

MARIE STOPES AUSTRALIA: REPRODUCTIVE COERCION WHITE PAPER

Children by Choice Submission to Marie Stopes Australia
Reproductive Coercion White Paper Development
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ABOUT CHILDREN BY CHOICE

Children by Choice provides counselling, information and education services on all options with an unplanned pregnancy, including abortion, adoption and parenting. We provide a Queensland-wide counselling, information and referral service to women experiencing unplanned pregnancy, offer financial assistance for contraceptive and abortion access, deliver sexual and reproductive health education sessions in schools and youth centres, and offer training for GPs and other health and community professionals on unplanned pregnancy options.

We also advocate for improvements to law and policy that would increase women's access to reproductive health services and information. We are recognised nationally and internationally as a key advocacy group for the needs and rights of women in relation to reproductive and sexual health.

In 2016-17 we received a total of 4039 contacts with or regarding 1678 clients, ranging in age from under 14 to over 50, and provided almost \$130,000 in financial assistance for contraceptive and abortion access. Our Annual Reports are available on our website at www.childrenbychoice.org.au.

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INTRODUCTION

Children by Choice is pleased to submit to the Marie Stopes Australia Reproductive Coercion Policy White Paper. This submission supports the initiative that Marie Stopes Australia is taking in promoting furthering understandings of, and sectors responses to, issues of reproductive coercion since 2014. The contents of this submission represent a significant investment of time and resource into the development of knowledge and resources in this niche area. We wish to retain intellectual property over all content in this submission such that it not be re-used or reprinted in part or whole without our written permission.

Children by Choice has been a lead voice for issues of reproductive coercion for Queensland women. Our experience in this area has supported us to develop knowledge, practice and resources around this issue as it relates to unplanned pregnancy support and abortion care. As such the content and recommendations of this report focus on these settings.

It is only through the generosity of the Samuel and Eileen Charitable Trust, managed by Perpetual, that Children by Choice has been sufficiently resourced to progress work around this issue in the last 18 months. We offer content, issues and ideas in relation to all components of the terms of reference. Although not requested, a definition of reproductive coercion warrants attention first.

DEFINING REPRODUCTIVE COERCION

A clear shared definition of reproductive coercion is important as it ensures that research can be easily compared, replicated and extended, and policy and practice across sectors can be consistent and integrated. Unfortunately, a review of the international literature reveals inconsistent definitions of reproductive coercion.

Some definitions offer broad statements about perpetrator behaviours in the absence of clear statements about the intention of the behaviour. However, any definition needs to attend to the intentionality of the reproductive coercion, to distinguish it from the unintentional impacts of violence and control on contraceptive use and negotiation.¹ Fortunately, many definitions include reference to the *maintenance* of power and control,² and this is in line with contemporary understanding of gendered violence.

Some women are subjected to reproductive coercion in the absence of other forms of violence and control.³ Thus, including a reference to the *establishment* of power and control aligns with research on identified patterns of reproductive coercion. Whilst there is much research still needed to explore the temporal relationship between reproductive coercion and other forms of violence and control, it is highly likely that it creates a context in which control can be established, and should be a feature of any contemporary definition.

Definitions often refer to the man and/or partner, yet the perpetrator may not be involved in a sexual relationship with the woman.⁴ Because of this, the broader term ‘perpetrator’ more clearly encompasses any person regardless of the nature of their relationship with the woman. Indeed,

research has identified that reproductive coercion can be perpetrated before a relationship is formalised, during the relationship or after separation, which warrants consideration in any definition⁵.

Perpetrator behaviours are often described temporally as pregnancy pressure, contraceptive sabotage and pregnancy outcome control.⁶ Therefore, including these temporal dimensions in a comprehensive definition provides an additional frame of reference for shaping up research as well as designing assessment and intervention.

The following definition attempts to incorporate all of these features:

Reproductive coercion is any perpetrator behaviour aimed at establishing and maintaining power and control over a woman who they are, were, or seek to be in a relationship with, by interfering with her reproductive autonomy, denying her control, decision-making and access to options regarding reproductive health choices. These behaviours may include pregnancy pressure, contraceptive sabotage, and pregnancy outcome control.

Recommendation 1: That the MSA White Paper include a clear definition of reproductive coercion, informed by contemporary research and understandings, such as the one offered above.

EXISTING RESEARCH ON REPRODUCTIVE COERCION

This section will explore how reproductive coercion is measured in the international research and its comparison to measures in Australia, prevalence and patterns of reproductive coercion from international research and the comparison with the very limited Australian data, and the implications for service delivery and future Australian research.

MEASURING REPRODUCTIVE COERCION

Having a clear understanding of how reproductive coercion is measured in different research and practice settings where data is captured is important in ensuring that research can be meaningfully compared. A review of the variation of scales used and their applicability to research in abortion care settings provides direction to future research agendas, and a standpoint from which to evaluate the generalisability of the Children by Choice data.

Of the available formal reproductive coercion scales reviewed, there is a clear focus on two temporal domains of reproductive coercion: specifically, pregnancy pressure, which typically involves physical or psychological threats against the woman to promote pregnancy; and contraceptive sabotage, which involves the active interference with contraception use, such as destroying oral contraceptive pills, the intentional breaking or removal of condoms, and forced unprotected sex.⁷ Problematically, questions regarding contraceptive sabotage predominantly focus on condom manipulation in all scales reviewed, with 60%-70% of questions exploring this issue.⁸ These questions tended to be very specific in nature, with questions about other contraceptive sabotage remaining more general and not specific to contraceptive type. Unfortunately, these scales may not capture more extreme violence related to interference with other contraceptive types such as the forcible removal of intrauterine devices and implants. Furthermore, questions regarding the temporal domain of pregnancy outcome control were also omitted among formal reproductive coercion scales. This was for both coercion to proceed with a pregnancy post-conception and coercion to abortion, and is particularly relevant to abortion care settings.

RECOMMENDATION 2: That a structured reproductive coercion scale be developed which includes pregnancy outcome coercion.

