and Experiences Identifying and Responding to Reproductive Coercion Among Patients: A Systematic Review and Meta-Synthesis

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Abstract

Reproductive coercion, which can involve contraceptive sabotage, pregnancy pressure, and/or pregnancy control, is a form of abuse predominately experienced by females. Despite rates of reproductive coercion appearing to be rising, little is known about health professionals' knowledge and ability to navigate this important issue. Consequently, this research aimed to explore health professionals' knowledge of reproductive coercion and how they screen, identify and respond to it. Five databases were searched; after appropriate screening and quality appraisal, nine high-quality studies from three countries, comprising 221 participants, were included in the research. A meta-aggregative meta-synthesis approach resulted in three synthesised findings related to the research aims. Key findings suggest that health professionals have limited knowledge about reproductive coercion, consequently leading to poor screening and identification, which is more evident in culturally diverse patients. Findings also suggest that responding effectively to reproductive coercion is complex, and health professionals have exhausted the minimal resources available to them. These findings further suggest that reproductive coercion is a multifaceted problem that leads to adverse reproductive outcomes which hinder a person's bodily autonomy and their right to reproductive freedom. Health professionals are ill-equipped to manage the issue alone and rely on multiple resources to assist patients experiencing reproductive coercion. Future research would benefit from a stronger emphasis on the different types of resources needed for health professionals to tackle reproductive coercion effectively.

Declaration

This report contains no material which has been accepted for the award of any other degree or diploma in any university and, to the best of my knowledge, contains no materials previously published except where due reference is made. I give permission for the digital version of this thesis to be made available on the web, via the University of Adelaide's digital thesis repository, the Library Search and through web search engines, unless permission has been granted by the School to restrict access for a period of time.

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26th September 2022

Contribution Statement

This thesis was conducted in collaboration with my supervisor, where we worked together to generate research questions of interest, design an appropriate methodology and develop and pre-register the study protocol. I generated the search terms in consultation with my research supervisor and an experienced research librarian. I then conducted the database searches. After removing duplicates, I co-screened a proportion of studies according to the inclusion/exclusion criteria with my supervisor before undertaking the remainder of the screening. The reporting quality of all eligible articles was assessed by myself and my supervisor. With guidance from my supervisor, I completed data extraction and the accompanying analysis and wrote up all components of the thesis.

Overview

Reproductive coercion is any behaviour which interferes with or compromises a person's autonomous decision-making about their reproductive health (Grace & Anderson, 2018). Global prevalence estimates of reproductive coercion range from 8% to 16%, with higher rates associated with socio-cultural factors (Clark et al., 2014; Kovar, 2018). Reproductive coercion is a significant issue in health care that disproportionately affects females, including single, African American, Latina and multiracial females, those of lower socio-economic status, those experiencing intimate partner violence (IPV), and females who frequently attend family planning clinics (Grace & Anderson, 2018). Reproductive coercion interferes with a person's human right to bodily autonomy (Grace & Anderson, 2018). Health professionals have a valuable role in reproductive coercion, including screening, identifying and responding to reproductive coercion among their patients. However, there is an absence of academic discourse that examines health professionals' experiences with reproductive coercion. This thesis, therefore, aims to enhance knowledge by systematically identifying, appraising and synthesising existing qualitative research about health professionals' knowledge of reproductive coercion and how they screen, identify and respond to it.

Definitions and Experiences of Reproductive Coercion

The domain of reproductive health decision-making is becoming increasingly complex. In particular, concern has arisen regarding reproductive coercion due to the potential consequences which follow coercive behaviours and practices (Grace & Anderson, 2018). Miller et al. (2010) formally identified reproductive coercion in 2010. Before its formal identification as a distinct form of coercive control, behaviours encompassed by reproductive coercion were commonly viewed as forms of gender-based violence and IPV. Such views likely arose as reproductive coercion is typically a by-product of control and a deliberate intent to tamper with and manipulate a person's reproductive autonomy (Tarzia &

Hegarty, 2021). However, even with formal recognition, confusion and debate remain about the classification and, to a lesser extent, the behaviours that constitute reproductive coercion. While more recently, researchers have argued that the behaviours should be referred to as 'reproductive coercion and abuse' (Tarzia et al., 2020; Tarzia et al., 2022; Wellington et al., 2021), a consensus on terminology has yet to be reached. In the absence of this consensus, Miller et al.'s (2010) term, 'reproductive coercion', will be used throughout this thesis. Additionally, while reproductive coercion is more often experienced by females, it can be experienced by people of all sexes and genders. In recognition of this, when the author is synthesising research to produce findings and recommendations, the term 'people' is used. However, when describing previous research, the author uses the sex or gender terms employed by the original researchers. The further complexities surrounding reproductive coercion can be seen below in its association with violence.

The Context of Reproductive Coercion and its Association with Violence

Most existing research examines reproductive coercion within frameworks of IPV, which, in Australia, is also described as "family violence" and "domestic violence". Researchers have reported that reproductive coercion and IPV are not independent, with higher rates of reproductive coercion present among women with a history of IPV (Sutherland et al., 2015). For example, Clark et al. (2014) found that among the 16% of their participants who reported reproductive coercion, one-third also reported IPV occurring within the same relationship.

IPV is strongly associated with poor reproductive outcomes among women globally (Silverman & Raj, 2014). IPV can be viewed as gender-based violence that comes from culturally conceived roles and power imbalances (Fay & Yee, 2018). It may fall into multiple categories, including physical, verbal, emotional, financial and reproductive abuse (Fay & Yee, 2018). The World Health Organisation (WHO) found that between 23% and 49% of

females aged over 15 experience IPV globally (Silverman & Raj, 2014). Within Australia, approximately 1 in 6 women and 1 in 16 men report having experienced IPV in the form of physical or sexual violence from a partner since the age of 15 (Duncan et al., 2021). In 2020, over 1.7 million women and 580,000 men in Australia experienced violence from their partners (Duncan et al., 2021). However, prevalence rates of IPV are likely to be underestimated, as most cases of IPV go unreported (Tarzia et al., 2019b).

Situating reproductive coercion can be complex due to its relationship with IPV and gender-based violence. A portion of the literature argues that reproductive coercion and IPV share too many commonalities for them to occur in isolation from one another and as such, must be treated as interrelated behaviours (Giacci et al., 2022; Tarzia et al., 2019a; Tarzia et al., 2019b; Wellington et al., 2021). However, Basile et al. (2019) recognise reproductive coercion as a specific type of IPV and argue that reproductive coercion intersects with two public health concerns: IPV and reproductive health. Furthermore, reproductive coercion's relationship with coexisting factors, some of which risk further harm to a person's health and wellbeing, makes reproductive coercion a major public health issue.

Forms of Reproductive Coercion

Reproductive coercion encapsulates specific types of coercion which change with different definitions and interpretations. Since Miller et al.'s (2010) formal recognition of reproductive coercion, a growing body of literature now details varying forms of reproductive coercion. Broadly, reproductive coercion is external pressure exerted on an individual by others to control a person's reproductive autonomy. This may include a widespread range of behaviours, from persuasion to pressure such as emotional blackmail, societal or family expectations to have children, and threats of or actual accounts of physical violence (Rowlands & Walker, 2019). At the time of its identification, reproductive coercion

encompassed contraceptive sabotage, pregnancy pressure and pregnancy control (Grace & Anderson, 2018).

Contraceptive Sabotage

Contraceptive sabotage, also commonly referred to as birth control sabotage, is any behaviour that intentionally interferes with a person's attempt to prevent pregnancy (Miller et al., 2010). These behaviours, typically performed by an intimate partner (Silverman & Raj, 2014), include deliberately damaging, hiding or otherwise tampering with a form of birth control (Tarzia & Hegarty, 2021). Some researchers include stealthing (the covert removal of a condom during intercourse) within behaviours constituting reproductive coercion as a form of contraceptive sabotage (Rowlands & Walker, 2019). However, others exclude it, arguing that stealthing is not about controlling someone's reproductive autonomy, but rather, is about sexual aggression and follows behaviours which are adjacent to rape and non-consensual sex (Brodsky, 2017; Chesser & Zahra, 2019).

Rowlands and Walker (2019), in a narrative review, reported that one in six people experience contraceptive sabotage. This prevalence rate is concerningly high and exposes people to poor health outcomes as people who report contraceptive sabotage have greater odds of contracting sexually transmitted infections (Willie et al., 2021).

Pregnancy Pressure

Pregnancy pressure, also known as pregnancy coercion (Miller et al., 2010), involves pressuring a person to become pregnant or to carry an unwanted pregnancy to term and occurs during the initial phases of a person trying to fall pregnant (Grace, 2016; Miller & Silverman, 2010). Pregnancy pressure is most commonly reported as being undertaken by males. Such behaviours manipulate people to comply with a male partner's desire for them to become pregnant or their desire for them to continue or terminate a pregnancy against the female's wishes (Silverman & Raj, 2014). Pregnancy pressure can be combined with threats

to leave a relationship or threatening to have a child with another partner if the person fails to comply. It has extensive consequences for females, such as their partners monitoring their menstrual cycles and gynaecology appointments, or forcing them to undergo tubal ligation, which medically prevents a pregnancy (Grace, 2016).

Pregnancy Control

Pregnancy control is the pressure to continue an unwanted pregnancy, or to terminate a wanted pregnancy against a person's wishes and occurs once a person becomes pregnant (Grace, 2016). This form of reproductive coercion can encompass abortion coercion, seeking to control a pregnancy by pressuring a person to have a termination, or forcing them to continue a pregnancy they wish to terminate (Grace & Anderson, 2018). In extreme cases, pregnancy control can include acts of violence, where a pregnant person is injured with the intent to cause a miscarriage (Park et al., 2016).

A recent systematic review by Grace and Anderson (2018), investigating reproductive coercion found that people have been coerced into both terminating and continuing pregnancies. For example, they found that four studies specifically described partner coercion regarding whether to terminate a pregnancy, with prevalence estimates ranging from 0.1% to 4%. Contrastingly, one study reported 8% prevalence of people being pressured to continue a pregnancy or being prevented from seeking abortion services (Grace & Anderson, 2018). Two of the included studies shared instances where women were threatened with harm or death by their partners if they chose to have an abortion. Notably, Grace and Anderson (2018) reported that the highest prevalence rates of reproductive coercion were self-reported by men in a male-only sample. They concluded that social desirability increases prevalence rates of reproductive coercion.

Price et al. (2022) conducted a retrospective analysis of calls to a telephone counselling and information service assisting with unplanned pregnancies. They found that of

the women who contacted the service more than once, 81.8% reported coercion to continue a pregnancy, compared to 16.6% of women coerced into an abortion (Price et al., 2022). Prevalence estimates of pregnancy coercion have been found to be the highest among multiracial women (27.5%), non-Hispanic Black women (25.9%), and among women born in the United States compared to those born elsewhere (Miller et al., 2011).

