Submission No 87

COERCIVE CONTROL IN DOMESTIC RELATIONSHIPS

Organisation: Marie Stopes Australia

Date Received: 29 January 2021

MARIE STOPES AUSTRALIA

29 January 2021

The Joint Select Committee on Coercive Control
Parliament of New South Wales
Submitted online via coercivecontrol@parliament.nsw.gov.au

To Whom It May Concern,

RE: Submission to the Joint Select Committee on Coercive Control in New South Wales

The Joint Select Committee on Coercive Control in domestic relationships is currently considering the NSW Government discussion paper on coercive control. Marie Stopes Australia appreciates the opportunity to contribute to discussions regarding the criminalisation of coercive control in New South Wales (NSW).

Background

Marie Stopes Australia is an independent, non-profit organisation dedicated to ensuring sexual and reproductive health services are equally accessible to all people living in Australia. Marie Stopes Australia is the only national accredited provider of abortion, contraception and vasectomy services, and the country's longest running provider of teleabortion. Our holistic, client-centred approach empowers individuals to control their reproductive health safely, and with dignity, regardless of their circumstances. Through active partnerships with healthcare providers, researchers and communities, our models of care ensure the total wellbeing of our clients is supported at every stage. We have three clinics in metropolitan NSW and a state wide teleabortion service. We work collaboratively with the NSW Government to support sexual and reproductive health access for all.

Response to discussion paper

Coercive control is a form of gender-based violence that requires strategic prevention and response mechanisms across jurisdictions in Australia. This submission is structured to address selected questions in the discussion paper. Regarding the broader questions, Marie Stopes Australia supports any submissions and the position paper on Coercive Control by the Australian Women Against Violence Alliance.[1]

Marie Stopes Australia
GPO Box 1635
Melbourne
Victoria 3001
Australia

Donations 1300 478 486
Enquiries 1300 003 707
Fax +61 (03) 9658 7579
info@mariestopes.org.au
www.mariestopes.org.au

Registered Charity Name
Marie Stopes Australia

Australian Business Number
63 093 595 192

1. What would be an appropriate definition of coercive control?

Definitions of coercive control should incorporate the concept of reproductive coercion. Pregnancy can be the direct result of coercion, and can tie the woman to an abusive partner for her lifetime. It is critical that reproductive coercion be named to, at the very least, acknowledge these victim-survivor experiences.

Reproductive coercion is defined as any behaviour that has the intention of controlling or constraining another person's reproductive health decision-making.[2] It can include:

- sabotage of another person's contraception
- pressuring another person into pregnancy
- controlling the outcome of another person's pregnancy
- forcing or coercing another person into sterilisation
- any other behaviour that interferes with the autonomy of a person to make decisions about their reproductive health.

Reproductive coercion can be interpersonal and structural. Interpersonal reproductive coercion is more likely to occur within contexts of structural coercion. [3] Reproductive coercion is a form of violence with an extensive resource base of evidence. [4]

People present at Marie Stopes Australia clinics with experiences of sexual and reproductive coercion.[5] Women and pregnant people are currently experiencing coercion linked to poverty and financial hardship, which is linked to unemployment and economic insecurity due to the pandemic.[6] People who already have restricted bodily autonomy are facing uniquely coercive contexts, for example people with disability, people on temporary visas, people who are incarcerated and people in state care. People accessing abortion care may also be at higher risk of intimate partner violence than the general population.[7]

7. What are the advantages and/or disadvantages of creating an offence of coercive control?

Coercive control should never be condoned. This is not to say that criminalisation is the answer. In order to conduct client centred and informed decision making processes, our staff need to sensitively enquire about risk of harm to self and risk of harm to others.[8] This sensitive inquiry process is critical to assess risk, enable space for disclosure and to determine if informed consent can be granted. In addition to this, it enables us to consider and support clients in accessing relevant referral pathways for ongoing care. Any moves to criminalise coercion should be mindful of the risk of creating additional barriers for disclosure between a client and their healthcare professional.

Criminalisation of coercive control also risks reducing agency for people with disability and other intersections of oppression. It is critical that legislative reforms on coercive control do not risk increasing systemic discrimination or inequity.[9]

15. What non-legislative activities are needed to improve the identification of and response to coercive and controlling behaviours both within the criminal justice system and more broadly?

