Restricted Reproductive Rights and Risky Sexual Behaviour: How Political Disenfranchisement Relates to Women’s Sense of Control, Well-Being and Sexual Health
Abstract

Few studies have investigated the role of disenfranchisement and denial of agency in women’s sexual health. To address this, a cross-sectional study of disenfranchisement, control (general and reproductive control), and health was conducted in Ireland, where abortion is severely restricted. Multiple mediation models ($N = 513$ women) indicated that general but not reproductive control mediates the association between disenfranchisement and psychological well-being. Additionally, serial mediation shows disenfranchisement is associated with lower sense of control, which is linked to poorer well-being and risky sexual behaviour. Disenfranchisement arising from socio-political contexts may have important implications for women’s sexual health.

Key words: disenfranchisement, control, health, well-being, abortion
Sexual and reproductive ill health is a major cause of morbidity and mortality; however, calls to enhance these dimensions of health have been neglected (Glasier & Gülmezoglu, 2006). Research suggests that having the freedom to decide if, when and how often to reproduce is central to sexual health, implying that access to abortion services is important. However, 25% of the world’s population lives in one of 66 countries where abortion is either prohibited, or allowed only where the pregnant woman’s life is at risk (Center for Reproductive Rights, 2017). In such countries, women do not have the capacity to decide if and when to reproduce, and are structurally disadvantaged with regard to their reproductive rights. Indeed, given that they cannot obtain abortion services should they want or need them, we argue that such women are disenfranchised: stripped of the power to make personal health-related decisions that impact their lives and well-being. We propose that this disenfranchisement reduces women’s sense of control. In turn, we predict that this reduced sense of control has deleterious effects for their well-being and sexual behaviour (Kerrigan, Fonner, Stromdahl, & Kennedy, 2013).

To date, few studies have investigated the role of disenfranchisement in women’s sexual health. We address this gap by investigating this issue in Ireland: one of two European countries where abortion is permitted only where the pregnant woman’s life is at risk (Center for Reproductive Rights, 2017). In Ireland, the Eighth Amendment to the constitution legislates against access to abortion services, by recognising the right to life of an unborn child as equal to the right to life of a pregnant woman. The Irish constitution can be changed only by referendum (The All-Party Oireachtas Committee of the Constitution, 2005), and the last opportunity for Irish women to influence law was the referendum inserting the Eighth Amendment in 1983 (Irish Family Planning Association, n.d.). As such, at the time of writing, no Irish woman of childbearing age has had the opportunity to vote on Ireland’s
current constitutional outlawing of abortion. Effectively, women in Ireland are politically disenfranchised with regard to their sexual health. In this study, we use the Irish setting to investigate the link between disenfranchisement, feelings of control, psychological well-being, and risky sexual behaviour.

**Sexual health and well-being**

In a global review of mental health aspects of women’s sexual health, the World Health Organization assert that sexual and reproductive rights are important aspects of human rights and overall health (WHO, 2009). Sexual health goes beyond the absence of disease and infections, to include the ability to control fertility and enjoy relationships free from discrimination (WHO, 2009). It is inextricably linked to well-being; women’s mental health suffers when reproductive rights are compromised (WHO, 2009).

In countries where abortion is illegal, the social and political environment can contribute to poorer mental health, particularly where women access abortion through illicit means (Krug, Mercy, Dahlberg & Zwi, 2002). Denying access to legal, safe, timely and affordable abortion means women in developed and developing countries may resort to unsafe, ‘backyard’ or self-inflicted procedures (WHO, 2009). Illegal and unsafe abortion is a source of stigma and a leading cause of preventable death in developing countries (Sedgh, Henshaw, Singh, Åhman & Shah, 2007). In predominantly Catholic European countries such as Poland and Ireland, women often travel to nearby countries to access legal abortion services. Estimates suggest that between 2001 and 2008, 18 Irish women a day travelled to the UK for abortion services, a trip that is expensive and entails the emotional and psychological burden of secrecy and deception (Gilmartin & White, 2011). Moreover, longitudinal evidence indicates that women who are denied abortion in pregnancy are more

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1 After data collection but prior to publication of this paper, a Citizen’s Assembly considered the issue of the Eighth Amendment and recommended it be replaced by legislation allowing access to abortion in a variety of circumstances that are yet to be defined (Irish Examiner, 2017).
likely to experience adverse emotional consequences than a matched cohort of mothers who desired their pregnancies (David, Dytrych, & Matejcek, 2003). These findings support an association between denial of reproductive rights and impaired well-being. We propose that the association between disenfranchisement and impaired psychological well-being is not limited to women who need to access abortion, but rather extends to all women whose reproductive rights are restricted as a result of social or structural circumstances.