Impact of Reproductive Coercion

Reproductive coercion leads to physical and psychological impacts. As noted previously, people who experience reproductive coercion are more likely to experience IPV as these two forms of violence can be experienced concurrently (Grace & Anderson, 2018; Grace et al., 2020; Rowlands & Walker, 2019; Silverman & Raj, 2014; Tarzia & Hegarty, 2021). Additionally, reproductive coercion is associated with poor reproductive health outcomes such as unplanned pregnancies, poor pregnancy outcomes and sexually transmitted infections (Silverman & Raj, 2014). The intersection of reproductive coercion and IPV is important to highlight; unplanned pregnancies are two to three times more likely to occur than planned pregnancies when IPV is present (Miller & Silverman, 2010). Rape, the fear of negotiating condom and other contraceptive use, inconsistent condom use (including stealthing) and partner interference with access to health care services all contribute to unplanned pregnancies when IPV is present (Miller & Silverman, 2010). Existing research has indicated that women who have experienced reproductive coercion, specifically contraceptive sabotage, have reported psychological impacts such as fear, shame and feelings of being deceived and abused (Lévesque et al., 2020). It is, therefore, important that health professionals are knowledgeable about reproductive coercion and can identify and respond to it appropriately.

Health Professionals and Reproductive Coercion

Despite the prevalence of reproductive coercion, associated health implications and high health care expenses, minimal research exists regarding health professionals and reproductive coercion (Zachor et al., 2018). Due to the relationship between IPV and reproductive coercion, health professionals may screen for reproductive coercion when assessing IPV (Grace & Anderson, 2018; Miller et al., 2010; Park et al., 2016; Tarzia & Hegarty, 2021; Zachor et al., 2018). Although recommendations exist for health professionals to *implement* routine screening for IPV, few recommendations state *how* health professionals should assess reproductive coercion (Zachor et al., 2018). Additionally, health professionals have reported multiple barriers to reproductive coercion (and IPV) assessment and clinical intervention, including a lack of time, topic discomfort (uncertainty about how to raise the topic of reproductive coercion) and being unsure with how to respond to reproductive coercion disclosures (Zachor et al., 2018). Such barriers are unfortunate considering that health professionals play a pivotal role in reproductive health care, where they have the potential to implement harm-reduction strategies and better patient care (Grace, 2016; Tarzia et al., 2018; Wellington et al., 2021). In light of existing findings and the important role of health professionals, it is wise to increase the understanding health professionals' have about reproductive coercion, screening practices and their responses to reproductive coercion disclosures.

Health Professionals' Knowledge of Reproductive Coercion

People who experience violence, including reproductive coercion, use health care services extensively (Tarzia et al., 2019b). For example, people who experience reproductive coercion are more likely to seek reproductive health care than people who do not (Kazmerski et al., 2014). Therefore, health professionals working in primary care and reproductive health care settings play vital roles in the detection of reproductive coercion, as they have the

potential to increase early intervention (Tarzia et al., 2019b). However, health professionals' ability to fulfil this role relies on their knowledge, perspectives and training concerning reproductive coercion. While health professionals' knowledge is a key part of identifying reproductive coercion, at present, little is known about health professionals' knowledge within this area. In reproduction-related settings, Tarzia et al. (2019b) examined 17 health professionals' views on reproductive coercion, finding that although most professionals understood reproductive coercion, it remained a complex and hidden problem in the medical field. Further research is needed to enhance understanding about health professionals' knowledge of reproductive coercion.

Health Professionals' Perspectives on Screening and Identifying Reproductive Coercion

The WHO Clinical and Policy Guidelines recommends routine screening for IPV and sexual violence (Cheng et al., 2021). This approach involves health professionals routinely asking women about current or recent abuse they might be experiencing using a list of standardised questions (Cheng et al., 2021). Routine screening for reproductive coercion would likely increase the identification of people experiencing such coercion, enabling them to receive assistance (Wellington et al., 2021). Since reproductive coercion's more recent global recognition, screening processes have been advocated internationally and have been advertised as an early intervention to address reproductive coercion within health care settings (Cheng et al., 2021; Grace & Anderson, 2018; Miller et al., 2010; Tarzia et al., 2019b). Women are more likely to engage with the management of clinical conditions associated with reproductive coercion, such as unprotected sex, sexually transmitted infections, and unplanned pregnancies (Miller et al., 2010). It is, therefore, not uncommon for reproductive coercion to be screened for in sexual and reproductive health care settings (Cheng et al., 2021). Currently, there is no universal screening for reproductive coercion. As a consequence, health professionals rely on open-ended questions to begin conversations

about reproductive coercion. Given that screening is highly recommended for the early intervention of reproductive coercion (Zachor et al., 2018), more needs to be known about health professionals' views towards and experiences of screening for reproductive coercion.

Health Professionals' Responses to Reproductive Coercion

Within Australia, most women accessing reproductive health care do so through a primary care clinician (e.g., a General Practitioner). However, little is known about clinicians' experiences of responding to reproductive coercion and associated abuse (Tarzia et al., 2019a; Tarzia et al., 2019b; Wellington et al., 2021). An important contributing factor to responding effectively to reproductive coercion is adequate training and appropriate resources for health professionals (Cheng et al., 2021). In a qualitative study, Wellington et al. (2021), described three central barriers to primary care clinicians working with reproductive coercion and offered insight into health professionals' lack of knowledge about responding to reproductive coercion. They noted a chronic lack of awareness about reproductive coercion and limited resources and training to equip health professionals to respond to reproductive coercion (Wellington et al., 2021). Additionally, health professionals had low confidence in their abilities to respond to reproductive coercion effectively and noted a lack of services to which they could refer patients for ongoing support. Health professionals also reported feeling disconnected and as though there was no one to assist them with managing such cases (Wellington et al., 2021). Existing literature does not focus on health professionals and their responses to reproductive coercion which emphasises the importance of closing this literature gap. This gap is heightened in research which often fails to acknowledge the important role of culture in reproductive coercion.

Reproductive Coercion and Culture

Health care services are provided within a cultural context. Therefore, is it important to consider the cultural context in which health professionals are practising and offering care

to people experiencing reproductive coercion. Reproductive coercion can co-exist in many different socio-cultural contexts, creating a global cause of concern (Moulton et al., 2021; Tarzia et al., 2022). Such socio-cultural factors are widespread and are amplified in certain cultural climates. These factors can include common cultural practises such as the control of women, rigid gender roles, social inequalities, pressure from families to conceive, and, in more extreme cases, preferences of newborn sex (to bear a son) and social exclusion (Moulton et al., 2021). Therefore, when researching reproductive coercion, cultural beliefs and practices must be considered.

Research Aims of the Current Study

This study aims to identify, appraise and synthesise qualitative research that has explored health professionals' knowledge and experiences of reproductive coercion among patients by addressing the following questions:

(1) What is health professionals' knowledge about reproductive coercion?
(2) What are health professionals' perspectives and experiences of screening for/identifying reproductive coercion?
(3) What are health professionals' perspectives and experiences of responding to reproductive coercion?

The information gathered will then be used to develop recommendations to improve health professionals' ability to identify and respond to reproductive coercion.

Method

Design

Qualitative syntheses are used in health research as they provide a balance between an objective framework, a rigorously scientific approach to data analysis and the required contribution of the researcher's subjectivity in the final work (Lachal et al., 2017). Qualitative synthesis informs fundamental aspects of evidence-based health care, particularly

health professionals' decision-making (Lockwood et al., 2015). Many forms of qualitative synthesis exist; meta-aggregation is often the preferred option as it aligns with the conventions for conducting higher-quality systematic reviews (Lockwood et al., 2015). Additionally, meta-aggregation is philosophically grounded in pragmatism and transcendental phenomenology (Lockwood et al., 2015). The key characteristics of a meta-aggregative review ensure that the reviewer avoids a re-interpretation of included studies. Instead, it works to present the findings of included studies accurately and reliably, as intended by the original authors (Lockwood et al., 2015). This thesis used a meta-aggregative approach to identify, critically appraise, analyse and synthesise health professionals' experiences of reproductive coercion. This meta-synthesis was also preregistered (XXXXXX).

Search Strategy

The *Preferred Reporting Items for Systematic Reviews and Meta-Analyses* (PRISMA; Page et al., 2021) guidelines were used throughout the review process. Five databases (PubMed, PsychINFO, Web of Science, CINAHL and Embase) were systematically searched to identify qualitative studies which examined health professionals' experiences in screening and responding to reproductive coercion. Search terms involved the use of controlled vocabulary and Boolean logic adapted to each database's indexing system (see Table 1; for full search grids see Appendix A). The search terms included: "reproductive coercion", "reproductive pressure", "reproductive control", "health professional", "health practitioner", "medical practitioner", "qualitative" and relevant variants. A research librarian also reviewed the search terms to maximise accuracy. The databases were searched from 2010 (the year reproductive coercion was formally defined) until March 2022, with identified references exported and screened in EndNote. Alerts were created to ensure that additional articles indexed or published after the initial search were assessed for possible inclusion.

Additionally, reference lists of articles that met the eligibility criteria were manually checked, and citation searches were conducted using Scopus to identify any further eligible studies.

Eligibility Criteria and Study Selection

Studies were included if they; (i) investigated health professionals' knowledge about reproductive coercion or their experiences of screening for/identifying reproductive coercion or responding to reproductive coercion; (ii) reported qualitative data (mixed method studies were eligible if the qualitative data was reported separately and in sufficient detail for data analysis); and (iii) were published in English and in a peer-reviewed journal. Studies were deemed as being qualitative if they employed qualitative data collection methods, including interviews and focus groups or qualitative data analysis methods, such as thematic analysis. Exclusion criteria included unpublished dissertations, conference abstracts, editorials and letters, and peer-reviewed journal articles that did not centrally examine reproductive coercion or did not explore reproductive coercion from health professionals' perspectives.

Table 1

Search Terms and Boolean (Logical) Operators used in the Database Searches

AND →

OR ↓

Reproductive Coercion	*Health Professionals*	*Qualitative*
reproductive health* reproductive coercion* coerced reproduction* intimate partner violence* manipulation* reproductive control* reproductive abuse* contraceptive sabotage* contraception sabotage* birth control sabotage* pregnancy pressure* pregnancy control*	health personnel* health professional* medical professional* healthcare professional* doctor* medical specialist* nurse* psychologist* social worker* mental health* health practitioner* healthcare practitioner* medical practitioner* general practitioner* primary care*	qualitative* focus group* interview* thematic analys* content analys* lived experience* personal experience* interpretive phenomenological analysis* ethnography* narrative* perspective*

Note. Search terms included stated terms in singular and plural forms, and appropriate variants.