All studies reviewed used the presence of single instance of pregnancy pressure or contraceptive sabotage as the threshold for the presence of reproductive coercion.⁹ However, one study that relied more heavily on semi-structured questions featured recognition of reproductive coercion across a temporal continuum that included post-conception coercion to continue the pregnancy as well as explorations of coerced abortion (pregnancy outcome control)¹⁰. This study most closely aligns with the way in which Children by Choice explore women's experiences of reproductive coercion.

CHILDREN BY CHOICE MEASURES

Data on reproductive coercion at Children by Choice is gathered by counsellors in their contacts with or on behalf of women seeking support around unplanned pregnancy. This support includes information, referral, counselling on all options with an unplanned pregnancy, post abortion counselling and support to access an abortion. Despite no formal reproductive coercion measure,

counsellors record either the absence or presence of reproductive coercion from what is known about the woman's circumstances at each contact with the service. Behind this binary recording sits complex and rich practice across all stages of service delivery: intake, assessment, intervention and evaluation. In particular, the presence of pregnancy pressure is explored in relation to the man involved in the pregnancy as well as others in the woman's network. Similarly, contraceptive sabotage is explored with relation to the full range of perpetrator behaviours and all contraceptive types, with counsellors reporting anecdotal examples of range of perpetrators actions, extending to more extreme violence such as the forcible removal of intrauterine devices and forced unprotected sex.

Pregnancy outcome control is of particular focus given all women contacting the service do so in relation to unintended pregnancy and abortion. Pregnancy outcome control usually includes exploration of women's experiences of perpetrators' attempts to prevent abortion access as well as women's experiences of coerced abortion.

The Children by Choice definition of reproductive coercion used to inform our data collection encapsulates a broad range of reproductive coercion strategies and captures more extreme violence. It explores perpetrator actions cross the temporal continuum, as well as including coerced abortion. Counsellors record the presence of reproductive coercion based on the detail of events shared by women even if the woman is not explicitly naming the events as coercive. Similar to other scales, any single form of reproductive coercion would be coded as the presence of reproductive coercion.

Importantly, our service data is captured by individual contacts, not as part of a broader client management system where the all contacts with individual women who seek support can be linked. As such we cannot accurately determine the numbers of individual women to whom this contact data relates, only the number of overall contacts with women in which reproductive coercion is identified. Caution should therefore be used in comparing prevalence and patterns data from the Children by Choice data with studies uses existing structured scales. Despite these limitations, prevalence rates and patterns emerging from the Children by Choice data show some consistency with those found within empirical research contexts, and therefore provides a foundation for beginning to understand reproductive coercion in the Australian context.

PREVALENCE OF REPRODUCTIVE COERCION

A search for prevalence data on reproductive coercion in Australia reveals very little except data published by Children by Choice. The Australian Bureau of Statistics does not report on reproductive coercion in their personal safety survey and it is not profiled in their domestic violence data. A growing body of research on prevalence and patterns of reproductive coercion can be found in peer reviewed work from the United States of American (US).

OVERALL RATES

Analysis of US data on overall prevalence rates of reproductive coercion is confounded by the fact that research studies sample women from widely different settings, from large population studies to young women from low socio economic backgrounds attending specialist sexual and reproductive health services. As such prevalence rates vary markedly. US population studies have placed overall rates of prevalence at about 9% of the female population¹¹. In populations known to ever have

experienced domestic or intimate partner violence rates of 8.6% were observed.¹² In contrast, those attending for obstetrics and gynaecology care have been found to experienced reproductive coercion at rates of about 16%¹³ and rates as high as 40% have been found amongst women attending sexual and reproductive health services in low socio-economic communities.¹⁴

An analysis of Children by Choice data collected from January 2015 to July 2017 reveals rates of 13.5% of all counselling service contacts recorded as having experienced reproductive coercion. No studies were found that offered rates specifically from populations seeking abortion care or unplanned pregnancy support with which to compare this data. However, it is within the range of prevalence data from US research especially that collected from broader obstetrics and gynaecology settings. Whilst detailed empirical Australian research across populations groups is clearly needed, this Children by Choice data provides an approximate picture of overall prevalence rates of reproductive coercion in Queensland.

RATES OF REPRODUCTIVE COERCION CO-OCCURRING WITH DOMESTIC VIOLENCE

US research again leads the way in shaping our understandings of reproductive coercion co-occurring with domestic violence. In one population of women known to have experienced intimate partner violence, 74% also experienced reproductive coercion.¹⁵ Rates in other studies were somewhat lower (43%¹⁶, 26%¹⁷, 16%¹⁸), perhaps due to a range of study design differences. Similarly, Children by Choice data found 32.5% of contacts disclosing domestic violence were also experiencing reproductive coercion.

RECOMMENDATION 3: All services and professionals involved in responding to the needs of women experiencing violence must be resourced and informed on reproductive coercion.

REPRODUCTIVE COERCION IN THE ABSENCE OF OTHER FORMS OF DOMESTIC VIOLENCE

Several of the US studies offer data on the prevalence of reproductive coercion in the absence of other forms of domestic violence, with rates of 45%¹⁹ to 53.4%²⁰ observed in health care settings compared to rates of approximately 23% in the Children by Choice data.

It is clear that reproductive coercion does occur at significant rates in the absence of any other forms of domestic violence. This pattern has significant implications for screening and responding. It compels us to ensure that reproductive coercion screening is done as a distinct part of violence screening, and to not assume that it is sufficient to only ask about reproductive coercion where other forms of violence have already been identified. It also invites further research on the temporal associations between reproductive coercion and domestic violence.

RECOMMENDATION 4: That reproductive coercion screening is implemented as a universal standalone aspect of violence screening, not only where other forms of domestic violence have been disclosed.

RECOMMENDATION 5: That the temporal relationship between reproductive coercion and domestic violence be more fully explored in future Australian research.

PATTERNS OF REPRODUCTIVE COERCION

PREVALENCE BY AGE

Relevant US research regarding people under 18 is not as prolific as for older cohorts due to the ethical limitations in research with minors. Studies reviewed did not use consistent age parameters when defining young people, making comparisons difficult. However, available research suggests that young people experience higher rates of reproductive coercion than older women. Population studies of young people place prevalence rates at 20% which is higher than the general population²¹ and over 35% in some minority groups of young people.²² While many studies had sample sizes too small to look at age cohort differences, one study found higher rates of reproductive coercion in 18-20 year olds than those 25 – 29 years of age.²³

This is in contrast with the Children by Choice age cohort data, in which those under 20 years of age report reproductive coercion at a rate of only 12.5% compared to 21.8% for those in the 20-29 year age cohort.