The health system has key responsibilities for the prevention of and response to coercive control, yet lacks strategy, investment and resourcing. Australia does have two national gendered health strategies, the *National Women's Health Strategy (2020-2030) and a National Men's Health Strategy (2020-2030)*. Both include measures that prevent and respond to violence, yet neither strategy is adequately resourced. Since they were published, the pandemic has influenced regression rather than progression in healthcare access and equity.[10] In addition to health policy, is critical that a *National Plan to Reduce Violence Against Women and Their Children* beyond 2022 be strategised, resourced and implemented to enable long term prevention, support and recovery.

Aboriginal and Torres Strait Islander populations need community-led, researched and funded initiatives. [11] Aboriginal and Torres Strait Islander women are at higher risk of reproductive coercion than non-Indigenous women, and are more likely to experience barriers of access and equity when seeking sexual and reproductive health care. [12] We support any submissions by the National Aboriginal Community Controlled Health Organisation as a community led voice in Aboriginal and Torres Strait Islander health care. [13]

Respectful relationships education in schools should be expanded or re-aligned to include comprehensive relationships and sexuality education, which encompasses protective behaviours, bodily autonomy, enthusiastic consent, pride in identity and culture and community responsive health care. [14] This would better provide protective measures for children and young people to make informed decision-making and access networks of support, particularly if they or a peer were living in contexts of coercive control. [15]

If you wish to discuss the details of this submission further, please contact Bonney Corbin, Head of Policy at [redacted]

Sincerely,

[redacted]

Jamal Hakim

Managing Director – Marie Stopes Australia

Attachments

Marie Stopes Australia, 2020, Hidden Forces 2nd Edition: A white paper on reproductive coercion in contexts of family and domestic violence.

Marie Stopes Australia, 2021, Situational Report on sexual and reproductive health rights in Australia.

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[5] Marie Stopes Australia (2020), Hidden forces: a white paper on reproductive coercion in contexts of family and domestic violence, second edition, at https://www.mariestopes.org.au/advocacy-policy/reproductive-coercion/.

[6] Marie Stopes Australia (2021), Situational Report: sexual and reproductive health rights in Australia, viewed 22 January 2021 at https://resources.mariestopes.org.au/SRHRinAustralia.pdf.

[7] Hall, M., Chappell, L.C., Parnell, B.L., Seed, P.T., & Bewley, S. (2014). Associations between Intimate Partner Violence and Termination of Pregnancy: A Systematic Review and Meta-Analysis. PLoS Medicine, 11 (1), e1001581.

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[10] Marie Stopes Australia (2021), Situational Report: sexual and reproductive health rights in Australia, viewed 22 January 2021 at https://resources.mariestopes.org.au/SRHRinAustralia.pdf.

[11] Close the Gap Steering Committee (2019), Our Choices, Our Voices, accessed via <https://www.humanrights.gov.au/our-work/aboriginal-and-torres-strait-islander-social-justice/publications/close-gap-report-our>

[12] Marie Stopes Australia (2020), Hidden forces: a white paper on reproductive coercion in contexts of family and domestic violence, second edition, at https://www.mariestopes.org.au/advocacy-policy/reproductive-coercion/.

[13] The National Aboriginal Community Controlled Health Organisations (2019), NACCHO, accessed via < https://www.naccho.org.au/>

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Situational Report:

Sexual and Reproductive Health Rights in Australia

A request for collaboration and action to maintain contraception and abortion care throughout the SARS-COV-2 / COVID-19 pandemic

Updated 22 January 2021

Acknowledgement

We acknowledge the Traditional Owners and Custodians of the land on which we live and work. We pay our respects to Aboriginal and Torres Strait Islander Elders past, present and emerging. We also acknowledge the enduring connection to their Traditional estates across Australia and to the ongoing passion, responsibility and commitment for their lands, waters, seas, flora and fauna as Traditional Owners and Custodians.

Publication details

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GPO Box 1635, Melbourne VIC, 3001

Marie Stopes Australia is a national, accredited not-for-profit sexual and reproductive health organisation. The aim of this document is to update key stakeholders about the current issues we are witnessing in contraception and abortion access in Australia.

Given the constantly evolving public health context, this content is most relevant at the date of publication. Throughout the pandemic, the most recent version will be online at this same link: https://resources.mariestopes.org.au/SRHRinAustralia.pdf.