The initial search yielded 3557 citations (see Figure 1); 1579 duplicates were removed, leaving 1978 studies to screen by title and abstract. After screening against the inclusion/exclusion criteria, 1895 articles were excluded, leaving 83 articles for full text screening. The author and the research supervisor co-screened a random sample of 198 studies (approximately ten percent of the identified studies) to reduce data-selection bias. Inter-rater agreement was high (97%, $K = .68$, $p < .05$) with any disagreements resolved by discussion. After full text review of the 83 studies, 74 were excluded, resulting in nine studies being assessed for methodological reporting quality. All nine studies were included based on quality assessment. Thus, the meta-synthesis comprised nine studies.

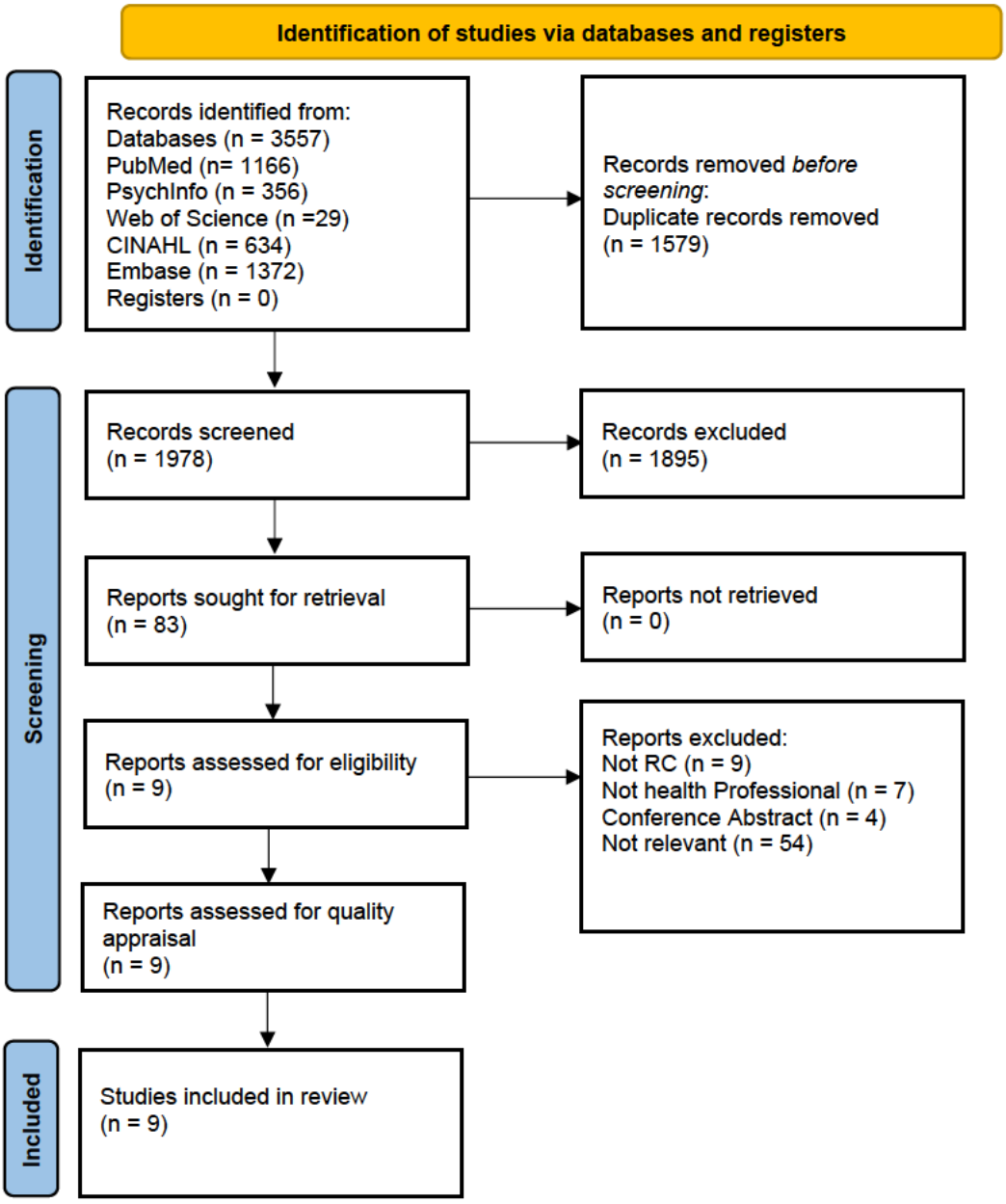
Appraisal of Reporting Quality

Critical appraisal plays a key role in the meta-aggregative approach as the quality of the included studies directly influences the quality of the resultant meta-synthesis (Korhonen et al., 2013; Lachal et al., 2017). The inclusion of only high-quality studies is likely to result in the generation of more appropriate recommendations.

The Qualsyst Quality Assessment Checklist (Kmet et al., 2004) was used to ensure that included studies met a minimum quality standard. The author and research supervisor co-screened a proportion of the eligible articles before the author appraised the remainder. Qualsyst comprises 10 items that can be appraised using a three-point scale (e.g., 'yes' = 2, 'partial' = 1, 'no' = 0). A summary of scores for each study was calculated by dividing its total score by the maximum possible score of 20, producing a potential score of 0-1, where higher scores indicate better quality. Kmet et al. (2004) have suggested two possible cut-off scores: a liberal cut-off score of .55/1.00 and a more conservative cut-off score of .75/1.00. The conservative cut-off score for inclusion was used to maximise the quality of the synthesis. All nine articles satisfied the conservative cut-off and, therefore, all were included.

Figure 1

PRISMA Flowchart of Study Selection Process for Comprehensive Systematic Review



Data Extraction and Synthesis

The 21-item Enhancing Transparency in Reporting the Synthesis of Qualitative Research guidelines (ENTREQ; Tong et al., 2012) were used in reporting this meta-synthesis (Appendix D). A study-specific data extraction sheet was used to collect study characteristics and relevant findings from included studies (Appendix B). The extracted data included (i) sample characteristics (e.g., sample size, age, gender, health profession); (ii) study characteristics (e.g., study aim, location, design, recruitment source) and (iii) reproductive coercion experiences.

An inductive meta-aggregative approach facilitated the identification of primary data from included studies relevant to addressing the research questions. Original findings (i.e., themes, metaphors etc) or definitive statements made by primary authors (if an article did not contain author-identified themes) were extracted and then grouped into categories based on shared meaning, before the categories were then grouped into synthesised findings (Korhonen et al., 2013; Lockwood et al., 2015). Finally, recommendations were proposed concerning reproductive coercion-related health care.

Reflexivity

An important element of qualitative research is self-reflexivity, which promotes self-awareness and authenticity with a researcher's connection to the research and audience (Tracy, 2010). Without reflexivity, bias can influence the process of study design, data collection and interpretation. The author is a young, white, cisgender female from a high-income country who has experienced reproductive coercion. While always important, given that the researcher has experienced reproductive coercion, extra caution was taken throughout the research process to minimise bias by the researcher frequently reflecting on her position and how this may influence data interpretation. Additionally, the author had regular

discussions with the research supervisor to minimise bias and facilitate a more balanced and impartial approach to the research.

Results

Study Characteristics

Table 2 summarises the key characteristics of the nine included studies. Studies were published between 2010 and 2022, with many studies originating from African countries and regions ($N_{studies}$ = 4). Qualitative data were collected via interviews ($N_{studies}$ = 7) and focus groups ($N_{studies}$=6). The most common methods of analysis were thematic analysis ($N_{studies}$ = 5) and thematic content analysis ($N_{studies}$ = 3); however, authors also used, Attride-Stirling Thematic Network Analysis ($N_{studies}$ = 1).

Participant Characteristics

The sample comprised 221 health care professionals ($N_{studies}$ = 9; see Table 3), 93 females ($N_{studies}$ = 4) and 26 males ($N_{studies}$ = 3); sex or gender was not specified for 102 participants ($N_{studies}$ = 3). Participants were aged between 23 and 58 years, based on data from 52 participants ($N_{studies}$ = 2), with a mean age of 37.66 years (*SD* = 7.94 years), according to the data from 29 participants ($N_{studies}$ = 1). Most participants were nurses or midwives (n = 87; $N_{studies}$ = 7), social workers or counsellors (n = 34; $N_{studies}$ = 1) or obstetricians or gynaecologists (n = 23; $N_{studies}$ = 1). Most participants (n = 52; $N_{studies}$ = 1) worked in reproductive health services, communal health stations (n = 29; $N_{studies}$ = 1), hospitals (n = 27; $N_{studies}$=3), or domestic violence settings (n = 26; $N_{studies}$ = 1). Limited data were available about location, with 12 participants in rural areas ($N_{studies}$ = 1), 10 participants from metropolitan areas ($N_{studies}$ = 1) and two participants from remote areas ($N_{studies}$ = 1).

Table 2

Characteristics of Included Studies

Lead Author	Country	Sample Size	Recruitment Source	Data Collection	Data Analysis	Quality Score
Adongo (2014)	Ghana (Western and Central regions)	52	Purposive sampling of health care workers who provide reproductive health services at community, district and regional levels.	Focus groups and in-depth interviews	Thematic Content Analysis	.90
Ganle (2015)	Ghana (Ashanti and Northern regions)	20	Advertised at popular local community places (e.g., churches)	Focus groups and in-depth interviews	Attride-Stirling Thematic Network Analysis	.90
Graner (2010)	Vietnam (Bavi district)	29	A demographic surveillance site	Focus group discussions	Content Analysis	.85

Schwandt (2013)	Ghana (Ashanti and Greater Accra regions)	40	Two teaching hospitals in Ghana	In-depth interviews and focus group discussions	Thematic Content Analysis	.80
Moyer (2014)	Ghana (Rural Northern region)	13	Employment roster at health facility	In-depth interviews and focus group discussions	Thematic Analysis	.90
Tarzia (2019a)	Australia	17	Purposive sampling of health professionals in a major public hospital	Semi-structured interviews	Thematic Analysis	.85
Tarzia (201b)	Australia	17	Targeted health professionals working in gynaecology and women's cancer branches of a hospital	Semi-structured interviews	Thematic Analysis	1.00

Tarzia (2022)	Australia	26	Recruited through services which met a set criteria created by a research team	Focus groups	Reflexive Thematic Analysis	1.00
Wellington (2021)	Australia	24	Recruited through purposive sampling of primary health networks	Semi-structured interviews	Thematic Analysis	1.00

Table 3

Participant Characteristics of Included Studies

Variable	$N_{studies}$	$N_{participants}$	M	SD	Range
Reproductive Coercion[a]	9	221			
Age (years)	1	29	37.66	7.94	23-52
Age	1	23			28-58
Gender					
Female	4	93			
Male	3	26			
Unspecified	2	102			
Location					
Metropolitan	1	10			
Rural	1	12			
Remote	1	2			
Type of health professional					
Obstetrician/gynaecologist	1	23			
Nurse/midwife	7	84			
Doctor	4	21			
Medical assistant/physician assistant	2	7			
Social worker/counsellor	3	34			
Community health officer	1	16			
Health care/public directors	1	7			
Health care providers[b]	1	13			

Community health volunteer	1	16			
Years of professional experience	1	29	13.8	7.73	2 months-30 years
	2	17			10-30 years
Type of health service					
Community/district/regional reproductive health services	1	52			
Communal health station	1	29			
Hospital	3	27			
Domestic violence	1	26			
Hospital – women's cancer and gynaecology branch	2	17			
Hospital – family planning clinic	1	17			
Health care facility	1	13			
Health directorate	1	8			
Community health	1	6			
Sexual health clinic	1	6			
Health centre	1	5			
Contraception/termination of pregnancy clinic	1	5			
General practice	1	4			

Drop-in clinic/outreach	1	2
Health service headquarters	1	2
Rural clinic	1	2

Note. [a] Tarzia (2019a) and Tarzia (2019b) use the same sample; participants were only counted once.