**Disenfranchisement and risky sexual behaviour**

Denying women’s reproductive rights means that the state, rather than women themselves, makes decisions regarding women’s reproductive trajectories. One proposed reason for restricting reproductive rights is that providing women with more reproductive control (e.g., over-the-counter access to contraception) increases their engagement in risky sexual behaviour. Yet, a prospective cohort study of 9,256 women provided little evidence to support such concerns (Secura, Buckel, Zhao, & Peipert, 2014). On the other hand, the extent to which women’s disenfranchisement in the context of restricted reproductive control influences risky sexual behaviour is unknown, and this study aims to address this gap.

Due to ongoing political controversies, successive Irish governments have avoided a referendum that might allow abortion even in limited circumstances, leading to de facto disenfranchisement on this issue (Fletcher, 2001). Therefore, perceived disenfranchisement is likely to be high in an Irish female sample, allowing us to consider its impact on women’s health. To date, limited research has examined the role of disenfranchisement in women’s health, or health in general. Far greater attention has been given to health outcomes associated with disempowerment. Given that disenfranchisement involves systematic exclusion from authoritative power, it is a form of disempowerment (Zimmerman, 2000). A substantial literature on disempowerment indicates that feelings of control are central to the empowerment process (Zimmerman, 1995). Most relevant to the current study are three
systematic reviews which link empowerment to sexual health and reduced risky sexual
behaviour in female sex workers (Kerrigan et al, 2013; Kerrigan et al, 2015), and in HIV and
AIDS sufferers (Wiggins, 2011). By extension, we argue that disenfranchisement should be
related to sexual health behaviour. In particular, we anticipate that disenfranchisement
predicts poorer sexual health behaviour through a reduced sense of control.

**Control and sexual health**

Extensive evidence demonstrates that perceptions of control are associated with health
outcomes across a range of physical and health domains (Bosma, Marmot, Hemingway,
Nicholson, Brunner, & Stansfeld, 1997; Ell, Mantell, Hamovitch, & Nishimoto, 1989;
Macrodimitris & Endler, 2001). Moreover, a sense of control has been found to mediate the
negative consequences of adverse conditions (Bobak, Pikhart, Rose, Hertzman, & Marmot,
2000). In examining the role of perceived control in sexual health, it is important to look
beyond general control and examine reproductive control. Reproductive control is defined as
a woman’s perception that she is able to make autonomous decisions with regard to her
sexual health (Moore, Frohwirth, & Miller, 2010; Upadhyay, Dworkin, Weitz & Foster,
2014). Control of women’s reproduction can be exerted by other sources, including partners,
parents or peers, through economic, emotional and financial means (Moore et al., 2010). At a
structural level, governmental legislation in relation to contraception, sex education,
vulnerability to violence, and access to abortion can also impact on women’s reproductive
control. Each of these factors may exert independent effects on women’s mental health
(WHO, 2009). The current study aims to investigate the role of women’s perceptions of
reproductive control, as well as more general perceptions of control, in explaining the link
between disenfranchisement, well-being and risky sexual behaviour.
The Present Study

This study aimed to explore women’s sexual health in a context where social, cultural, and structural conditions restrict women’s reproductive rights. In Ireland, the outlawing of abortion was enshrined in the constitution more than two generations ago. In this setting, this cross-sectional study investigates the underexplored links between disenfranchisement, feelings of control (both general and reproductive), psychological well-being and risky sexual behaviour. Drawing on the evidence reviewed, the following hypotheses were generated. First, disenfranchisement will be negatively associated with psychological well-being and this relationship will be mediated by both reduced general control and reduced reproductive control (H1). Second, disenfranchisement will be associated with increased risky sexual behaviour, and this association will be mediated by reduced general control and reproductive control (H2). Finally, our third hypothesis draws these assumptions together and predicts that disenfranchisement will be associated with increased risky sexual behaviour, and this relationship will be serially mediated by reduced feelings of control (both general and reproductive) and poorer psychological well-being (H3).

Method

Participants and Procedure

Women aged 18 and over were recruited to a cross-sectional survey study via an email invitation to the student population at a university in the Republic of Ireland. Participants read the information sheet detailing the questionnaire content, and indicated their consent before completing the questionnaire. Demographic items were presented first, followed by measures of religiosity, attitudes to abortion, well-being, disenfranchisement, risky sexual behaviour, general control and reproductive control. Upon completion, participants were directed to the debriefing page which provided details on the study aims.
and information on sexual health clinics. Ethical approval was obtained from the faculty Research Ethics Committee.