These two samples come from different service delivery contexts: the US study from within a cohort of young people accessing a range of sexual and reproductive health services; and the Children by Choice cohort from those seeking unplanned pregnancy support only. Some studies report that young women who have experienced abuse may be more likely to continue their pregnancy compared to older young women.²⁴ The suggestion that young women are more vulnerable to successful coerced pregnancy has significant implications for all pregnancy care settings as well as for those offering a broader range of social supports. It also points the way to much needed research on the issues.

RECOMMENDATION 6: Antenatal services include reproductive coercion screening as part of broader violence screening, especially with young women.

RECOMMENDATION 7: Future research explore patterns of reproductive coercion in young women with a focus on pregnancy outcomes.

The insights from US research on the patterns of reproductive coercion amongst young women also offer specific implications for assessment and intervention with at risk young women. They are more likely to:

- Be living with a partner;
- Be in a relationship with an older partner;
- Have low recognition of abusive behaviours;
- Report low comfort levels when communicating with their sexual partner;
- Have chlamydia; and
- Report intimate partner violence.²⁵

RECOMMENDATION 8: That domestic violence and reproductive coercion screening is incorporated as part of STI screening.

RECOMMENDATION 9: That reproductive coercion and perpetrator behaviour awareness be included in sexuality education provided to young people.

RECOMMENDATION 10: That broader domestic violence support services be more responsive to the needs of young women.

RECOMMENDATION 11: That specialist support services for pregnant and parenting young women build their capacity to screen for violence and pregnancy coercion among their clients and increase the support they are able to provide for young women around these issues.

PREVALENCE BY RACE AND CULTURE

A number of US studies explore comparative prevalence rates of reproductive coercion amongst non-Caucasian women. Significantly higher prevalence rates of reproductive coercion have been found amongst women of African American descent and others of a non-Caucasian backgrounds across a number of studies. This was the case for study samples across a range of settings including women known to have experienced domestic violence²⁶, those accessing mainstream obstetrics and gynaecology services²⁷, and those attending specialist sexual and reproductive health clinics.²⁸

The Children by Choice data reveals similar trends, with women who identified as Aboriginal and/or Torres Strait Islander experiencing reproductive coercion in approximately 18% of contacts (compared to general rates of 13.5%), and women from culturally and linguistically diverse backgrounds disclosing reproductive coercion in about 22% of contacts.

RECOMMENDATION 12: That any screening or intervention measures in pregnancy care settings are culturally sensitive for women from diverse backgrounds.

RECOMMENDATION 13: future research give priority to further understanding the unique cultural dimensions to reproductive coercion.

ASSOCIATIONS WITH UNINTENDED PREGNANCY

Associations between domestic violence, unplanned pregnancy and abortion are well established in the literature.²⁹ Several US studies identify higher rates of unplanned pregnancy and abortion in reproductively coerced women, in populations of women known to have experienced domestic violence³⁰ as well as other studies involving more diverse populations.³¹

Up until June 2017 the reproductive coercion data collected by Children by Choice did not delineate between coercion towards abortion versus coercion towards pregnancy. Early trends from July 2017 onwards suggest that this ratio is approximately 1:5, which indicates that of the women disclosing reproductive coercion, the vast majority are being coerced towards a *pregnancy* that they did not want rather than an abortion they did not want. This confirms the strong associations between reproductive coercion and unplanned pregnancy and abortion in our Queensland data.

RECOMMENDATION 14: That the reproductive health sector continue to advocate for the decriminalisation of abortion across all Australian jurisdictions, and work to improve equity of access to services.

GESTATION AT TIME OF PRESENTING FOR ABORTION CARE OR ABORTION ACCESS SUPPORT

It is well established in the literature that women experiencing domestic violence present for abortion care at a higher gestation.³² Perhaps because most US research on reproductive coercion is done in settings other than unplanned pregnancy services or abortion provision settings, pregnancy gestation has not been the focus of research questions.

The Children by Choice data does offer some concerning insights into this issue, with women who report experiencing both domestic violence and reproductive coercion being over-represented in those presenting from twelve to twenty weeks gestation. Given that many Australian states still have constraints to abortion access, including gestational limits in law and provision, reproductive justice for Australian women subjected to reproductive coercion is compromised. Selected or targeted screening for reproductive coercion should be informed by this issue, and is of particular significance for abortion providers involved in second trimester provision.

RECOMMENDATION 15: That Medicare funding for termination of pregnancy be increased, particularly in relation to second trimester procedures.

MENTAL HEALTH ISSUES

While the mental health effects of domestic violence are well established in the literature³³, very few studies have explored the impact of reproductive coercion on mental health. One study involving women from Cote d'Ivoire suggests that reproductive coercion may be a significant contributor to adverse mental health.³⁴ Indeed, early data analysis Children by Choice shows a significant over-representation of women disclosing reproductive coercion who also named mental health issues (58%) compared to those who did not report reproductive coercion (25.7%).

RECOMMENDATION 16: That future research more closely analyse/investigate the possible link between reproductive coercion and poor mental health.

RECOMMENDATION 17: That trauma informed principles underpin all pregnancy care provided in health settings, including abortion care provision.

RELATIONSHIP STATUS

Women experiencing domestic violence may be more likely to report their relationship as single or separated at the time of seeking abortion care.³⁵ Relationship status of those experiencing reproductive coercion may also vary from others as found in one study of OBGYN patients, with women experiencing reproductive coercion are two times more likely to report being single or dating, and six times more likely to report being uncertain or ambivalent about their relationship status.³⁶

Children by Choice data also shows differences in the relationship status of women experiencing reproductive coercion, with women:

- experiencing reproductive coercion with no co-occurring domestic or sexual violence being more likely to report being single;
- experiencing co-occurring domestic or sexual violence being much more likely to report being separated; and
- not reporting any kind of violence and control much more likely to report being defacto or married.