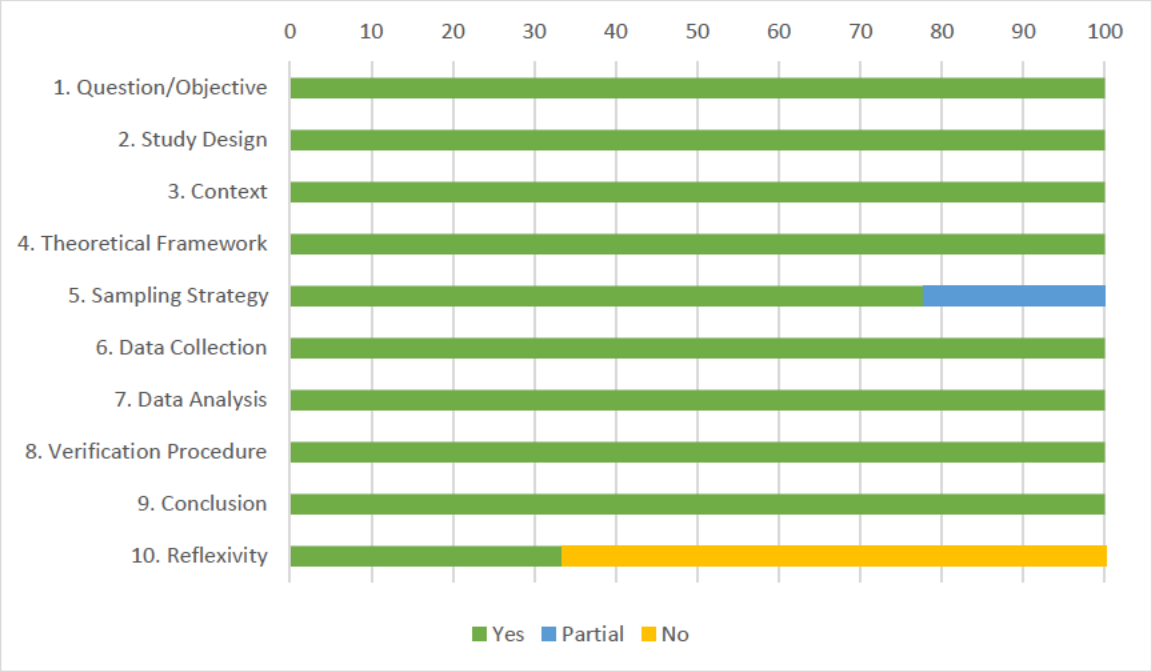
[b] health care providers consist of medical assistants, midwives, nurses and physicians.

Reporting Quality of Included Studies

The reporting quality of all included studies was assessed using the Qualsyst Quality Assessment Checklist (Kmet et al., 2004), as shown in Figure 2 (for a detailed assessment of each study refer to Appendix C). The included studies were high-quality, with scores between .85 and 1.0, and fulfilled at least 8 out of the 10 criteria. All studies specified their research question/objective, study design and context, connected to a theoretical framework/wider body of literature, data collection and analysis procedures, verification procedures and reported appropriate conclusions from their data (*Items 1-4, 6-9*: 100% fulfilled). Most studies clearly described and justified their sampling strategy (*Item 5;* 77.78% fulfilled and 22.22% partially fulfilled). However, only some researchers reported reflexivity (*Item 10*: 33.33% fulfilled).

Figure 2

Qualsyst Criteria Scores by Percentage of Included Studies



Synthesised Findings

Overview

From experiences reported in the nine included studies, three synthesised findings relating to the research questions were created (see Table 4). The meta-synthesis resulted in nine categories: Understanding that reproductive coercion is a distinct but grey area of abuse; Health professionals lack adequate knowledge and information about reproductive coercion; Acknowledgement of the difference between personal opinions and medical judgements; Identifying reproductive coercion is complex, with difficulties heightened by certain cultural and religious views and practices, making it challenging to separate social norms from coercive behaviours; Silence and denial surrounding reproductive coercion hinders the screening and identification of reproductive coercion by health professionals; Cultural barriers often prevent health professionals from differentiating abuse from culture in the screening phase; Health professionals need to create a safe space for

Table 4

Synthesised Findings and Component Categories of Reproductive Coercion and Health Professionals

Health professionals' knowledge about reproductive coercion and abuse: Reproductive coercion is a distinct but grey form of abuse about which health professionals lack sufficient knowledge and where there can be a conflict between personal opinions and medical judgement.
• Understanding that reproductive coercion is a distinct but grey area of abuse.
• Health professionals lack adequate knowledge and information about reproductive coercion.
• Acknowledgement of the difference between personal opinions and medical judgements.
  o There is little research on the knowledge health professionals have about reproductive coercion Termination of pregnancy is still taboo, especially for health professionals.
  o Health professionals' knowledge about reproductive coercion and abuse can be skewed and reflect their own beliefs and attitudes.

Health professionals' perspectives and experiences of screening for/identifying reproductive coercion and abuse: Lack of universal recognition, silence and denial, and cultural norms hinder health professionals' abilities to screen for and identify reproductive coercion. • Identifying reproductive coercion is complex, with difficulties heightened by certain cultural and religious views and practices, making it challenging to separate social norms from coercive behaviours.

○ Diversity in the understanding of reproductive coercion helps different cultures and religions to grasp the preventative outcomes of reproductive coercion. • Silence and denial surrounding reproductive coercion hinders the screening and identification of reproductive coercion by health professionals. • Cultural barriers often prevent health professionals from differentiating abuse from culture in the screening phase. ○ Women are seen as the reproductive property of society.
Health professionals' perspectives and experiences of responding to reproductive coercion and abuse: Health professionals must provide a safe environment for patients to freely discuss reproductive coercion, but have often exhausted the already limited resources available, such that it is easier not to converse about reproductive coercion for fear they cannot help patients. • Health professionals need to create a safe space for patients to talk freely about reproductive coercion. • An overall exhaustion of minimal resources available to health professionals. ○ Health professionals avoid asking questions for fear they have nowhere to send patients. • Responding effectively to reproductive coercion is harder and more complex than it looks. ○ Structural and contextual barriers prohibit effective responding. ○ Health professionals have insufficient training to tackle reproductive coercion.

patients to talk freely about reproductive coercion; An overall exhaustion of minimal resources available to health professionals; and Responding effectively to reproductive coercion is harder and more complex than it looks.

Health Professionals' Knowledge of Reproductive Coercion

The meta-synthesis of health professionals' knowledge of reproductive coercion was derived from nine studies, grouped into three categories and two sub-categories (Table 4), to generate the overall synthesised finding: *Reproductive coercion is a distinct but grey form of abuse about which health professionals lack sufficient knowledge and where there can be a conflict between personal opinions and medical judgement*.

Understanding that Reproductive Coercion is a Distinct but Grey Form of Abuse. The grey understanding of reproductive coercion and the failure to isolate it from other forms of abuse results in a magnitude of potential consequences, from referring patients to the wrong services to incorrectly treating and managing patient concerns (Tarzia et al., 2019b; Wellington et al., 2021). Most health professionals failed to distinguish reproductive coercion from other forms of abuse, and it often fell under other headings. As one social worker wrote, *"a lot of the time I guess it* [reproductive coercion] *comes in the form of family violence for us…"* (Tarzia et al., 2019b, p. 1399). When health professionals fail to differentiate reproductive coercion from overlapping forms of abuse, it can affect how they respond to reproductive coercion. In turn, health professionals may provide patients with less relevant information (e.g., providing patients presenting with reproductive coercion with information about domestic violence). Many health professionals lacked clarity about what constituted reproductive coercion or confused it with other forms of violence and, as a result, incorrectly identified reproductive coercion. One doctor illustrated a need to refer to online resources to determine if a behaviour constituted reproductive coercion, stating, *"I must have to say, when I do need to look it up each time…I Google domestic violence Victoria, there are*

some that I've used. It's terrible that I'm using Google but there's nowhere else that I can search" (Wellington et al., 2021, p. 5). Health professionals are unclear about what constitutes reproductive coercion and do not have access to trusted resources about reproductive coercion. Consequently, they struggle to provide appropriate care.

Health Professionals Lack Adequate Knowledge and Information about Reproductive Coercion. Several different perspectives on what health professionals know and understand about reproductive coercion were postulated (Adongo et al., 2014; Ganle et al., 2015; Graner et al., 2010; Moyer et al., 2014; Schwandt et al., 2013; Tarzia et al., 2019b; Tarzia et al., 2022). These perspectives varied according to health professionals' discipline, influencing interactions with patients who have experienced reproductive coercion. Some professionals expressed that multiple barriers impact their knowledge of reproductive coercion, with reproductive coercion not as widely recognised in the medical domain as people would hope (Tarzia et al., 2019b). Confusion between reproductive coercion and other forms of violence make it difficult for health professionals to gain knowledge solely on reproductive coercion, with studies focusing on reproductive coercion being relatively scarce (Wellington et al., 2021). Health professionals displayed confusion when confronted with reproductive coercion; *"well to be quite honest with you, I don't think I've seen it (RC), but I don't think I've been keeping an eye out for it either ... the fact that I don't know very much about it or how to approach it confidently with a patient might be a barrier, on my part at least"* (Wellington et al., 2021, p. 4). Some health professionals not only lacked adequate knowledge about reproductive coercion, but instead, drew on their own ideologies in specific cases of reproductive coercion, resulting in misinformed medical judgements and improper communication with patients; *"unfortunately, you see, because of the stigmatisation of abortion,* [health care] *professionals tend to be a bit…hostile or kind of judgemental"*

(Schwandt et al., 2013, p. 515). The lack of knowledge and confusion between concepts is a barrier to health professionals' ability to deal with reproductive coercion effectively.