Contents

Executive Summary

Access to contraception and abortion now will mitigate broader public health risks for years to come.[1] At Marie Stopes Australia, since March 2020 we have had to:

- Evolve models of care in an effort to maintain access to care amidst continually changing localised movement restrictions and physical distancing requirements
- Respond to medication shortages for medical abortion alongside increased demand for medical abortion via telehealth
- Respond to situations of delayed presentation and associated complexities
- Reduce in-clinic list capacity and cancel surgical abortion care lists
- Reduce financial support for clients experiencing financial hardship
- Reduce our national gestational limit for surgical abortion to 22 weeks
- Charter private flights for clinical staff in order to keep regional clinics open
- Navigate reduced availability and fluctuating costs of PPE
- Respond to patients experiencing sexual and reproductive coercion

Key recommendations at this point in the pandemic include:

- Ensure all governments and health and hospital services continue to maintain abortion as an essential service with Category 1 classification
- Decriminalise abortion in South Australia and enable access to medical abortion via telehealth for all people in South Australia
- Reinstate Medical Benefits Scheme (MBS) support for all providers of medical abortion, contraception, Sexually Transmitted Infections (STI) and Blood Borne Viruses (BBV) telehealth consultations
- Increase medical abortion provision to 70 days/10 weeks gestation, supported by the Pharmaceutical Benefits Scheme (PBS)
- Provide financial support for women and pregnant people who want contraception or abortion but cannot afford the cost of healthcare
- Embed sexual and reproductive coercion prevention and response mechanisms across sectors
- Do not criminalise women and pregnant people who attempt unsafe abortion
- Undertake collaborative research to measure the impact of delayed access to healthcare and evolving models of care

This document provides further detail on these points and a longer list of recommendations that Australia will need to consider in order to maintain sexual and reproductive health rights.

The Situation

Abortion is time-critical and essential

Abortion is a procedure that has strict time constraints, increasing in complexity and risk with gestation. Both the World Health Organisation (WHO) and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) urge that reproductive healthcare, including abortion, be considered an essential service.[2] In Australia, abortion can be classified as an elective, semi-elective or essential procedure. Classification varies by state/territory government, health and hospital system, and at the individual clinic level.

While international and national health associations have spoken up and clarified that abortion should be considered essential during the pandemic, those organisations do not have the power to determine how this is applied in clinical settings. In practice both contraceptive and abortion care provision is largely up to the individual health or hospital service, and the treating doctor, to determine one of three outcomes: 1) healthcare is provided; 2) the patient is referred elsewhere, or 3) the patient is turned away without a referral.

Telehealth has enabled ongoing access to medical abortion. From April to September 2020, national uptake for medical abortion via telehealth at Marie Stopes Australia increased by 69%, when compared to the same time in 2019. In Victoria, the jurisdiction with the longest temporary movement restrictions, medical abortion via telehealth uptake increased by 126%. Medical abortion via telehealth uptake increased in all states and territories, apart from Tasmania where rates remained unchanged. This increase did not necessarily demonstrate an increase in the number of abortions; rather it indicated a change in how and where people are choosing to access abortion care.

Access to contraception and surgical abortion has decreased

During the pandemic, there has been reduced access to contraception and emergency contraception,[3] condoms, gloves and dental dams,[4] and pregnancy and sexually transmitted infection testing. Public health providers continue to refer to private health providers for contraceptive and abortion care.

Currently medical abortion can only be provided up to 63 days/9 weeks gestation, after which surgical abortion is the primary option. Surgical abortion remains largely inaccessible in many regional, rural and remote areas of Australia, and during the course of the pandemic, surgical abortion access has been further reduced.

Clinics are experiencing staffing shortages due to ongoing movement uncertainty, decreased flight availability, additional unpaid caregiving roles, or precautionary self-

isolation. Clinical capacity and viability are also affected by reduced patient volume due to physical distancing measures, so even as movement restrictions fluctuate and clinics may become physically easier to access, physical distancing is required and therefore clinical volume remains lower than pre-pandemic.

There is an Australian shortage of medication for medical abortion

There is currently a stock shortage of medication for medical abortion in Australia.[5] The not-for-profit pharmaceutical distributor of abortion medication in Australia, MS Health has alerted the Therapeutic Goods Administration (TGA) of a stock shortage of medical abortion medication during late January 2021.