Seven hundred and twenty-four volunteers entered the survey, 513 (71%, aged 18-54) completed all survey items and were included in the final sample. The majority identified as white Irish (80%) or other white background (13%); 4% of the sample did not specify their ethnicity or nationality. The greatest proportion identified as heterosexual (85%), 12% bisexual, 1% gay/lesbian, and 2% as “other”. Most did not have children (n = 495, 97%) and had not had a pregnancy terminated (n = 496, 97%). Twelve participants said they had had a pregnancy terminated (2%) and five preferred not to answer (1%).

Measures

Where necessary, scores were recoded so that higher scores represented higher levels of each construct measured.

Political disenfranchisement

Political disenfranchisement was assessed using the Political Efficacy Scale (Schulz, 2005), containing 9 items rated on a 4-point Likert scale from strongly agree to strongly disagree (e.g., ‘I know more about politics than most people my age’).

Health measures

Psychological well-being. The 12-item version of the General Health Questionnaire (GHQ; Goldberg, 1992) includes items used to measure psychological well-being (e.g., ‘Have you recently lost much sleep over worry?’), rated using a 4-point Likert scale, as in previous research (e.g., Schmid & Muldoon, 2015).

Risky sexual behaviour. The Student Sexual Risks scale (self-assessment version; DeHart & Birkimer, 2010) consists of 38 items with responses obtained using a 3-point scale, agree, undecided, or disagree (e.g., ‘If my partner wanted me to have unprotected sex, I
would probably give in’). This scale includes six subscales and here we used all items to create an overall measure of risk.

**Mediating variables: Control**

**General control.** General sense of control was measured using a total score from the short version of the Sense of Control Measure (Lachman, & Weaver, 1998). This comprises 5 items scored on a 4-point scale from *a lot* to *not at all* (e.g., ‘I can do just about anything I put my mind to’).

**Reproductive control.** This construct was measured using 6 items based on the conceptual framework on reproductive control outlined by Moore and colleagues (2010). Each participant responded to 6 items related to reproductive control and contraception on a 5-point scale from *completely agree* to *completely disagree* (e.g., ‘I cannot control the effectiveness of my contraception’).

**Covariates**

**Religiosity.** The Duke University Religion Index (Koenig & Büssing, 2010) is a 5-item measure commonly used to measure religiosity, containing items related to frequency of public and private religious behaviours rated on a 6-point scale from *never* to *once a week or more* (e.g., ‘How often do you attend church or other religious meetings?’), and items on religious belief and experience rated on a 5-point scale from *rarely or never* to *more than once a week* (e.g., ‘My religious beliefs are what really lie behind my whole approach to life’).

**Attitudes to abortion.** The Abortion Attitude Scale (Smith & Son, 2013) contains 7 items about different situations a woman could have access to a legal abortion, with a 5-point Likert scale ranging from *strongly agree* to *strongly disagree* (e.g., ‘Please indicate whether or not you think it should be possible for a pregnant woman to obtain a legal abortion if the woman’s own health is seriously endangered by the pregnancy?’).
Results

Relationships between Disenfranchisement, Control, and Health

Descriptive statistics and correlations for our study variables are displayed in Table 1. Disenfranchisement was inversely correlated with psychological well-being ($r = -0.13, p = .003$), as expected, but not with risky sexual behaviour ($r = 0.02, p = .66$). Psychological well-being and risky sexual behaviour were negatively related ($r = -0.12, p = .007$). Religiosity was negatively correlated with attitudes to abortion ($r = -0.42, p < .001$).

Predicting Well-being and Risky Sexual Behaviour

Figure 1 (a and b) displays multiple mediation models using PROCESS, for disenfranchisement and our health variables, controlling for religiosity and attitudes to abortion. Contrary to our H1 prediction, disenfranchisement had no significant direct effect on psychological well-being (Fig. 1a; $\beta = -0.05, SE = 0.07, t = -0.65, p = .51, 95\% CI [-.18, -.09]$). However, there was a significant indirect effect, such that the association between disenfranchisement and psychological well-being was mediated via general control ($\beta = -0.17, SE = 0.04, 95\% CI [-.26, -.09]$). Disenfranchisement was associated with lower general control ($\beta = -0.18, SE = 0.04, t = -4.39, p < .001, 95\% CI [-.27, -.20]$), and general control was positively associated with well-being ($\beta = 0.94, SE = 0.07, t = 13.17, p < .001, 95\% CI [0.81, 1.08]$). Disenfranchisement did not predict reproductive control ($\beta = -0.04, SE = 0.05, t = -0.80, p = 0.41, 95\% CI [-.14, .06]$), but reproductive control was directly associated with well-being ($\beta = 0.25, SE = 0.46, t = 4.26, p < .001, 95\% CI [0.13, 0.36]$). As such, H1 was partly supported.