Acknowledgement of the Difference Between Personal Opinions and Medical Judgements. Patients experiencing reproductive coercion are vulnerable and often seek contraceptives and advice on pregnancy options (whether to continue or terminate a pregnancy; Tarzia et al., 2019b). Some health professionals created barriers to their patients seeking a termination of pregnancy due to stigma and religious views (Schwandt et al., 2013). Health professionals' responses were, at times, skewed, as one family planning nurse wrote, "*because she was very young, I began to advise her not to abort the pregnancy"* (Schwandt et al., 2013, p. 514). Controversies within reproductive coercion care are amplified in the settings of pregnancy termination. Opinions, attitudes and personal beliefs can dictate the knowledge health professionals have or choose to display when managing reproductive coercion (Schwandt et al., 2013; Tarzia et al., 2019a; Tarzia et al., 2019b). Not all health professionals responded in a manner that aligned with community and professional standards of care:

> *"I recall having conversations with doctors in the community when I was working for a larger termination provider. They had no concept of the services available, of what the issues surrounding pregnancy entail for women, they just, they don't get it, they don't understand it"* (Tarzia et al., 2019b, p. 1401).

Health professionals indicated that the opinions and attitudes that follow pregnancy termination can result in barriers to care for patients wanting a termination:

> *"We've had women going to their doctor asking for a termination and the doctor doesn't do it, so they send them to another doctor who also doesn't do terminations and then they get sent to another doctor who also doesn't do*

> *terminations, and so by the time they eventually get to us, you know they're quite late in their pregnancy"* (Tarzia et al., 2019b, p.1401).

Despite this evidence, minimal research examines health professionals and reproductive coercion and little is known about how health professionals' personal opinions influence screening practices.

Health Professionals' Perspectives on Screening and Identifying Reproductive Coercion

The meta-synthesis of health professionals' ability to screen for and identify reproductive coercion was derived from nine studies and grouped into three categories (Table 4), resulting in the overall synthesised finding: *Lack of universal recognition, silence and denial, and cultural norms hinder health professionals' abilities to screen for and identify reproductive coercion*.

Identifying reproductive coercion is complex, with difficulties heightened by certain cultural and religious views and practices, making it challenging to separate social norms from coercive behaviours. A major part of reproductive coercion recognition is acknowledging cultural differences (Ganle et al., 2015; Graner et al., 2010; Moyer et al., 2014). At times, health professionals contend with screening for and identifying reproductive coercion among people with culturally diverse backgrounds (Ganle et al., 2015). One health care provider noted:

> *"A fundamental challenge we face in this with regards to women's access to skilled care is the culture of the people. You know, patriarchal norms are very strong in many communities; and so unlike many of Southern Ghana where because of the matrilineal system, women are better able to own property and make their own decisions, in this region women are really very disadvantaged"* (Ganle et al., 2015, p. 11).

In specific regions of Ghana, the environment where childbirth occurs is a very important part of the birthing process (Ganle et al., 2015; Moyer et al., 2014). This process, however, is not always up to the person giving birth; family members and community religious leaders typically choose where the birth occurs, especially in rural Northern regions of Ghana (Moyer et al., 2014). Other stakeholders play vital roles in a person's pregnancy. Health professionals working in the Ashanti and Northern regions of Ghana recognised this as a screening problem:

> *"I think one of the biggest reasons is that many of our women are powerless when it comes to decision-making in the household. This is particularly so with childbirth where decision-making may be collective or communal in which case husbands, mothers-in-law, TBAs* [traditional birth attendants] *and other family or community members might actually have more power in the decision-making process than the pregnant woman herself"* (Ganle et al., 2015, p. 11).

Although reproductive coercion may be theoretically recognised, its definition and interpretation in practicality depend on a patient's culture.

Silence and Denial Surrounding Reproductive Coercion Hinders the Screening and Identification of Reproductive Coercion by Health Professionals. The stigma associated with reproductive coercion silences patients and denies them access to adequate health care (Tarzia et al., 2019b). One counsellor stated that reproductive coercion *"is very uncomfortable material. It's not nice to talk about…and no one wants to really think about it. As a consequence, the actual level of violence women are experiencing around reproduction…is really silenced"* (Tarzia et al., 2019b, p. 1401). The silence of reproductive coercion is magnified further among culturally diverse women (Tarzia et al., 2019b; Tarzia et al., 2022). However, reproductive coercion is not *"isolated to one group of women.*

Culturally, I would see here some cultures more than others, so I think there are some cultural problems, but I don't think it's isolated to one culture (Tarzia et al., 2019b, p. 1401). Tarzia et al. (2022) emphasised this cultural finding, reporting that *"women from migrant minority ethnic backgrounds can be adversely affected by gendered community norms around women's role within a relationship and the broader family context"* (Tarzia et al., 2022, p. 471). Screening and identification of reproductive coercion are contingent on social and cultural norms, and diversity in reproductive coercion care is required to aid better patient outcomes.

Cultural Barriers Often Prevent Health Professionals from Differentiating Culture from Abuse in the Screening Phase. Health professionals must consider cultural differences when responding to reproductive coercion (Adongo et al., 2014; Ganle et al., 2015; Graner et al., 2010, Moyer et al., 2014; Schwandt et al., 2013; Tarzia et al., 2019b; Tarzia et al., 2022). Cultural diversity influences gender roles and reproductive practices. Tarzia et al. (2022) reported cultural differences in migrant minority ethnic populations, where *"culturally, it might be that their understanding is the role of the man to make certain decisions in the relationship, including when to have children and not, and it's the role of the woman to breed, essentially, and just have children"* (Tarzia et al., 2022, p. 471). The importance of culture was reported in further links to females wanting to conceive at an early age due to pressure from socio-cultural norms (in Western and Central regions of Ghana; Adongo et al., 2014). Health professionals reported that the discussions about reproductive coercion often occurred with females in culturally diverse settings, where males experienced reproductive coercion. For example, despite low rates of post-vasectomy complications, vasectomy is still heavily stigmatised in some regions and cultures within Ghana, where females forbid their husbands from receiving a vasectomy (Adongo et al., 2014). Some health professionals' described occasions where females threatened their partners; *"for instances*

[when] *men want to do the vasectomy, the women warned them against it, so you realise that it is the women who prevent the men from doing* [the] *vasectomy"* (Adongo et al., 2014, p.4). However, in different cultures, the sex or gender of the person who holds the most power about reproductive decision-making may vary. As the experience of reproductive coercion differs according to culture and societal pressure, health professionals must consider this when responding to reproductive coercion.

Health Professionals' Perspectives and Experiences of Responding to Reproductive Coercion

The meta-synthesis of health professionals' perspectives and experiences of responding to reproductive coercion was derived from nine studies, grouped into three categories (Table 4), providing the overall synthesised finding: *Health professionals must provide a safe environment for patients to freely discuss reproductive coercion, but have often exhausted the already limited resources available, such that it is easier not to converse about reproductive coercion for fear they cannot help patients*.

Health Professionals Need to Create a Safe Space for Patients to Talk Freely About Reproductive Coercion. The barriers which prevent people experiencing reproductive coercion from accessing health care play a pivotal role in navigating how health professionals respond to patients and their health care needs (Adongo et al., 2014; Ganle et al., 2015; Graner et al., 2010; Moyer et al., 2014; Tarzia et al., 2019a, Tarzia et al., 2019b, Tarzia et al., 2022; Wellington et al., 2021). In light of the insidious nature of reproductive coercion, health professionals stated that reproductive coercion is not always directly visible when a patient comes forward to a health care setting (Tarzia et al., 2019b). Certain health professionals also expressed the importance of creating a safe space for patients allowing them to speak freely about their reproductive concerns (Tarzia et al., 2019a). Health professionals also spoke of the importance of patient confidentiality:

> *"Even if someone has brought* [a woman] *in, we greet them at the waiting area and we always say, "Look, we need to talk to her and this is our policy. This is just what we do with everyone". We always meet with women on their own, just so that they have that opportunity to have that safe, confidential space"* (Tarzia et al., 2019a, p. 459).

Health professionals noticed that when they approached their patients in an open and non-judgemental manner, their patients were better able to discuss reproductive coercion:

> *"People will disclose ... if they feel like you're open and you're not judging them and you're interested in what they've got to say and you're there to support them and they feel safe ... And if they feel like you might be able to help them, that's the other thing. It's all of those things combined"* (Tarzia et al., 2019a, p. 459).

Health professionals also noted that they can offer support to ensure that their patients are *"...not alone in experiencing* [reproductive coercion]*"* (Tarzia et al., 2019a, p. 459). Health professionals benefit from practising in a supporting manner to assist patients in feeling comfortable when disclosing reproductive coercion. However, the practicality of this care depends on the resources readily available for health professionals to use.

An Overall Exhaustion of Minimal Resources Available to Health Professionals. Health professionals stretched the minimal reproductive coercion resources available to them to their furthest capacity (Graner et al., 2010; Wellington et al., 2021). Multiple health professionals expressed their concerns that reproductive coercion is not a health issue that can be tackled through any one resource; instead, it requires a multifaceted approach. Some participants spoke of their low levels of confidence when responding to reproductive coercion; *I'm trying to do the best I can for my patient, but* [I am thinking] *are you doing a good job for them I don't know ... But I don't think* [I am] *confident at all* (Wellington et al.,

2021, p. 5). As a consequence of the dearth resources, health professionals are resorting to difficult measures in an attempt to lessen the number of patients presenting with reproductive coercion (Wellington et al., 2021). Health professionals explained that they avoid asking questions about reproductive coercion, assume that patients who show potential signs of reproductive coercion do not require medical intervention, and refer patients to other professionals that they believe can offer them more support (Wellington et al., 2021). Health professionals can be *"…a little bit scared* [because] *there's always this thing of opening a can of worms and not knowing where to go with it"* (Wellington et al., 2021, p. 5). A deficiency in resources also means that health professionals have *"nowhere to send women" and "there's not much* [health professionals] *can do"* (Wellington et al., 2021, p. 5). Such deficiencies adversely hinder health professionals' ability to effectively respond to reproductive coercion, and in turn, create issues with patient care.