COVID-19 workforce restrictions in Spain prevented a shipment for several weeks with a further delay by a severe snow-storm which closed the airport for three days and created a significant airfreight backlog. MS Health is working with its wholesalers, dispensers and prescribers to make sure that remaining stock is distributed to the areas and to the people most in need. They are organising priority checks and release on medication arrival in Australia and will ensure it is distributed across the supply network as soon as possible.

Telehealth resourcing has been intermittent and lacks clarity

Delivery of medical abortion via telehealth is a safe, acceptable and effective method of abortion access in Australia.[6] Nurses and doctors provide clinical care, medication is delivered via courier, and patients have 24-7 access to after care. In terms of patient privacy, telehealth can provide similar or superior levels of discretion in healthcare provision.[7] Medicare Benefits Scheme (MBS) item numbers for telehealth provide subsidies and reduce cost to consumers.

Until 20 July 2020, medical abortion access had been supported by telehealth reforms that provided temporary MBS item numbers, enabling patients with Medicare Cards to access bulk-billed doctor consultations via telehealth. From March until July 2020, these reforms had enabled timely and more affordable sexual and reproductive health services, including medical abortion.

These MBS item numbers have now been made permanent, however, access has been restricted. The MBS item numbers can at this stage only be accessed via GPs or GP practices that have provided at least one face-to-face consult with the patient over the preceding twelve months.[8] However even if someone has regular access to a GP, less than 2,500 of Australia's 37,000 GP's are authorised prescribers of medical abortion. Subsequently, patients seeking abortion care often need to source alternative health providers in which case they cannot access the MBS subsidy.

The Department of Health is considering exceptions to MBS item numbers for telehealth appointments, which could reinstate increased access to sexual and

reproductive healthcare. These considerations are part of an MBS item number review which is expected to be finalised in early 2021.

Medical abortion via telehealth is not just a temporary model of care during the pandemic, it is a long term and trusted healthcare method.[9] Medical abortion via telehealth provided by sexual and reproductive health providers has become an important mechanism for early gestation abortion access.[10] Further clarity is required to understand if or how specialist health practitioners can access MBS item numbers via telehealth.

South Australia experiences inequity without medical abortion via telehealth

For patients in South Australia, medical abortion is not yet available via telehealth.[11] This means that in South Australia, patients can only access abortion care if they leave their house. Some need to travel long distances with overnight stays in order to access a clinical setting, which is difficult in a pandemic context.

South Australian legislation and policy requires the first dose of medication for medical abortion to be taken in clinic. Effectively, people in South Australia are not trusted to administer their own medication. When it is legal, safe and supported in every other state and territory, it becomes questionable as to why South Australia discriminates against patient autonomy.

The *Termination of Pregnancy Bill 2020* passed the Legislative Council with amendments on 3 December 2020. The Bill now needs to return to the Legislative Assembly in early 2021. It is critical that this legislation can enable medical abortion via telehealth, without introducing any unnecessary provisions that could risk further strain on our health systems.

Western Australia does not have safe access to abortion care

Anti-choice people have resumed picketing in Western Australia (WA). The ongoing presence of anti-choice picketers outside health services is intimidating and stressful for patients, their support people and health workers.[12]

Each year picketers spend approximately 2,295 hours outside the Marie Stopes Australia Midland Clinic. In 2018, Marie Stopes Australia spent more than $6,000 upgrading security cameras and protective measures for staff and clients. Picketers outside abortion care facilities can erode community trust and feelings of safety for staff working at these facilities and patients accessing services. In the pandemic context, the harm caused by their behaviour has been magnified.

The WA *Public Health Amendment Bill 2020* proposed measures that would enable safe access zones for people in WA. The Bill passed the Legislative Assembly and is

yet to pass the Legislative Council. Given the pending state election, it will not be tabled again until mid to late 2021. This means that clients and staff of sexual and reproductive health clinics in WA face another year of escalating picketing, especially throughout the Lent period. Considerations for legislative reform have been summarised in a paper by the University of Queensland and the Australian Women Against Violence Alliance.[13]

The rates of delayed presentations and complex cases have increased

Patients seeking abortion are presenting with complex cases and potential trauma linked to the pregnancy.[14] Delayed presentation of medical concerns occurs due to a lack of agency – and is more prevalent in situations of reduced health literacy, systemic discrimination, trauma and financial distress. The pandemic context has enhanced these enablers of delayed presentation. Usually, delayed presentation creates a waitlist bottleneck, however, when medical concerns are time-bound it means that some people cannot access their desired medical procedure at all.