Figure 1b summarises our findings relative to risky sexual behaviour (H2). Disenfranchisement showed no direct association with risky sexual behaviour ($\beta = 0.05, SE = 0.16, t = 0.32, p = 0.74, 95\% CI [-0.28, 0.39]$). Neither the indirect effect for general control nor reproductive control were significant (results not shown), meaning H2 was not supported.
Reproductive control significantly predicted risky sexual behaviour (\(\beta = - .39, \ SE = .74, t = -2.72, p = .006, 95\% \ CI [-.67, -.011]\)).

**Predicting Risky Sexual Behaviour: A Role for Disenfranchisement, Control and Well-being**

To test H3, that disenfranchisement was *indirectly* linked with risky sexual behaviour via psychological well-being, we conducted a final analysis. In search of a more parsimonious explanation of the relationships between our variables, we conducted a serial mediation model, including general control and psychological well-being as serial mediators of the relationship between disenfranchisement and risky sexual behaviour. Reproductive control was not included here as it was unrelated to disenfranchisement in our earlier models. We again controlled for abortion attitudes and religiosity. This model was a good fit to the data; political disenfranchisement had an indirect effect on risky sexual behaviour because of shared associations of these two variables with general control and psychological well-being (\(\beta = .05, \ SE = .03, 95\% \ CI [.02, .11]\)).

As illustrated in Figure 1c, higher levels of disenfranchisement significantly predicted lower general control (\(\beta = -.18, \ SE = .04, t = -4.30, p < .001, 95\% \ CI [-.26, -.10]\)). General control predicted lower psychological well-being (\(\beta = -.17, \ SE = .04, 95\% \ CI [-.26, -.09]\)), which in turn predicted higher levels of risky sexual behaviour (\(\beta = -.99, \ SE = .07, t = 13.88, p < .001, 95\% \ CI [0.85, 1.14]\)). In a model reversing the order of our health variables (psychological well-being and risky sexual behaviour), the indirect effect was no longer observed, offering support for the proposed direction of these relationships.

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**Figure 1**

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Discussion

This study aimed to investigate the underexplored role of disenfranchisement in women’s psychological well-being and sexual health. Specifically, in a setting where women are excluded from abortion services, we investigated whether perceived disenfranchisement was associated with a reduced sense of general control, impaired psychological well-being, and more risky sexual behaviours. Our study has three key findings. First, political disenfranchisement was indirectly associated with impaired psychological well-being, via a reduced sense of control. Second, the link between political disenfranchisement and risky sexual behaviour, although not apparent when examined directly, was evident via reduced general control and impaired psychological well-being. Finally, although reproductive control was not a significant mediator, it predicted better psychological well-being and reduced risky sexual behaviour.

Based on previous evidence that women’s mental health is negatively affected where their reproductive rights are restricted (WHO, 2009), and wider epidemiological research associating structural disenfranchisement with poorer health (Marmot, 2004; Wilkinson & Pickett, 2009), we predicted that women’s perceived political disenfranchisement would directly relate to decreased psychological well-being. The absence of this direct relationship was unexpected. However, it is important to note that the existing research in this area tends to focus on women who are trying to access abortion. In our study, we aimed to investigate the effect of disenfranchisement on all women. As such, although prior research has shown negative mental health implications for women seeking an abortion when they live in a country where it is illegal (Krug et al., 2002), it may be that such effects are evident only in those denied access to abortion. That is, disenfranchisement has immediate consequences for mental health when it blocks access to healthcare.
However, it is important that the indirect path via general control was observed. This indicates that regardless of whether women have needed abortion services, feelings of disenfranchisement are associated with a reduced sense of control, which links to impaired psychological well-being. This provides empirical support for a link between empowerment and control over health decisions (Andreassen & Trondsen, 2010) and is consistent with epidemiological research relating structural disenfranchisement to concepts such as control over one’s health and well-being (Marmot, 2004; Wilkinson & Pickett, 2009). Moreover, by focusing on the perception of disenfranchisement and how this relates to psychological well-being via perceptions of control, our findings extend previous knowledge about the links between disenfranchisement and general control (Andreassen & Trondsen, 2010), psychological well-being (Marmot, 2004; WHO, 2009; Wilkinson & Pickett, 2009), and risky sexual behaviour (Kerrigan et al., 2013, Kerrigan et al., 2015), as well as links between each of these variables (e.g., Bobak et al., 2000; Ell et al., 1989; Macrodimitris & Endler, 2001). We provide a more nuanced understanding of how political disenfranchisement relates to reduced feelings of control, and the way it connects to psychological well-being and risky sexual behaviours. This represents an important addition to the existing literature.