Responding Effectively to Reproductive Coercion Is Harder and More Complex Than It Looks. Health professionals recognise that an increasing number of patients are presenting to health care settings with reproductive coercion (Tarzia et al., 2019b; Tarzia et al., 2022; Wellington et al., 2021); *"I would say it's probably about a quarter of the women that we speak to"* (Tarzia et al., 2019b, p. 1400). Structural barriers, a lack of resources and trained professionals all hinder how well health professionals can care for patients experiencing reproductive coercion (Adongo et al., 2014; Ganle et al., 2015; Graner et al., 2010; Moyer et al., 2014; Tarzia et al., 2019a, Tarzia et al., 2019b; Tarzia et al., 2022; Wellington et al., 2021). In addition to this, an array of social, cultural and personal barriers limit effective responding to reproductive coercion (Ganle et al., 2015; Tarzia et al., 2019a). Overall, health professionals in the included studies had insufficient knowledge and training to respond to reproductive coercion effectively. However, health professionals who are *"women-led and women-focused in their approach to responding to reproductive abuse"*

(Tarzia et al., 2019a, p. 459) were viewed to have an increased likelihood of effectively responding to reproductive coercion than those professionals for whom reproductive coercion *"*[is] *not even in the frame"* (Wellington et al., 2021, p. 4) due to insufficient training. An increase in training and support needs to be in effect to ensure health professionals understand reproductive coercion, allowing them to identify, screen and respond in appropriate ways.

Discussion

Overview

Health professionals globally deal with reproductive coercion, and the relationship between reproductive coercion and providers is multifaceted and complex. To the author's knowledge, no other meta-synthesis has explored health professionals' perspectives on reproductive coercion. In the current study, findings from nine included studies were aggregated into nine categories and seven subcategories to produce three synthesised findings related to health professionals' knowledge about reproductive coercion and how they screen for, identify and respond to reproductive coercion. These findings are discussed and guidelines are provided for health professionals who wish to improve their care of patients experiencing reproductive coercion.

Summary of Findings

Health Professionals' Knowledge of Reproductive Coercion

Health professionals' knowledge about reproductive coercion is primarily based on what they have observed during clinical practice and is frequently constrained by cultural and societal conventions. A Eurocentric ideology serves as the common foundation for the concept of reproductive coercion. Health professionals practising in populations that accept this ideology are more likely to have an objective understanding of reproductive coercion, where there is a clear divide between personal opinions and medical judgements. However,

health professionals who work in culturally diverse settings commonly experience a subjective understanding of reproductive coercion due to socio-cultural differences. These socio-cultural differences were particularly evident in the included studies set in specific regions within Ghana, potentially hindering health professionals' knowledge and conceptualisation of reproductive coercion (Adongo et al., 2014; Ganle et al., 2015; Moyer et al., 2014; Schwandt et al., 2013).

Previous research has highlighted the issues within the definition of reproductive coercion and how its interpretation is manipulated to suit certain contexts and environments (Tarzia et al., 2022). The definitional and conceptual complexity of reproductive coercion is relevant to the current study as the included studies noted confusion and miscommunication between health professionals and what reproductive coercion entails. Broadly, two formal sets of reproductive coercion-related terms are utilised within the literature. The first is often referred to as 'reproductive coercion', as defined by Miller et al. (2010), and the second, labelled as 'reproductive coercion and abuse', which intends to foreground the context of fear and control which commonly occurs as a subset of reproductive coercion (Tarzia et al., 2022). In this study, the variance in criteria researchers used to define reproductive coercion in the included studies, if they did so at all, was an interesting finding. Included studies from 'Western', educated, industrialised, rich and democratic (WEIRD) populations used well-known, defined terms of reproductive coercion ranging from 'reproductive coercion' (Tarzia et al., 2019b), to 'reproductive abuse' (Tarzia et al., 2019a) and 'reproductive coercion and abuse' (Wellington et al., 2013; Tarzia et al., 2022). In contrast, the remaining included studies did not clearly *define* reproductive coercion; instead, they defined and reported *practices* which were considered to be coercive (Adongo et al., 2014; Ganle et al., 2015; Graner et al., 2010; Moyer et al., 2014; Schwandt et al., 2013).

Studies containing WEIRD samples had a strong emphasis on the definitional-based context of reproductive coercion within its established population (e.g., the set criteria for what reproductive coercion entails). Additionally, they reported reproductive coercion occurring as a consequence of violence against women and commonly referred back to components of IPV and how it intersects with reproductive coercion. The remaining included studies from different cultures illustrated how socio-cultural contexts can enable practises regarded as 'coercive' to flourish instead of making a clear distinction between reproductive coercion and violence. The difference in definitions, and as such, interpretations of reproductive coercion, affected health professionals' perspectives in the included studies. Consequently, a universal and culturally appropriate definition of reproductive coercion is needed to allow people from various cultures, religions and social contexts to be aware of the problem and take preventative measures to lessen the adverse effects reproductive coercion can lead to.

Health Professionals' Perspectives and Experiences of Screening For/Identifying Reproductive Coercion

In Australia, health professionals are not mandated to report reproductive coercion, which can influence health professionals' and their efforts to screen and identify reproductive coercion. The risk factors of reproductive coercion are not entirely clear; however, existing research has consistently suggested that reproductive coercion is associated with forms of domestic and sexual violence. Additionally, there is an increased likelihood of domestic violence victims reporting their abuse to a higher power (Voce & Boxall, 2018). If screening and identifying reproductive coercion remains difficult for health professionals, alternative measures must be considered, such as 'gateway screening' of reproductive coercion through overlapping areas of abuse (including IPV and domestic violence screening). Increasing the amount of screening and identification of reproductive coercion cases is paramount to

people's health and welfare given the relationship reproductive coercion has with associated forms of violence (Sheeran et al., 2022). Such screening must be done with caution, though, as there is no official legislated protocol for reporting reproductive coercion.

The first recorded routine screening of reproductive coercion in Australia was implemented in clinical consultations by Family Planning New South Wales in December 2018; this is the only Australian jurisdiction that offers formal reproductive coercion screening (Cheng et al., 2021). In the absence of mandated screening, health professionals rely on their 'gut instincts' to identify patients experiencing reproductive coercion as there is no regulated reporting in place, leaving reproductive coercion vulnerable to professional interpretation (Tarzia et al., 2019a; Tarzia et al., 2019b). Screening for reproductive coercion is not always beneficial when done in isolation, and as the data suggests, this rarely happens. Approaching reproductive coercion from associated areas of abuse including screening in domestic violence, family planning and reproductive health care settings increases the likelihood of identifying people experiencing reproductive coercion, and in turn, can lessen detrimental outcomes including unintended pregnancy and unsafe relationships (Cheng et al., 2021). This approach may be beneficial for general practitioners in Australia, as research has shown that people prefer to disclose IPV to these professionals over other health professionals (such as justice workers or domestic/family violence workers; Wellington et al., 2021).

Health professionals and their ability to screen for reproductive coercion needs to be expanded on a much larger scale, especially given the rise in the number of people reporting reproductive coercion and associated abuse. For example, more than 54% of recorded assaults to the Australian Police in 2019 were related to family and domestic violence cases (Australian Institute of Health and Welfare, 2022).

Grace (2016) found that screening and identifying people experiencing IPV assists people in naming the behaviours they experience as coercive, allowing them to seek assistance in reclaiming autonomy and control over their reproductive health. This finding is significant since there are several ways that reproductive coercion and IPV interact and coexist. However, caution is recommended with this finding as, to the author's knowledge, few stand-alone *formal* screening tools exist for reproductive coercion, especially within culturally diverse settings, and existing screening instruments used for overlapping areas, such as domestic violence, do not always contain discrete questions on reproductive coercion, or may not be culturally appropriate in certain socio-cultural contexts (Marie Stopes Australia, 2020).

None of the health professionals in the included studies used an official scale to measure reproductive coercion, which is surprising as there are tools available that aim to quantify, screen and identify reproductive coercion in various culturally diverse and societal contexts. Such scales can be utilised in clinical and research settings. For example, Upadhyay et al. (2014), in the United States, developed a multidimensional instrument measuring reproductive autonomy, named the Reproductive Autonomy Scale. The scale assesses reproductive coercion via questions relating to freedom from coercion, communication and decision-making within the area of reproductive health. Additionally, Elizabeth Miller created the Reproductive Coercion Scale, focusing on the two underlying domains of pregnancy coercion and condom manipulation as a means to assess reproductive coercion (McCauley et al., 2017). Despite the creation of these scales, they receive minimal acknowledgement and are, consequently, rarely employed. Their lack of use may be due to multiple factors, including cultural differences, poor conceptual clarity about reproductive coercion, and issues with funding and resources (McCauley et al., 2017). In the absence of

clear and widely used screening protocols, specifically for reproductive coercion, health professionals need to consider broader screening processes for reproductive coercion.

Health Professionals' Perspectives and Experiences of Responding to Reproductive Coercion

With an increasing number of patients presenting to health professionals with reproductive coercion, the response of these professionals is critical to effective practice. The lack of screening methods specific to reproductive coercion and differentiating reproductive coercion from other types of violence hampers its detection. Difficulties in identifying reproductive coercion places health professionals in challenging situations where they may be unable to provide effective patient care. This conclusion is consistent with previous literature, which reports the importance of distinct and consistent screening for reproductive coercion to ensure effective responding from health professionals (Cheng et al., 2021; Marie Stopes Australia, 2020; Price et al., 2022). Due to the potential for partners of people experiencing reproductive coercion to be manipulative and violent, responding to reproductive coercion in a discrete and confidential manner may assist in patients achieving autonomy over their reproductive decision-making. People experiencing reproductive coercion may contend with a multitude of barriers in disclosing to health professionals, including the fear of an intimate partner becoming violent, a lack of adequate finances which can be used for health care and power dynamics within intimate settings which prevent people from attending health care services (Grace & Anderson, 2018; Tarzia et al., 2019b).

The nature of reproductive coercion is emerging in research findings and clinical practice without such practices necessarily being labelled as 'coercion'. Grace and Anderson (2018) noted that health professionals feel more comfortable screening and responding to reproductive coercion when provided with specific screening skills and tools. However, time constraints and a lack of tools remain a barrier for non-English speaking health professionals.

To assist with communication surrounding reproductive coercion (and IPV), stronger training programs and communication skills for health professionals to assist in responding to reproductive coercion have been recommended (Zachor et al., 2018). Zachor and his research team (2018) utilised a communication model labelled 'Ask-Tell-Ask' (also known as 'Elicit-Provide-Elicit'), which involves asking the patient what they understand about reproductive coercion, followed by requesting the permission to provide information, and ending by asking the patient to confirm if they understood the health professional correctly. An additional communication model implements the 'N-U-R-S-E' (Name the client's emotion, Understand and validate their emotion, Respect their strengths, Support without conditions and Explore the context for their emotions) skill. This model aids health professionals in learning the skills required to respond to any perceived emotions which may be linked to reproductive coercion. A wider use of communications skills such as those used by Zachor et al. (2018) can ensure that health professionals are equipped with appropriate tools and resources, increasing the likelihood of effectively responding.