Sexual and reproductive health concerns can have chronic and intergenerational physical, mental and social health impacts.[15] The risks of these impacts increase with delayed or late presentations. Delayed presentation of people seeking treatment for STIs can lead to future infertility and congenital conditions. Delayed presentations of unintended pregnancy can lead to unsafe abortion and unwanted births. Delayed presentations of reproductive coercion can lead to anxiety, depression, heart disease, stroke, physical violence and homicide.[16] Due to increased complexity and risk, delayed presentations can incur higher financial costs, adding to financial stress.

Sexual and reproductive coercion is occurring

People are presenting with experiences of sexual and reproductive coercion.[17] We are gathering evidence of coercion linked to poverty and financial hardship linked to unemployment and economic insecurity primarily due to the pandemic. Recent research provides evidence about the recent prevalence of gender-based violence.[18] In the lead up to and during the pandemic, 2.2% of women experienced sexual violence, and 5.8% of women experienced coercive control. Emotionally abusive, harassing and controlling behaviours were experienced by 11.6% of women, 2.8% for the first time.

People who already have restricted bodily autonomy are facing uniquely coercive contexts, for example people with disability, people on temporary visas, people who are incarcerated and people in state care. People accessing abortion care may also be at higher risk of intimate partner violence than the general population.[19] It is critical that the *National Plan to End Violence Against Women and Their Children* beyond

2022 be strategised, resourced and implemented to enable long term prevention, support and recovery.

People are making different choices about pregnancy and care giving

The pandemic context is affecting when people choose to access healthcare. Some people have been fast to identify unplanned pregnancy and access early abortion care, whilst others have delayed or deferred care. Reasons for escalating or delaying care include pressure from existing caregiving roles, financial hardship or general financial insecurity, fear of virus exposure or distress linked to uncertainty.

The pandemic context is affecting people's current caregiving roles and their pregnancy outcome choices. Family planning needs and desires are changing. For example, some people with planned pregnancies have decided to access abortion due to unforeseen financial insecurity and other emerging stressors. Some people want to change to more efficient methods of contraception, knowing that abortion access could be difficult. Some people with fetal anomalies who could not access their first choice of abortion have instead chosen to access care or kinship care. We are hearing of complex situations related to interpersonal and structural reproductive coercion where some people are more likely to continue with an unplanned pregnancy.

People experiencing financial hardship cannot afford abortion care

Non-profit women's health centres, community centres and domestic and family violence support agencies fill a health funding gap in abortion care. When a woman or pregnant person wants to access abortion and cannot afford out of pocket costs, our communities step in with crowdfund fundraising measures and by dipping into organisational reserves. These non-profit services cannot afford to continue subsidising healthcare access, particularly during a pandemic.

As a non-profit healthcare provider, Marie Stopes Australia uses income from full fee-paying patients and philanthropic donations to provide bursaries to patients experiencing financial hardship. These measures support those patients to access essential healthcare they want but could not otherwise afford.

In 2019 Marie Stopes Australia provided 1,100 bursaries for women and pregnant people seeking abortion and experiencing financial hardship. This cost the organisation in excess of $561,000. In addition, we issued $71,000 worth of no interest payment plans. This level of hardship support is not financially sustainable.

Over half (64%) of bursaries provided in 2019 were for patients living in New South Wales (NSW), compared to 38% in 2018. The remaining were living across every State and Territory in Australia. Many financial hardship patients also rely on financial support from women's health centres and sexual, family and domestic violence

services. These services fundraise to cover part or all of their patients' clinical care and/or travel costs.

People who can't access abortion need support and protection

During the pandemic we have had to reschedule and cancel later gestation surgical lists due to movement restrictions, travel limitations and reduced availability of clinicians. Patients without access to abortion care have had to continue with their pregnancies, forced towards one of the remaining options of adoption, care, kinship care or parenting. Some were experiencing fetal anomalies, and all were experiencing varying degrees of hardship. Some are now preparing for stillbirths.

Women and pregnant people have been empowered to take control over their own healthcare, which has the potential for a combination of positive and negative impacts.[20] During the pandemic people faced with an unplanned pregnancy have felt forced to take matters into their own hands, and some have attempted unsafe abortion.[21] We have had contact from women and pregnant people who could not access abortion experiencing suicidal ideation and considering unsafe abortion methods. Unsafe abortion risks increasing rates of maternal mortality and could lead to chronic health issues.[22]

Women and pregnant people who have attempted unsafe abortion are at risk of social stigma, healthcare discrimination and criminalisation. Whether their attempt at unsafe abortion was successful or not, these women and pregnant people will require ongoing healthcare. In order to access healthcare, they should be able to disclose their experiences to a health professional without fear of judgement or discrimination.