This supports the idea of relationship transience as a motivating factor in perpetrators establishing a securer connection to the woman through pregnancy.³⁷ Relationship status may give some understanding about the temporal associations between reproductive coercion and domestic violence (see recommendation 5, page 8).

RECOMMENDATION 18: That further research examines the link between relationship status and the experience of violence and/or coercion.

RECOMMENDATION 19: That where universal screening for reproductive coercion is not possible due to service constraints, that relationship status is used as a potential identifier for targeted or selective screening.

DISCLOSURE AT FIRST CONTACT

The Children by Choice data clearly shows that reproductive coercion is much more likely to be disclosed at a second or subsequent contact (85% of disclosures but only 60% of the contacts) with the service than at the initial contact (15% of disclosures). This has particular relevance to the provision of medical abortion, since women have more than one contact with the abortion provider (surgical abortion largely being provided in a single) and should inform how screening is incorporated into clinical flow in all health care contexts where medical abortion is provided. The American College of Obstetricians and Gynecologists recommends screening for reproductive coercion at periodic intervals ideally done as part of each consultation.³⁸

RECOMMENDATION 20: That repeat reproductive coercion screening is incorporated into clinical flow, in all contexts where medical abortion is provided.

The parallels in the Children by Choice patterns with international research provide solid direction for shaping responses in the Australian context. The prevalence of reproductive coercion with co-occurring domestic violence compels us to actively collaborate with domestic violence sector. Patterns of reproductive coercion provide useful guides for shaping up universal, targeted and selective interventions, and directs us to ensure these are trauma informed.

ADDRESSING GAPS IN RESEARCH

There is a clear need for empirical prevalence data in Australia. One possible step forward would be for the inclusion of research questions about reproductive coercion in population studies regularly carried out in Australia, for example the Australian Bureau of Statistics' Personal Safety Survey and the La Trobe University & the Australian Research Centre for Sex, Health and Society's National Survey of Australian Secondary School Students and Sexual Health.

RECOMMENDATION 21: That existing population studies already examining the prevalence of domestic violence or those with a reproductive health component, incorporate questions specific to reproductive coercion.

As discussed above, the development of a structured reproductive coercion measure applicable to pregnancy care settings including abortion will facilitate quality empirical research in these fields.

The publication of Children by Choice data on reproductive coercion could also provide a foundation for beginning to understand the prevalence and patterns of reproductive coercion in the Australian context, and identify and support priorities for research agendas. Data sets relating to gestation at time of help seeking could be replicated in abortion provision settings.

To further resource a national research agenda, the Australian National Research On Women's Safety could ensure future research grants include those focusing on reproductive coercion, and

encourage reproductive coercion to be considered in the design of other Australian research initiatives especially those within antenatal, reproductive health contexts. and those exploring cross cultural dimensions to gendered violence.

RECOMMENDATION 22: That research grants bodies include and encourage initiatives which could help further illuminate issues of reproductive coercion in an Australian context.

With service development initiatives in other states and contexts, more service level data could become available in the coming years. A nationally coordinated response to reproductive coercion should include a clearinghouse for this service delivery data to be analysed and compared across service delivery settings to contribute to national understandings of patterns and prevalence in Australia.

RECOMMENDATION 23: The establishment of a national clearinghouse for emerging research and service delivery data relating to reproductive coercion.

EXISTING PRACTICES, MODELS AND TOOLS

INTERNATIONAL MODELS

FUTURES WITHOUT VIOLENCE

Futures Without Violence have a strong presence in the United States of America, working towards ending violence against women and children and provide leadership to foster ongoing dialogue about gender-based violence. They stand out as pioneers in work around issues of reproductive coercion. Their website (<https://www.futureswithoutviolence.org>) offers a range of free resources including a comprehensive and practical guide to responding to reproductive coercion in health care settings. This guide includes tips for creating a safe environment for disclosure, best practice around assessment and harm reduction in relation to suitable contraception and STI risks, how to use their tailored resources in this process, trauma informed reporting, documenting and referring. The guide was used to inform some of the initiatives of the Children by Choice screening to safety project.

RECOMMENDATION 24: That any trialled intervention models in Australia be informed by the work of Futures Without Violence.

Literature and research reviews carried out as part of the Children by Choice Screening to Safety Project reveals a small number of documented interventions to address reproductive coercion internationally. Of most significance is the ARCHES (Addressing Reproductive Coercion in Health Settings) intervention due to its peer reviewed evaluation. This intervention was informed by the work of Futures Without Violence.³⁹

The ARCHES intervention is designed to bring universal education and enhanced screening, to contribute to harm reduction, counselling, and supported referral through integrating this with all clinical encounters with female family planning clinic patients. Included in the desired outcomes of this intervention is recognition of reproductive coercion knowledge and use of harm reduction strategies (such as contraception less vulnerable to detection and sabotage) and ultimately the reduction of reproductive coercion. This healthcare practitioner intervention is assisted with the aid of a palm sized leaflet for women to take away. This leaflet was used as the inspiration for the Children by Choice palm sized leaflet entitled “Who controls pregnancy decisions in your relationship?” (see Appendix 1).

Patient and provider evaluations of the intervention show the acceptance of universal education around this issue and the acceptance by patients of the intervention.⁴⁰ An evaluation of the effectiveness the ARCHES intervention to enact harm reduction behaviours was also carried out. It demonstrated a capacity to reduce reproductive coercion of women subjected to multiple forms of this abuse.⁴¹ Findings also show that women who received information about safety issues such as reproductive coercion were more likely to report ending a relationship because they viewed it as unhealthy or they felt unsafe.⁴²

DOMESTIC MODELS: CHILDREN BY CHOICE INITIATIVES

For some years staff at Children by Choice had become aware of emerging themes in the anecdotal evidence offered by Queensland women, alerting us to reproductive coercion. We sought to connect this anecdotal practice knowledge to research and service data.

EARLY LITERATURE REVIEW

In 2014 a group of students from the University of Queensland Pro Bono Centre, TC Berne School of Law provided a comprehensive literature review, confirming those trends and issues that were emerging from anecdote, and establishing a foundation of knowledge for the organisation in further considering its service response to these issues.