Methodological Considerations

The methodological rigour of qualitative meta-syntheses is comparable to that of systematic reviews in reference to consistency, reliability and generalisability (Pearson et al., 2011). The current study had many strengths. A priori protocol was developed, and the study followed PRISMA guidelines and ENTREQ reporting guidelines. The rigour of the current meta-synthesis was strengthened by selecting a high threshold on the Qualsyst quality checklist (Kmet et al., 2004) to ensure that only high-quality papers were included, resulting in an authentic meta-synthesis. Additionally, the research supervisor verified the quality of the included studies, increasing reliability and validity. The meta-synthesis also included the three foundational forms of reproductive coercion (i.e., contraceptive sabotage, pregnancy pressure and pregnancy control), offering a more substantial insight into the behaviour.

While the current research possessed many strengths, its conduct and findings must also be considered in light of potential limitations. One significant limitation, not only of the current study, but also of the field in general is the lack of definitional and conceptual clarity concerning reproductive coercion. Use of varying terminology such as 'reproductive coercion' and 'reproductive coercion and abuse' as well as debates about the inclusion of stealthing and where to situate reproductive coercion alongside IPV and gender-based violence makes research in the field complicated. Furthermore, it makes comparisons between studies challenging. As well as its research implications, these definitional issues impact health care provision. Considering that reproductive coercion is a major public health issue in which the phenomena occurs globally, if health professionals do not have a clear, universal understanding of reproductive coercion, it can lead to poor reproductive outcomes and significant declines in health and well-being (Moulton et al., 2021).

Additional to the overarching issue within the field pertaining to definitions, the individual studies included in this systematic review and meta-synthesis can also act as a study limitation. Although high-quality, limitations of the included studies impacted the inferences drawn from the current research. A collective limitation of included studies related to sample composition. Potential issues include the deliberate recruitment of participants who had a general interest in reproductive coercion, a lack of diversity among participants, and concern that the singular recruitment of health professionals' perspectives would silence the voices of those who have first-hand experience of reproductive coercion (Tarzia et al., 2019a; Tarzia et al., 2019b; Tarzia et al., 2022; Wellington et al., 2022). Also, nuances in the meaning of certain words and phrases were lost through the translation from the local (spoken) language to English, affecting the generalisability of results (Adongo et al., 2014; Moyer et al., 2014). Additionally, most participants were also derived from WEIRD populations (Tarzia et al., 2019a; Tarzia et al., 2019b; Tarzia et al., 2022; Wellington et al.,

2022), which may have skewed the data, and extrapolating findings to other populations should be done with caution.

Although a robust search strategy was created**,** restricting studies to English-only articles may have limited cultural diversity, and other potentially relevant studies may have been missed resulting in the current study representing a deficient picture of health professionals' perspectives regarding reproductive coercion. The included studies also reported low reflexivity. Therefore, the extent to which author biases affected the data collection, analysis and interpretation of the original studies is unknown. However, the current researcher engaged in self-reflexivity and maintained objectivity while conducting the research to minimise author bias affecting the synthesised findings.

Recommendations

A universal overarching recommendation, which guides all other recommendations, is the implementation of the Addressing Reproductive Coercion in Health Settings (ARCHES) Intervention. The ARCHES Intervention Study is an American community-based research project that aims to assess the short-term (3-4 months) and long-term (12 months) effects of a clinician-delivered, universal education and counselling intervention to reduce IPV, reproductive coercion and unintended pregnancy in family planning clinic settings (Tancredi et al., 2015). The ARCHES program includes (1) universal education and assessment of IPV and reproductive coercion, (2) harm reduction counselling, and (3) supported referrals to victim services that are offered to all clients regardless of disclosure (Marie Stopes Australia, 2020). Evaluation of the ARCHES program has shown that it increases health professionals' confidence in enacting harm-reduction behaviours such as using trauma-informed practice and fosters greater knowledge of violence-related resources among clients (Marie Stopes Australia, 2020).

The following recommendations have been developed based on the findings of this meta-synthesis in combination with insights from the ARCHES Intervention and work by Marie Stopes Australia (2020), an organisation which has researched reproductive coercion extensively. Such recommendations draw on current literature addressing reproductive coercion and focus on three areas: knowledge, screening and identification and responding to reproductive coercion (within health care settings).

Recommendation 1: National Health Care Professional Training & Knowledge Program of Reproductive Coercion

The development of a national health professional training program in consultation with higher-education facilities and sexual and reproductive health professionals will assist in ensuring that all health professionals obtain the required knowledge about reproductive coercion. Such a program could be tailored for health care settings with professionals who are likely to come into contact with reproductive coercion, including obstetricians, gynaecologists, general practitioners, abortion providers and maternal and child health professionals (Marie Stopes Australia, 2020). A comprehensive reproductive coercion training program is not currently offered to health professionals at a national level in Australia. A further recommendation is that such a program be implemented at a universal level to ensure health professionals are educated at a broader cultural and social context. This program targets: (i) health professionals' education and knowledge about reproductive coercion; (ii) the required skills and applications needed when facing reproductive coercion; and (iii) ensures health professionals working with WEIRD and non-WEIRD populations are equipped with effective knowledge about reproductive coercion.

Recommendation 2: Development of an International Strategy through Screening and Identifying Reproductive Coercion

This recommendation focuses on international sexual and reproductive health rights, specifically on the interpersonal and structural drivers of reproductive coercion in culturally diverse settings. This approach would ensure that screening and identifying concerns related to contraception, sexual health and reproductive health care are accessible through specialised resources. To ensure this strategy is inclusive, it would benefit from focusing on minority populations, including low socio-economic communities, culturally and linguistically diverse communities, Aboriginal and Torres Strait Islander peoples, young people, people with disabilities, regional and rural communities and LGBTQIA+ communities (Marie Stopes Australia, 2020). This strategy: (i) has an international and culturally inclusive focus on reproductive coercion; (ii) ensures minority populations affected by reproductive coercion are prioritised; and (iii) extends and strengthens current screening and identification tools used for reproductive coercion.

Recommendation 3: Embedding Reproductive Coercion into IPV and Domestic Violence Policies to Sustain Effective Responding

The close association between reproductive coercion, IPV and domestic violence creates issues in policy development and poor responding. Although most Australian states and territories recognise coercive control as abuse, current Australian legislation on coercive abuse does not include reproductive coercion practices (Otter et al., 2022). Recently, efforts have been made to legislate against coercive control as a means to facilitate effective responding; however, these new legislations do not appear to cover reproductive coercion. Despite the Crimes and Legislation Amendment (Coercive Control) Bill 2022 criminalising 'coercive control' in New South Wales, the Bill does not address reproductive coercion (Parliament of New South Wales, 2020). To rectify the minimal legislation against reproductive coercion and increase the likelihood of perpetrators of reproductive coercion being accountable for their behaviour, reproductive coercion should be embedded in policies,

including initiatives such as the National Plan to Reduce Violence Against Women and Their Children (Australian Government Department of Social Services, 2019). This policy-based recommendation focuses on including reproductive coercion in any future reviews which develop policies surrounding family violence, IPV and/or sexual violence at a national level in Australia. This strategy targets: (i) policy-based intervention of reproductive coercion; (ii) holding reproductive coercion perpetrators accountable at a legislative level; and (iii) associating reproductive coercion with interrelating types of abuse, increasing effective responding to reproductive coercion.

Future Research

Although the results from this current study provide valuable insights, they also elicit further points of inquiry about the broader, interrelated picture of reproductive coercion from both clinical and research standpoints. Additionally, the barriers to reproductive coercion are multidimensional and still postulate causes of concern.

The international nature of reproductive coercion suggests that reproductive coercion falls victim to definitional confusion, misinterpretation and personal judgement of those in decision-making roles. Reproductive coercion cannot be considered in isolation within a single demographic as legislation and policy in different contexts posit different associations of reproductive coercion. The lack of clarity regarding what constitutes reproductive coercion affects health professionals' relationships with patients. For example, responding to reproductive coercion requires screening and identification, but screening and identification of reproductive coercion requires knowledge of reproductive coercion. Recommendations for lessening adverse effects used in reproductive coercion frameworks may not apply to culturally diverse contexts, as these recommendations were based on Australian research (Marie Stopes Australia, 2020). Recent literature which examines reproductive coercion in a broader cultural framework is becoming more common (Sheeran et al., 2022). However, an

influx of knowledge about the relationship between reproductive coercion and culture is still required. The complexity of reproductive coercion is heightened in culturally diverse areas, making the knowledge, screening, identification and response of reproductive coercion difficult to research.

Ultimately, future research needs to determine whether the current mechanisms to reduce reproductive coercion (such as the implementation of ARCHES) are effective in improving health professionals' practice. The viability of screening tools used to quantify reproductive coercion need to be investigated further as well, to determine if culturally diverse scales are required to gain stronger cultural competency.

Conclusion

This systematic review and meta-synthesis explored health professionals' knowledge of reproductive coercion and how they screen, identify and respond to it. Reproductive coercion is a complex area for health professionals to navigate, especially given definitional confusion and intersections with IPV. Factors such as culture, societal norms, and personal judgement influence how health professionals screen, identify and respond to reproductive coercion. Moving forward, conceptual clarity, enhanced health professional training about what reproductive coercion entails and how to screen and respond effectively, and policy changes may invoke shifts in how current stakeholders participate in reproductive coercion-related care.