Other pregnancy options are not necessarily any easier to access. For example, adoption requires consent from all parents on the birth certificate. In an abusive relationship, this can result in child safety involvement or a custody dispute. Care in the context of a pandemic may involve extended periods of out-of-home care. Kinship care has complexities in contexts of isolation and physical distancing. In contexts of adoption, care and kinship care, additional legal support may be required.

There is enhanced healthcare inequity and discrimination

We have noted patient confusion around shifting movement restrictions, fear of over-policing and border checks, fear of police discrimination due to reasons for movement being to access abortion care, and fear of barriers to returning home after abortion care. For clinics this means that patients are more likely to cancel last minute, not show up to their appointment or struggle to find a support person. This places additional strain on both communities and our health systems.

Inequity during the pandemic has been greater for people who already experience barriers to healthcare, including Aboriginal and Torres Strait Islander communities,

migrant and refugee communities including those on temporary visas, people with disability, sex workers, LGBTIQ+ populations, young people, people who are incarcerated and people living in regional, rural and remote areas.

These patients are less likely to have access to ethical decision-making frameworks in clinical care and are at greatest risk of healthcare discrimination.[23] Community controlled health providers and specialist services have experienced additional pressure to respond to the impacts of violence, reproductive coercion and/or unplanned pregnancies.[24]

Discrimination in the health sector impacts staff wellbeing

Racist behaviour within communities has reduced our ability to maintain safe workplace environments at a time when wellbeing is critical.[25] Australia's health workforce is highly skilled, experienced, intersectional and diverse. Discrimination against health workers during the pandemic has increased workplace stress and reduced healthcare capacity.

Relationships in institutional settings can replicate toxic behaviours from local communities. Racism that evolved during the pandemic, including myths that a virus can be racialised, has been witnessed within clinical settings. Health workers have experienced a combination of covert and overt discrimination from both patients and their support people. Some patients refused to be treated by health workers of colour, withdrawing some or all consent for treatment and demanding another practitioner.

Experiences of discrimination in workplaces during the pandemic are an extension of discrimination that existed prior to the pandemic. We need increasingly intersectional and community-controlled health leadership structures that co-design systemic health reforms in partnership with health consumers.

Co-design in virtual healthcare is future proofing

We are at a turning point of clinic design. Multi-disciplinary teams are essential to design for infection control and systemic wellbeing. Health consumer advisors have provided important perspectives that have informed our crisis response. Co-design of telephone, online and face to face clinical care models have been critical throughout the pandemic. Integrating virtual care will be essential for health systems evolution.

All communication mechanisms have their limitations, and telehealth will never entirely replace in person health communication. Any clinical interaction that requires an examination doesn't translate well to telehealth. In the context of sexual and reproductive health, these include vulval and pelvic examinations. We require innovative solutions, including advances in health systems literacy and revisiting expectations of all people involved in providing and receiving clinical care.

Longer term investment in virtual care will enable us to better bridge gaps between in person care and telehealth.[26] We can learn from telehealth histories in remote healthcare, and we can build on the strengths of telehealth systems reform that has occurred during the pandemic.

Access to PPE is critical

Availability of Personal Protective Equipment (PPE) has been intermittent. Since March we have faced increased cost of PPE and decreasing quality of PPE, adding to existing procurement challenges. As community needs for PPE change, Therapeutic Goods Administration (TGA) approved PPE needs to remain available to all health services.

It is as important as ever to consider mental health PPE.[27] While parts of Australia may begin to reflect pre-pandemic routine, the global pandemic continues, as does the strain on mental health for health professionals and their families. There is a continued risk to health professional mental health including compassion fatigue, vicarious trauma, trauma and burnout.[28] Given that some health professionals work in multiple clinical settings, collaboration within the health sector is required to protect sector health and wellbeing.