DATA COLLECTION AND ANALYSIS

Since January 2015, Children by Choice has been collecting data about reproductive coercion with all contacts with or on behalf of women who seek support around unplanned pregnancy and abortion. Rudimentary analysis of the data has been used to inform our initiatives in this area. Learnings from the data has been discussed in more detail in discussion above (see page 7-12). Children by Choice has entered into partnership with Griffith University and University of Queensland to carry out a thorough analysis of the data we have collected so far with a view to publication.

CHILDREN BY CHOICE SCREENING TO SAFETY PROJECT:

Working with some of Queensland's abortion providers and with sections of the women's sector we have:

Resourced clinics to develop a clinic environment that is supportive of disclosure through practical support (e.g., poster on domestic and sexual violence in waiting areas, signage indicating patients will be seen on their own).

Developed domestic and family violence screening tools for abortion provision settings that incorporate screening questions about coerced pregnancy (see Appendix 2). This is further explored in the section on screening below.

Reviewed intake and admissions processes to offer advice on changes to tools and procedures. The focus of this review looked at the information routinely collected in abortion care settings and how this might inform which women were most likely to be experiencing violence, for example previous termination or miscarriage is an indicator of risk for violence. (See Appendix 3) for a more complete account of these indicators). Whilst these indicators are relevant to domestic violence, not reproductive coercion specifically, they inform selective screening from which issues or reproductive coercion could be explored.

Developed and distributed a tailored resource for guiding health care practitioners and others in their contraceptive counselling of women subjected to reproductive coercion. It is available for download here:

https://www.childrenbychoice.org.au/images/downloads/DVRCcontraceptionchart_final.pdf

Some of the content of this resource has also been added to the Children by Choice website. The project is encouraging other abortion providers and broader sexual and reproductive health services

to consider including information about discrete contraception options (can it be detected, can it be tampered with) alongside mainstream contraceptive information provision.

Provided training to clinic staff on identifying and responding to the needs of women experiencing coerced pregnancy (12 providers) and coerced abortion (6 providers). In some settings this involved nursing staff and some administration staff but not doctors. It was noted that most effective systems changes came about in clinic where doctors were actively involved in the training and discussion.

Worked to develop three short online video training modules. With provision of medical abortion through GP providers, it was important that the project be able to reach these providers through its initiatives. These videos are in the final stages of completion and will shortly be made available to GP providers of medical abortion through MS Health.

Established the Screening to Safety LARC Access Fund, which enables women experiencing violence, including reproductive coercion to access suitable cost-subsidised LARC at time of TOP through our ten partnering private abortion providers. Clinics are reimbursed for associated costs by the Screening to Safety LARC Access Fund, administered by Children by Choice. Since July 2016, this fund has supported 84 women, with about 13 of these women directly supported by the clinic. Some clear trends are already emerging. Women experiencing domestic violence and reproductive coercion take up the option of LARC at time of TOP when financial barriers are removed. Partnering abortion providers that ask their patients routinely and directly about experiences of violence and pregnancy coercion are much more likely to be providing LARC through this fund than providers who do not. The early success of this fund warrants replication in other abortion provision setting. The fund will cease when all monies are spent. It is recommended that Children by Choice seek additional funds and further review this initiative at the expenditure of all current monies.

Collaborated with the domestic violence sector: Limited consultations and training to workers in the domestic violence and broader women's sector have also been carried out. Issues papers and posters have been presented at four domestic violence conferences. As a result of these combined initiatives, some specialist domestic violence services have now incorporated reproductive coercion screening and safety planning into their safety and risk tools, and have indicated that they will include unplanned pregnancy risk assessment and pregnancy testing as part of domestic violence refuge intake and admissions processes. There is still a need for further sector wide capacity building around this issue. Collaboration with peak organisations involved in issues of gendered violence in the development of the MSA White paper will be an important step.

OTHER DOMESTIC MODELS AND REFERRAL PATHWAYS

TRUE Relationships and Reproductive Health (formally known as Family Planning Queensland) have recently developed, and are now trialling, a full day training package for health care practitioners which includes a focus on reproductive coercion.⁴³ This has been done in partnership with Children by Choice.

We are also aware of, and commend, the work of the Pregnancy Advisory Centre in Adelaide, and the Penrith Women's Centre, in incorporating reproductive coercion in their service settings. An account of these initiatives is contained within the National Alliance of Abortion and Pregnancy Options Counsellors (NAAPOC) submission to the development of this White Paper.

The development of local referral pathways has been incorporated into the Screening to Safety project to a limited extent. It was hoped that local domestic violence and sexual assault services could be more actively involved in training with clinics. However, sector workload pressures limited the extent to which this was possible. As a baseline abortion providers were given information about DV crisis lines and local domestic violence services and their referrals pathways along with service brochures and business cards.

RECOMMENDATION 25: Any initiative aimed at capacity building around reproductive coercion with the DV sector will need to take workload pressures into consideration in resourcing and designing the process.

As part of the Screening to Safety project, clinical flow was observed in several participating abortion clinics to inform how planned project initiatives could better take account of clinic context. Particular attention was paid to the intake and admissions process. From these observations two issues emerged: that healthcare providers need adequate time to build rapport, assess for reproductive autonomy and coercion, and explore contraception options; and that clinical time and space is required for specialist DV referrals. Often the physical space in clinics, combined with patient flow do not afford the time to make telephone referrals, especially to services with high demand where call wait times may be lengthy. Some change will be necessary to facilitate the important role that health care providers can play across a range of pregnancy care and general health settings.

RECOMMENDATION 26: That a Medicare item number for domestic violence screening be introduced.

RECOMMENDATION 27: that specialist domestic violence services evaluate their referral protocols to ensure that they are accessible to referrals from within a health care setting, such as emailed or faxed referrals.

ADDRESSING GAPS IN SERVICE PROVISION: LEARNINGS FROM DOMESTIC INITIATIVES

RECOMMENDATION 28: Information on discrete contraception be included in contraceptive information and education provided in all settings.