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Appendix A

Logic Grids for Database Searches

	Reproductive Coercion	Health Professionals	Qualitative
PubMed	"coercion"[mh] OR "pregnancy"[mh] OR intimate partner violence[mh] OR coercion[tiab] OR pregnancy[tiab] OR reproductive coercion[tiab] OR coerced reproduction[tiab] OR reproductive control[tiab] OR reproductive abuse[tiab] OR contraceptive sabotage[tiab] OT contraception sabotage[tiab] OR birth control sabotage[tiab] OR pregnancy pressure[tiab] OR pregnancy control[tiab] OR contraception manipulation[tiab] OR contraceptive manipulation[tiab]	"health personnel"[mh] OR health personnel[tiab] OR health professional[tiab] OR doctor*[tiab] OR specialist*[tiab] OR nurse*[tiab] OR psychologist*[tiab] OR eating disorder specialist*[tiab] OR mental health*[tiab] OR practitioner*[tiab] OR professional*[tiab] OR medical practitioner*[tiab] OR clinician*[tiab] OR primary care[tiab]	"qualitative research"[mh:noexp] OR "focus groups"[mh] OR qualitative*[tiab] OR focus group*[tiab] OR interview[tiab] OR thematic analysis*[tiab] OR content analys*[tiab] OR lived experience*[tiab] OR personal experience*[tiab] OR interpretative phenomenological analysis[tiab] OR ethnography[tiab] OR case stud*[tiab] OR narrative*[tiab] OR perspective*[tiab]
PsychINFO	"coercion" OR "pregnancy" OR "intimate partner violence" OR "reproductive coercion" OR "coerced reproduction" reproductive control OR "reproductive abuse" OR "contraceptive sabotage" OR "birth control sabotage" OR "pregnancy pressure" OR	"health personnel" OR psychologist* OR clinician* OR "health professional*" OR "educator*" OR doctor* OR specialist* OR nurse* OR "mental health*" OR practitioner* OR professional* OR specialist* OR "medical	qualitative methods.sh OR focus group.sh OR qualitative*.ti,ab OR focus group*.ti,ab OR interview*.ti,ab OR thematic analys*.ti,ab OR content analys*.ti,ab OR lived experience*.ti,ab OR personal experience*.ti,ab OR interpretative phenomenological

	"pregnancy control" OR "contraception manipulation"	practitioner*" OR "primary care" OR clinician	analys*.ti,ab OR ethnograph*.ti,ab OR case stud*.ti,ab OR narrative*.ti,ab OR perspective*.ti,ab
Web of Science	"coercion"[mh] OR "pregnancy"[mh] OR intimate partner violence[mh] OR coercion[tiab] OR pregnancy[tiab] OR reproductive coercion[tiab] OR coerced reproduction[tiab] OR reproductive control[tiab] OR reproductive abuse[tiab] OR contraceptive sabotage[tiab] OT contraception sabotage[tiab] OR birth control sabotage[tiab] OR pregnancy pressure[tiab] OR pregnancy control[tiab] OR contraception manipulation[tiab] OR contraceptive manipulation[tiab]	"health personnel" OR psychologist* OR clinician* OR "health professional*" OR "educator*" OR doctor* OR specialist* OR nurse* OR "mental health*" OR practitioner* OR professional* OR specialist* OR "medical practitioner*" OR "primary care" OR clinician	"qualitative research" OR qualitative* OR "focus group*" OR interview* OR "thematic analys*" OR "content analys*" OR "lived experience*" OR "personal experience*" OR "interpretative phenomenological analys*" OR ethnograph* OR "case stud*" OR narrative* OR perspective*
CINAHL	MH "coercion" OR MH "pregnancy" OR TI "intimate partner violence" OR AB "reproductive coercion" OR TI "coerced reproduction" OR AB "reproductive control" OR TI "reproductive abuse" OR AB "contraceptive sabotage" OR TI "contraception sabotage*" OR TI "birth control sabotage" OR AB "pregnancy sabotage" OR TI	MH "health personnel +" OR TI "health personnel" OR TI "psychologist*" OR TI "clinician*" OR TI "health professional*" OR TI "doctor*" OR TI "specialist*" OR TI "nurse*" OR TI "mental health*" OR TI "practitioner*" OR TI "professional*" OR TI "medical practitioner*" OR TI "primary care" ORAB "health personnel"	MH "qualitative studies" OR TI "qualitative*" OR AB "qualitative*" OR MH "focus groups" OR TI "focus group*" AB "focus group*" OR MH "interviews" OR TI "interview*" OR AB "interview*" OR MH "thematic analys*" OR TI "thematic analys*" OR AB "thematic analys*" OR MH "content analys*" OR TI "content

	"pregnancy control" OR AB contraception manipulation"	OR AB "psychologist*" OR AB "clinician*" OR AB "health professional*" OR AB "doctor*" OR AB "nurse*" OR AB "mental health*" OR AB "practitioner*" OR AB "professional*" OR AB "medical practitioner*" OR AB "primary care"	analys*" OR MH "life experiences" OR TI "lived experience*" OR AB "lived experience*" OR TI "personal experience*" OR AB "personal experience*" OR TI "interpretative phenomenological analys*" OR AB "interpretative phenomenological analys*" OR TI perspective* OR AB perspective*.tw.
Embase	coercion.sh OR pregnancy.sh OR imitate partner violence.ti,ab OR reproductive coercion.ti,ab OR coerced reproduction*.ti,ab OR reproductive control.ti,ab OR reproductive abuse.ti,ab OR contraceptive sabotage.ti,ab OR birth control sabotabe.ti,ab OR pregnancy sabotage.ti,ab OR pregnancy control.ti,ab OR contraception manipulation.ti,ab	health personnel.sh OR health personnel.ti,ab OR health professional*.ti,ab OR doctor*.ti,ab OR specialist*.ti,ab OR nurse*.ti,ab OR psychologist*.ti,ab OR mental health*.ti,ab OR practitioner*.ti,ab OR professional*.ti,ab OR specialist*.ti,ab OR medical practitioner*.ti,ab OR clinician*.ti,ab OR primary care.ti,ab	qualitative research.sh OR qualitative analysis.sh OR qualitative*.ti,ab OR focus group*.ti,ab OR interview.sh OR interview*.ti,ab OR thematic analys*.sh OR thematic analys*.ti,ab OR content analys*.sh OR content analys*.ti,ab OR personal experience*.sh OR lived experience*.ti,ab OR interpretative phenomenological analys*.ti,ab OR ethnograph*.ti,ab OR case stud*.ti,ab OR narrative*:ti,ab OR perspective*.ti,ab

Appendix B

Data Extraction Sheet

<table>
<tr><td colspan="3">Title</td></tr>
<tr><td colspan="3">Author and year</td></tr>
<tr><td colspan="3">Reference</td></tr>
<tr><td colspan="3">Study Design</td></tr>
<tr><td colspan="3">Type of study</td></tr>
<tr><td colspan="3">Study question</td></tr>
<tr><td colspan="3">Method of data collection</td></tr>
<tr><td colspan="3">Method of data analysis</td></tr>
<tr><td>Study country</td><td colspan="2">Sample size</td></tr>
<tr><td>Gender</td><td colspan="2">Age
Mean:
Range:</td></tr>
<tr><td>Relationship

Married
Partnered
Single
Separated
Other
Not specified</td><td>Ethnicity</td><td>Residence

Rural
Remote</td></tr>
</table>

Type of health practitioner	Type of reproductive coercion (RC)
Doctor	Pregnancy pressure
Nurse	Pregnancy control
Midwife	Abortion coercion
General practitioner	Correlated with IPV
Other	Not specified
Not specified	

Findings and Outcomes

Themes	Extracts	Page no.

Appendix C

Qualsyst Evaluation of Methodological Quality of Included Studies

	Qualsyst Criteria										
Lead Author (Date	Question/Objective	Study Design	Context	Theoretical Framework	Sampling Strategy	Data Collection	Data Analysis	Verification Procedure	Conclusion	Reflexivity	TOTAL
Adongo (2014)	●	●	●	●	●	●	●	●	●	○	.90
Ganle (2015)	●	●	●	●	●	●	●	●	●	○	.90
Graner (2010)	●	●	●	●	◖	●	●	●	●	○	.85
Moyer (2014)	●	●	●	●	●	●	●	●	●	○	.90
Schwandt (2013)	●	●	●	●	●	●	●	●	●	○	.80

Tarzia (2019a)	●	●	●	●	◖	●	●	●	●	○	.85
Tarzia (2019b)	●	●	●	●	●	●	●	●	●	●	1.00
Tarzia (2022)	●	●	●	●	●	●	●	●	●	●	1.00
Wellington (2021)	●	●	●	●	●	●	●	●	●	●	1.00

Appendix D

ENTREQ Checklist

Item	Guide and Description	Reported on Page Number
Aim	State the research question the synthesis addresses.	17
Synthesis Methodology	Identify the synthesis methodology or theoretical framework which underpins the synthesis and describe the rationale for choice of methodology (e.g., metaethnography, thematic synthesis, critical interpretive synthesis, grounded theory synthesis, realist synthesis, meta-aggregation, meta-study, framework synthesis).	17-18
Approach to Searching	Indicate whether the search was pre-planned (comprehensive search strategies to seek all available studies) or iterative (to seek all available concepts until theoretical saturation is achieved).	18-19
Inclusion Criteria	Specify the inclusion/exclusion criteria (e.g., in terms of population, language, year limits, type of publication, study type).	19
Data Sources	Describe the information sources used (e.g., electronic databases (MEDLINE, EMBASE, CINAHL, psychINFO, Econlit), grey literature databases (digital thesis, policy reports), relevant organisational websites, experts, information specialists, generic web searches (Google Scholar), hand searching, reference lists) and when the searches were conducted; provide the rationale for using the data sources.	18
Electronic Search Strategy	Describe the literature search (e.g., provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research and search limits).	18-19 & Appendix A
Study Screening Methods	Describe the process of study screening and sifting (e.g., title, abstract and full text review, number of independent reviewers who screened studies.	20-21
Study Characteristics	Present the characteristics of the included studies (e.g., year of publication, country, population, number of participants, data collection, methodology, analysis, research questions).	23-28
Study Selection Results	Identify the number of studies screened and provide reasons for study exclusion (e.g., for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications to the research question and/or contribution to theory development).	19-20

Rationale for Appraisal	Describe the rationale and approach used to appraise the included studies or selected findings (e.g. assessment of conduct (validity and robustness), assessment of reporting (transparency), assessment of content and utility of the findings).	20
Appraisal Items	State the tools, frameworks and criteria used to appraise the studies or selected findings (e.g. Existing tools: CASP, QARI, COREQ, Mays and Pope [25]; reviewer developed tools; describe the domains assessed: research team, study design, data analysis and interpretations, reporting).	20, 22
Appraisal Process	Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required.	20
Appraisal Results	Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale.	21, 29-30 & Appendix C
Data Extraction	Indicate which sections of the primary studies were analysed and how were the data extracted from the primary studies? (e.g. all text under the headings "results /conclusions" were extracted electronically and entered into a computer software).	22 & Appendix B
Software	State the computer software used, if any.	18
Number of Reviewers	Identify who was involved in coding and analysis.	20
Coding	Describe the process for coding of data (e.g. line by line coding to search for concepts).	22
Study Comparison	Describe how were comparisons made within and across studies (e.g. subsequent studies were coded into pre-existing concepts, and new concepts were created when deemed necessary).	17-18
Derivation of Themes	Explain whether the process of deriving the themes or constructs was inductive or deductive.	22
Quotations	Provide quotations from the primary studies to illustrate themes/constructs, and identify whether the quotations were participant quotations or the author's interpretation.	33-42
Synthesis Output	Present rich, compelling and useful results that go beyond a summary of the primary studies (e.g. new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct).	30-42