International aid and development is valued

The threat and disruption caused by this global public health crisis will not truly end for anyone, until it ends for everyone. Outside of Australia the pandemic is having devastating impacts on sexual and reproductive healthcare for our global friends, families and communities.[29] A coalition of more than 150 Australian organisations have joined the #EndCovidForAll campaign.[30]

In Australia, 72% of the public support ‘the provision of expertise and increased financial support to the poorest nations to help tackle the pandemic’.[31] Current Australian aid policy includes mention of maintaining sexual and reproductive healthcare as an essential service.[32] The policy focuses on health security, stability, and economic recovery with a geographic focus on Indonesia, the South Pacific and Timor-Leste.

If the virus is left unchecked, it will return to Australia from other countries once our borders are reopened, decimate our trading partners and therefore affect our economy by extension, and make our world more volatile overall. It is important that international aid and development funding is protected or increased to support countries to manage sexual and reproductive healthcare now and into the future.[33]

Recommendations

In order to enable sexual and reproductive health rights in Australia, we need the Federal, State and Territory Governments to make contraceptive and abortion care a priority.

Decriminalise sexual and reproductive healthcare

1. Women and pregnant people who attempt unsafe abortion during the pandemic must not be criminalised.
2. Legislative and policy barriers in South Australia (SA) should be lifted.[34] SA is the only jurisdiction in Australia that cannot access medical abortion via telehealth. The first dose of medication must be witnessed in person in a clinical setting, which makes medical abortion via telehealth impossible.
3. Western Australia (WA) needs safe access zones.[35] People who picket during the pandemic create additional barriers to care and additional pressure on healthcare staff and police resources.
4. We need to avoid any new legislation, healthcare or otherwise, that could further limit sexual and reproductive health rights in Australia.

Embed sexual and reproductive health in pandemic management planning

5. Sexual and reproductive health rights must be adequately covered within State and Territories pandemic plans, to ensure continued and safe access to services and make certain that we do not compound future public health issues.
6. Further support and assistance by Government Funded mechanisms set up to deal with international supply chain disruptions due to COVID-19 is required, to ensure medicines that are critically important to the health and wellbeing of people in Australia, such as medical abortion, are considered for the national priority list.
7. Ensure long term access to PPE:
    a. All accredited sexual and reproductive healthcare providers, including private and community health providers, need access to the National Medical Stockpile for relevant PPE and medications.
    b. Mental health PPE is essential, supporting the health and wellbeing of all of our frontline sexual and reproductive healthcare, including mechanisms for physical rest and some form of emotional recovery between shifts.

c. Private PPE providers should not discriminate against accredited abortion care providers. As an essential service, abortion care requires access to TGA approved PPE.

8. Sexual and reproductive health components of pandemic management plans should be designed and implemented with consumer input and community leadership.
9. Where needed, doctors and patients should be able to travel interstate or intrastate to deliver and access surgical abortion care. Doctors should be exempt from mandatory isolation providing they do not have a diagnosis or symptoms of the COVID-19 virus, or a history of high-risk exposure.
10. When reasons for patient or health professional movement require processing, relevant agencies need to maintain confidentiality at all times related to reasons for travel, for patients, their support people and the health professionals who provide abortion care.
11. Implement funding models that support people experiencing financial hardship to reduce out of pocket healthcare costs, including contraception and abortion care.
12. Support for foster, kinship care and care agencies given the escalated risk of unintended pregnancy and decrease in abortion care access.
13. Increase public health messaging to prevent discrimination in clinical settings. Ensure our messaging can be responsive to various intersections of discrimination that emerge during the pandemic.
14. Overseas-trained doctors should have temporary exemptions to Section 19AB of the Australian Government Health Insurance Act 1973, in order to increase clinical capacity for the provision of sexual and reproductive healthcare.
15. Emergency contraception pill prescription and dispensation limitations should be lifted to ensure that pharmacists can prescribe to consumers of any age, that more than one pill can be accessed at a time, that they can be collected on behalf of another person, and that they can be stored at home in case of future need to access this option. Barriers to access vary by state and territory.
16. Make pregnancy tests, condoms, dental dams and menstrual health products freely available, while enabling privacy in collection/delivery and disposal.