RECOMMENDATION 29: MSHealth as the licensed distributor of the MS2Step continue to integrate training and resources relevant to the area reproductive coercion to health care practitioners licenced to provide medical abortion

RECOMMENDATION 30: Abortion care settings in Australia universally screen for reproductive coercion.

RECOMMENDATION 31: Contraceptive counselling in the context of violence, control and reproductive coercion be a core competency for health care providers in all sexual and reproductive health care settings, settings including abortion care settings.

RECOMMENDATION 32: Abortion providers, especially public and not-for-profits, facilitate access to LARC at time of abortion for women experiencing reproductive coercion. Partnership's with not-for-profits such as the Screening to Safety LARC funded be established in other states and territories to support LARC access at time of TOP for women reliant on private abortion clinics.

RECOMMENDATION 33: The Medicare Benefits Schedule Review include research and understandings of reproductive coercion as relevant contemporary clinical evidence to all Medicare items related to abortion and contraception.

RECOMMENDATION 34: Access to TOP and LARC be viewed as a domestic violence safety strategy for women subjected to reproductive coercion.

RECOMMENDATION 35: That the Royal College of Australian General Practitioners clinical guideline on abuse and violence be updated to include a section on reproductive coercion and contraceptive counselling in the context of violence and control, to ensure that this information is readily available to health care practitioners in a wide range of settings.⁴⁴

SCREENING TOOLS

Literature and research reviews conducted by Children by Choice reveal no stand-alone *formal* screening tools for reproductive coercion, and none of the existing evaluated domestic violence screening instruments reviewed contained a discrete question on reproductive coercion. The research literature does, however, contain a number of reproductive coercion measures which are discussed in greater detail in the in the research section of this submission.

There are several resources that offer suggested scripts or prompts to support sensitive enquiry around reproductive coercion. The ideas offered in these resources show significant similarity and have been trialled in the interventions discussed above. Together they provide a consistent set of

ideas for moving forward. The American College of Obstetricians and Gynecologists of the following questions for reproductive coercion screening:

- Has your partner ever forced you to do something sexually that you did not want to do or refused your request to use condoms?
- Has your partner ever tried to get you pregnant when you did not want to be pregnant?
- Are you worried your partner will hurt you if you do not do what he wants with the pregnancy?
- Does your partner support your decision about when or if you want to become pregnant?⁴⁵

A structured guide to screening for reproductive coercion is well documented in the Futures Without Violence resources⁴⁶. These offer scripts and prompts for screening for reproductive coercion using a safety card with questions such as:

- Has my partner ever tried to pressure or make me get pregnant?
- Has my partner ever hurt or threatened to hurt me because I didn't agree to get pregnant?
- Has my partner told me he would hurt me if I didn't do what he wanted with the pregnancy?
- Does my partner support my using birth control?
- Does my partner make me have sex when I don't want to?
- Does my partner mess with my birth control or try to get me pregnant when I don't want to be?
- Am I afraid to ask my partner to use condoms?
- Am I afraid my partner would hurt me if I told him I had an STD and needed to be treated?
- Have I ever hidden birth control from my partner so he wouldn't get me pregnant?

Early consultations carried out as part of the Screening to Safety Project revealed that some services use a generic domestic violence screening tool, and follow up further sensitive enquiry about reproductive coercion where violence and control is disclosed. However, sole reliance on this approach is problematic given merging understandings about the patterns of reproductive coercion, specifically that a significant proportion of women who disclose experiencing some form of reproductive coercion in the absence of any other form of violence and control. As such direct questioning is warranted. The questions in the screening tools developed for abortion providers by the Children by Choice Screening to Safety project (see Appendix 2) include the following two questions:

- Is anyone forcing you to have an abortion when you do not want to?
- Has anyone forced you to become pregnant when you did not want to be?

These questions recognise that reproductive coercion can present as both coerced abortion and coercion in the direction of pregnancy and motherhood. Including both questions also recognises that a woman can experience coercion in both directions within the same pregnancy. However, it does not offer detailed questions to unpack the experience. Supplementary questions framed around the three temporal dimensions of reproductive coercion; pregnancy pressure, contraceptive sabotage and pregnancy outcome control, are explored in implementation training and contained in the previously mentioned tailored reproductive coercion resources as follows:

- Do you feel confident talking to your partner/sexual partners about using contraception like condoms or the pill?

- Has anyone ever messed or tampered with your contraception to try to make you become pregnant?
- Do condoms seem to break often or your pills go missing?

Does your partner respect your decision if you do not want to have sex?

- Have you ever been forced to have sex when you did not want to?
- Do you feel okay about talking to your partner about if or when you might want to get pregnant? Would he always respect your wishes about this?
- Has anyone ever made you feel afraid if you didn't do what they wanted you to do with a pregnancy – whether forcing you to continue OR end your pregnancy?

These resources provide a solid foundation for implementing sensitive enquiry around experiences of reproductive coercion across a range of clinical settings. An example of a compilation of these is offered at Appendix 4. The focus moving forward needs to be on the systematic implementation of screening and responding to issues of reproductive coercion into clinical flow across provider settings, and the maintenance of workforce knowledge and skill in this area. As a national abortion provider Marie Stopes Australia may consider adopting implementation of this as a key focus for their contribution to this issue, building on the work already started by the Screening to safety project. The Children by Choice Screening to Safety project hopes to include some specific resources or ideas about maintenance of workforce knowledge and skill in its final phase.

CONCLUSION

We are hopeful that the MSA White Paper will facilitate the adoption of a shared definition of reproductive coercion to support the continued development of national understandings and responses. There are opportunities to build on the emerging prevalence and patterns data and to guide a national research agenda. Continued progress towards universal screening for and responding to reproductive coercion is essential. A national approach and collaboration across sectors is much needed to foster these opportunities.

“If you care about Intimate Partner Violence, you should care about Reproductive Justice because a woman’s reproductive capacity can be used by her abuser to assert further control as a component of all possible forms of abuse—sexual, physical, emotional and economic.”

- Jill C. Morrison, National Women’s Law Center, USA. [2009].

APPENDIXES

APPENDIX 1: PALM SIZED LEAFLET FOR WOMEN

Relationship violence can come in many forms, and one of the things it affects could be your sexual and reproductive health.