Although predictions relating to reproductive control were not supported, this construct is worthy of future research. In particular, reproductive control predicted both outcomes – higher reproductive control was associated with greater psychological well-being and lower risky sexual behaviour. Put another way, limited reproductive control is associated with reduced psychological well-being and more risky sexual behaviour. This is important because while it is known that a lower level of reproductive control (as such reproductive coercion) is associated with higher rates of unwanted pregnancy (Upadhyay et al., 2014), there was previously limited evidence that reproductive control is associated with measures of well-being. Our results also build on studies that focus on interpersonal control and how
this relates to the use of contraceptives, or not (Tschann et al., 2002), by showing how social structural conditions impacting sense of control may also impact risky sexual behaviour.

The study’s implications go beyond theoretical advances in our understanding of the links between disenfranchisement, control, psychological well-being and risky sexual behaviour. There are clear practical implications for societies that limit women’s access to reproductive and sexual healthcare. The social and political context in which people make their health decisions, or are prevented from doing so, has an impact on sexual and reproductive health. Where women feel they have no political influence on an issue, this has clear everyday relevance for their sense of general control. Often in psychology we think of people as operating in an ‘intrapsychic’ way; however, this finding suggests that the broader social and political landscape has consequences for how we feel about our ability to control our own lives and well-being.

A second broader implication of our findings is the paradoxical consequence of political positions that limit women’s reproductive autonomy to protect the right to life of ‘the unborn’, as in the Irish constitution. Ironically, legislation seeking to protect the life of the unborn has led to a situation where women feel they have no control, and this lack of control is related to risky sexual behaviour, effectively increasing the likelihood of unwanted pregnancies. As such, we have a status quo where legislation designed to protect the unborn may have the opposite effect. This highlights that restrictions on reproductive rights are unlikely to protect anyone’s health, and may have far-reaching unforeseen negative consequences.

**Limitations and Future Directions**

Our findings are limited by the cross-sectional nature of our design, which precludes making causal inferences. Experimental and longitudinal research designs could usefully be
employed in future research. In addition, qualitative methods could complement our current approach, providing insight into the nuances of the survey findings.

It would also be useful to investigate the role of another important dimension of perceived control: collective control or efficacy. While each woman is an individual, with personal characteristics and indeed personal identity, they also share a social category: women. Stollberg, Fritsche and Bäcker (2015) argue that shared group memberships can satisfy the human need for control, a recognised human motive (Fritsche et al., 2013). Stollberg et al. (2015) argue that when personal control is threatened, group-based control can bolster people’s sense of general control. As such, we suggest that future research include a measure of collective efficacy related to the group ‘women’ or perhaps ‘feminists’, to see how this fits with disenfranchisement and the other aspects of control included in the present study.

In this study, we measured participants’ perceptions of reproductive control using a measure originally devised to determine the control that someone else or social structures have over a woman’s sexual health (Moore et al., 2010). Reproductive control is a complex concept related to reproductive autonomy (a women’s ability to make autonomous decisions with regard to her reproductive health) and reproductive coercion (the direct and deliberate interference on a women’s attempts to either avoid or become pregnant; Grace & Anderson, 2016). Literature on these constructs is in the early stages of development (Upadhyay et al., 2014), tending to focus on women’s personal control over their contraceptive use (Tschann, Adler, Millstein, Gurvey, & Ellen, 2002) rather than perceived restriction in accessing contraception, or control over other elements of reproduction and sexual health (e.g., pregnancy itself, sexual health screening), or control related to wider structural forces. Therefore, clearer conceptualization of control, autonomy, and coercion in relation to sexual and reproductive health is important to advance research in this area.
Our sample of university students also limits the study, as women at different life stages may experience reproductive health and autonomy differently. Additionally, attitudes to abortion were rather positive in this sample, and the pattern of results may differ where attitudes are less positive. We also have limited knowledge of the personal relevance of this issue for our sample; while we know that the majority have not accessed abortion before, we do not know about other experiences they may have of abortion (e.g., close friends or family members having abortions), whether they were sexually active, or what they would do if they became pregnant. Such measures would further advance research in this area.