Every woman should have the right to choose if and when she gets pregnant.

For information and support on all your pregnancy options - abortion, adoption and parenting - or about contraceptive methods which might give you more control, visit us online at childrenbychoice.org.au or free call 1800 177 725 Queensland-wide.

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who controls pregnancy decisions in your relationship?

Do you feel confident talking to your partner about using contraception, like the pill?

Does he respect your decision if you don't wish to have sex?

Do you feel okay about talking to your partner about if or when you might want to get pregnant? Would he always respect your wishes about this?

If you answered yes to these questions it sounds like you might be in a healthy relationship right now. You can help others by giving this card to someone you might be worried about.

Are you worried or afraid to talk with your sexual partner about using contraception?

Has anyone ever messed or tampered with your contraception to try to make you become pregnant? Do condoms seem to break often, or pills get thrown away?

Have you been forced to have sex when you did not want to?

Has anyone threatened you or made you feel afraid if you didn't do what they wanted you to with a pregnancy - whether forcing you to continue OR to end your pregnancy?

Has your partner (or others) ever put pressure on you to get pregnant when you did not feel ready or right about it?

If you answered yes to any of these questions you may not be in control of pregnancy decisions in your relationship.

Talk to your doctor or antenatal care professional about your concerns (maybe even take this brochure with you), or find your local support service at 1800respect.org.au.

APPENDIX 2: SCREENING TOOLS FOR ABORTION PROVIDERS

A: FULL VIOLENCE SCREENING TOOL

Domestic and Sexual Violence Screening Tool: Queensland Abortion Providers

Patient details or label here:

First Name:

Last Name:

DOB:

Establishing the context:

Ensure: the woman is **alone** and in a confidential space before introducing the screening tool. Use a professional interpreter if required.

Introduce the tool: explain to the woman that we ask all women who visit the clinic/medical practice for abortion care about domestic and family violence and their safety and well-being because we know violence and abuse can start or get worse during pregnancy.

Explain confidentiality: Explain to the woman that everything she may share with you where possible can remain confidential unless she or someone else is at serious risk of harm, or she discloses something you are obligated to share by law.

Due to cultural or disability issues, some women may struggle with understanding. It may be useful to ask the woman if she identifies as having a disability or what helps her to understand information. Check for understanding by asking "Can you tell me in your own words what we just talked about?" If she is struggling to understand you may need to modify the wording of some questions.

TIPS: *Significant other* may need to be substituted for concrete examples like *family, friend, support worker, or carer. Humiliated* could be substituted for *made to feel bad*. Concrete examples can also help, for example *sexual activities* could be explained as things like *touched your breasts or between your legs, made you rub their penis*.

In exceptional circumstances consider asking the woman if they would like someone with them to help them understand the questions. Be mindful that anyone who has attended the clinic with her on the day may be a perpetrator of violence and control.

Following pre-amble

1. Ask: Would it be okay if I ask you some questions about your experience now? Yes/No

If the woman declines to respond to your questions please let her know that she has the option to discuss these matters with you later if she wants to. Offer her safety resources such as pamphlets that she could give to a friend or family member whose safety she may be worried about.

Ask the woman about her experience:

2. (So that we can give you sensitive care while you are here today can I ask) Did you agree to have/consent to the sex involved in this pregnancy? Yes/No

(If the woman discloses that the pregnancy is as a result of rape proceed to validation and action, and return to other screening questions if and when appropriate)

3. Has the man involved in your pregnancy (a past partner or a significant other):

- | | |
|--|--------|
| (a) Made you feel afraid? | Yes/No |
| (b) Physically hurt or threatened you? | Yes/No |
| (c) Repeatedly humiliated you or put you down? | Yes/No |

APPENDIX 2: SCREENING TOOLS FOR ABORTION PROVIDERS

B: ABRIDGED VIOLENCE SCREENING TOOL

Domestic and Sexual Violence Screening Tool: Queensland Abortion Providers

<i>Patient details or label here:</i>
First Name:
Last Name:
DOB:

Ensure: the woman is **alone** and in a confidential space before. Use a professional interpreter if required. Assess capacity for understanding where cultural or disability issues as present.

Introduce the tool and confidentiality: “We ask all women who visit the clinic for abortion care about some aspects of domestic and family violence and their safety and well-being because we know violence and abuse can start or get worse during pregnancy. Everything you share can remain confidential today unless you or someone else is at serious risk of harm”.

1. Ask: Would it be okay if I ask you some questions about your experience now? Yes/No

If the woman declines to respond to your questions let her know she can discuss these matters with you later if she wants to. Offer her safety resources such as pamphlets that she could give to a friend or family member whose safety she may be worried about.

Ask the woman about her experience:

2. So that we can give you sensitive care while you are here today can I ask, did you agree to have/consent to the sex involved in this pregnancy? Yes/No

3. Is anyone forcing you to have an abortion when you do not want to? Yes/No

If yes, check if she is still wanting to have the termination done today or not?

4. Has anyone forced you to become pregnant when you did not want to be? Yes/No

If yes, offer information about contraception options that would make it harder for him to do this in future. Consider offering funding for LARC at time of TOP from the CbyC fund.

Action on disclosure (tick):

- | | |
|---|---|
| <input type="checkbox"/> Assistance offered but declined | <input type="checkbox"/> Woman’s safety plans discussed |
| <input type="checkbox"/> Victim Assist information given | <input type="checkbox"/> Information/referral to DV/SA services |
| <input type="checkbox"/> Victim Assist Medical Certificate completed | <input type="checkbox"/> Contraception/advice given |
| <input type="checkbox"/> Evidence of current physical injuries and other disclosures recorded on file | <input type="checkbox"/> Pregnancy support options discussed |
| | <input type="checkbox"/> Other (specify) |
-

Documenting: if a disclosure has been made explain to the woman:

- What information will be kept as part of her confidential medical file
- A record will remain on her file should she need to access it the future.
- Other people need her written permission to access the information.