**Conclusion**

Overall, this study advances our understanding of how social and structural factors impact on sexual and reproductive health. In particular, perceptions of political disenfranchisement contribute to lower perceptions of general control, which are associated with poorer psychological well-being and more risky sexual behaviours. Additionally, reproductive control is directly associated with psychological well-being and risky sexual behaviour. Taken together, these findings suggest that limiting women's access to reproductive healthcare may damage their health in terms of their psychological well-being and sexual behaviour. Ironically, the findings point to the fact that banning abortion may serve to make unwanted pregnancy more likely, by facilitating disenfranchisement, and thus negatively impacting women’s psychological well-being and sexual health.
Acknowledgements

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References


Table 1. Descriptive statistics and inter-correlations for study variables (N = 513).

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean (SD)</th>
<th>Min.</th>
<th>Max.</th>
<th>Cronbach’s α</th>
<th>1.</th>
<th>2.</th>
<th>3.</th>
<th>4.</th>
<th>5.</th>
<th>6.</th>
<th>7.</th>
<th>8.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Age</td>
<td>21.83 (4.93)</td>
<td>18</td>
<td>54</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<td>-</td>
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<tr>
<td>2. Disenfranchisement</td>
<td>25.03 (3.37)</td>
<td>13</td>
<td>35</td>
<td>.70</td>
<td>.008</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>3. Sense of control</td>
<td>16.89 (3.25)</td>
<td>7</td>
<td>24</td>
<td>.76</td>
<td>.09*</td>
<td>-.20**</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4. Reproductive control</td>
<td>22.75 (3.97)</td>
<td>10</td>
<td>30</td>
<td>.59</td>
<td>.12**</td>
<td>-.02</td>
<td>.16**</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>5. Psychological well-being</td>
<td>34.42 (6.07)</td>
<td>12</td>
<td>46</td>
<td>.89</td>
<td>.04</td>
<td>-.13**</td>
<td>.53**</td>
<td>.24**</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6. Risky sexual behaviour</td>
<td>36.10(12.62)</td>
<td>16</td>
<td>90</td>
<td>.87</td>
<td>.12**</td>
<td>.02</td>
<td>-.05</td>
<td>-.12**</td>
<td>-.12**</td>
<td>-</td>
<td>-</td>
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<tr>
<td>7. Religiosity</td>
<td>9.93 (4.89)</td>
<td>5</td>
<td>26</td>
<td>.87</td>
<td>-.07</td>
<td>-.07</td>
<td>.003</td>
<td>-.02</td>
<td>.07</td>
<td>.08</td>
<td>-</td>
<td>-</td>
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<tr>
<td>8. Attitudes to abortion</td>
<td>27.70 (7.29)</td>
<td>7</td>
<td>35</td>
<td>.93</td>
<td>.04</td>
<td>-.05</td>
<td>.10</td>
<td>-.15**</td>
<td>-.02</td>
<td>-.07</td>
<td>-.42**</td>
<td>-</td>
</tr>
</tbody>
</table>

Note. Higher scores on each measure indicate higher endorsement of the construct (including more positive attitudes to abortion). *p < .05  **p < .01
Figure 1. Unstandardized regression coefficients for the relationship between disenfranchisement, $x$, and psychological well-being ($y$, Figure 1a) / risky sexual behaviour ($y$, Figure 1b), as mediated by sense of control, $m_1$, and reproductive control $m_2$. The $c'$ pathway refers to the direct effect of $x$ on $y$; the $c_1$ pathway refers to the indirect effect of $x$ on $y$ through the mediator, $m_1$, and the $c_2$ pathway refers to the indirect effect of $x$ on $y$ through the mediator, $m_2$. $^* p < .05; ^*^* p < .001$
Figure 1c. Unstandardized regression coefficients for the relationship between disenfranchisement, x, and psychological well-being, y, as mediated by sense of control, m1, and psychological well-being, m2. The c' pathway refers to the direct effect of x on y, whilst the c pathway refers to the indirect effect of x on y through the serially mediated pathway, m1, m2.

*p < .05  **p < .001