Name of worker:

Signature:

Date:

APPENDIX 2: SCREENING TOOLS FOR ABORTION PROVIDERS

C: ABRIDGED VIOLENCE SCREENING TOOL WITH INTAKE REVIEW

Domestic and Sexual Violence

Screening Tool:

Queensland Abortion Providers

Review: prior to commencing screening review information gathered so far to identify flags for violence, specifically:

- Pre-admission form questions: previous termination and/or miscarriage, and reports not being in a relationship at the time of the termination of pregnancy?
- Gestational information: is pregnancy advanced and has this been recalculated today?
- Pre-operative counselling discussions: does the man involved in the pregnancy know about the termination of pregnancy and is he providing financial support to end the pregnancy? Did the woman report the pregnancy to have been planned?

Ensure: the woman is **alone** and in a confidential space before. Use a professional interpreter if required. Assess capacity for understanding where cultural or disability issues as present.

Introduce the tool and confidentiality: We ask all women who visit the clinic for abortion care about some aspects of domestic and family violence and their safety and well-being because we know violence and abuse starts or get worse during pregnancy. Everything you share can confidential unless you or someone else is at serious risk of harm.

1. Ask: Would it be okay if I ask you some questions about your experience now? Yes/No

If the woman declines let her know she can discuss these matters with you later if she wants to. Offer safety resources (eg pamphlets) that she could give to a friend or family member whose safety she may be worried about.

Ask the woman about her experience:

2. So that we can give you sensitive care while you are here today can I ask, did you agree to have/consent to the sex involved in this pregnancy? Yes/No

3. Is anyone forcing you to have an abortion when you do not want to? Yes/No

If yes, check if she is still wanting to have the termination done today or not?

4. Has anyone forced you to become pregnant when you did not want to be? Yes/No

If yes, offer information about contraception options that would make it harder for him to do this in future.

Consider offering funding for LARC at time of TOP from the CbyC fund.

Action on disclosure (tick):

- | | |
|---|---|
| <input type="checkbox"/> Assistance offered but declined | <input type="checkbox"/> Woman's safety plans discussed |
| <input type="checkbox"/> Victim Assist information given | <input type="checkbox"/> Information/referral to DV/SA services |
| <input type="checkbox"/> Victim Assist Medical Certificate completed | <input type="checkbox"/> Contraception/advice given |
| <input type="checkbox"/> Evidence of current physical injuries and other disclosures recorded on file | <input type="checkbox"/> Pregnancy support options discussed |
| | <input type="checkbox"/> Other (specify) _____ |

Documenting: if a disclosure has been made explain to the woman:

- What information will be kept as part of her confidential medical file
- A record will remain on her file should she need to access it the future.
- Other people need her written permission to access the information.

Name of worker:

Signature:

Date:

Patient details or label here:

First Name:

Last Name:

DOB:

APPENDIX 3: INDICATORS OF VIOLENCE IN WOMEN ATTENDING FOR ABORTION CARE



Indicators of domestic violence in women presenting for termination of pregnancy

Unintended pregnancy and abortion are two to three time more common in women who have experienced intimate partner violence than those that have not.¹ Understanding the characteristics of this subset of women presenting for termination of pregnancy can assist health care professionals in identifying them and responding to their specific needs. The following check-list is intended as a supplement to other indicators of domestic and intimate partner violence, not as a finite list. It specifically relates to woman presenting for termination of pregnancy and is drawn from current research findings. Women who are currently or have experienced IPV presenting for termination of pregnancy are more likely to:

1. Have had a previous termination of pregnancy and/or a previous miscarriage²
2. Present with a more advanced pregnancy than those that are not exposed to violence.³
3. Under-estimate the gestation of their pregnancy and have it recalculated at the time of their appointment⁴
4. Report non-use or intermittent use of contraception⁵
5. Report not being in a relationship at the time of the termination of pregnancy⁶
6. State that the man involved in the pregnancy does not know about the termination of pregnancy⁷
7. Indicate that she has no financial support to end the pregnancy from the man involved⁸
8. Report the pregnancy to have been planned⁹

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⁷Hall et al (2014) op cit.; Jones, R. K., Moore, A. M., & Frohwirth, L. F. (2011). Perceptions of male knowledge and support among U.S. women obtaining abortions. *Women's Health Issues*, 117-23.

⁸Hall et al (2014) op cit.

⁹Bourassa, D., & Bérubé, J. (2007) op cit.

APPENDIX 4: A COMPILATION OF PROMPT QUESTIONS FOR EXPLORING WOMEN'S EXPERIENCES OF REPRODUCTIVE COERCION

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Prompt questions for exploring women's experiences of reproductive coercion

Pregnancy pressure

- Do you feel okay talking to your partner about if or when you might want to get pregnant? Would he always respect your wishes about this?
- Does he support your decision about when or if you want to become pregnant?
- Has he/anyone forced you to become pregnant when you did not want to be or did not feel right about it?
- Has he/anyone ever hurt you, or threatened you because you didn't agree to get pregnant?
- Are you afraid to talk to your sexual partner about contraception?

Contraceptive sabotage

- Does he/your sexual partner support you using birth control?
- Has he/anyone ever messed or tampered with your contraception to try to make you become pregnant?
- Has he/your sexual partner ever refused your request to use condoms?
- Do condoms seem to break often?
- Has he/your sexual partner ever taken off a condom during sex without your knowledge or consent?
- Has he/your sexual partner ever promised to withdraw but failed to do?
- Has he/your sexual partner tried to mess with your birth control, for example has he thrown away or hidden your contraceptive pills or thrown away or damaged a contraceptive device, such as condoms or your diaphragm?
- Have you ever felt you needed to hide contraception from your sexual partner so he wouldn't get you pregnant?
- Has he/others prevented you from accessing emergency contraception?
- Has he ever threatened or tried to forcibly remove your Implanon rod/IUD?
- Does he/your sexual partner make you have sex when you don't want to?

Pregnancy outcome control

- Are you worried your partner will hurt you if you do not do what he wants with a/ the pregnancy?
- Has anyone ever made you feel afraid or threatened consequences if you didn't continue your pregnancy?
- Has anyone ever made you feel afraid or threatened consequences if you didn't end your pregnancy?
- Is anyone/has anyone forced you to have an abortion when you do not want to?

Screening to Safety Project

Prepared for DVConnect

February, 2018

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