Public health and hospital services should enable reproductive autonomy

17. Abortion care is an essential service. All governments, health and hospital services should maintain Category 1 classification for abortion care.[36]

18. Public health and hospital services should not delay or refuse provision of abortion care. At a minimum, they need to provide high obstetric risk abortions.
19. Governments should fully fund all patients who choose abortion, particularly those with Health Care Cards and those with or without Medicare access who are experiencing financial hardship.
20. If a doctor or clinic objects to providing abortion care they should support the woman or pregnant person to access an alternative service that is willing to provide care as a duty of care.
21. All emergency departments should be able to provide emergency contraceptive options, including emergency contraceptive pills and the copper intrauterine device (IUD).
22. All stakeholders need to work together to ensure access to surgical abortion, particularly second trimester abortion. This includes working together to provide gestational scanning and sharing clinicians where required.
23. Contraceptive options should be provided at time of abortion and live birth.[37]

Invest in Pharmaceutical and Medicare Benefits Schemes

24. Pharmaceutical Benefits Scheme (PBS) review to support:
    a. Medical abortion access up to 70 days/10 weeks gestation. In Australia, medical abortion is only available up to 63 days/9 weeks gestation and is covered by the PBS. The US Food and Drug Administration has licensed Mifepristone up to 70 days/10 weeks gestation.[38]
25. Medicare Benefit Scheme (MBS) review to support:
    a. Additional item numbers for specialist sexual and reproductive care via telehealth, including Pre-Exposure Prophylaxis (PrEP) and medical abortion access.[39]
    b. Extended scope of health professionals including telehealth consults with Registered Nurses and Midwife Practitioners.
    c. Extended scope of consults including telehealth consults for STI prevention and screening within contraceptive consultations.
    d. Ultrasound provision by Registered Nurses with relevant training.
    e. Contraceptive implant care led by Registered Nurses and Midwife Practitioners.
    f. Additional item numbers for patients experiencing reproductive coercion to access sexual and reproductive telehealth at no cost, including medical abortion and contraception.

g. Additional MBS codes to account for pregnancy options care for complex medical cases or delayed presentations.

h. Consider which areas of sexual and reproductive healthcare cannot be addressed via telehealth and ensure that face to face services can be enhanced and maintained throughout potential future lockdowns.

Evolve models of care

26. Nurse-led care can increase healthcare access:[40]

    a. Abortion providers should consider evolving nurse-led approaches to abortion care, including nurse-led manual vacuum aspiration (MVA).

    b. Nurse-led ultrasound is required in order to maintain capacity to deliver medical and surgical abortion care.[41]

27. In preventing unplanned pregnancy, consider the off-label/extended use of contraceptive devices including the contraceptive implant and intrauterine devices.[42]

28. If it is known that a patient is at risk of unplanned pregnancy, the patient should be advised about their emergency contraceptive options, including a copper IUD. If emergency contraceptives are not accessible to them, health professionals should consider whether safety planning is required.

29. Where relevant and possible, health services should either screen or implement sensitive enquiry mechanisms to prevent and respond to sexual and reproductive coercion.

30. Invest in clinical education for health professionals to increase capacity for sexual and reproductive healthcare during the pandemic, particularly contraceptive care, medical abortion care, and STI and reproductive coercion prevention in General Practice settings. Consider how virtual care can be integrated into communications components of clinical education.

Consider that mental health is sexual and reproductive health

31. Ensure that all people in Australia have access to non-judgemental and all-options pregnancy choices counselling, including options for abortion, adoption, care, kinship care and parenting. Any additional government funding for pregnancy counselling during the pandemic should prioritise all options, non-judgemental counselling and providers that employ qualified counsellors.

32. People need access to non-judgemental counselling when their first preference for health treatment cannot be honoured by the health system. Women and pregnant people who want an abortion but cannot access abortion should have optional access to non-judgemental telehealth counselling specific to the

second pregnancy option of their choice -- adoption, care, kinship care or parenting.

33. Pregnancy choices counselling providers should be required to openly disclose to clients if they do not support all pregnancy options, and if they are not a member of a relevant professional regulatory body. This should be communicated clearly on their website, disclosure statements and via any client referral mechanisms. Providers who choose not to provide all options pregnancy counselling services should be subject to the same duty of care as medical practitioners and be required to ensure that clients are given sufficient information to access the care that clients request.
34. Women and pregnant people who cannot access abortion and those who attempt unsafe abortion should be supported to access health and social services without judgement.

Collaborate for equity, access and agency

35. Embed health consumer perspectives through evolving models of care to ensure their perspectives inform design, quality improvement and evaluation processes.
36. Consider how evolved models of sexual and reproductive healthcare that have developed during the pandemic can be evaluated, with efficiencies integrated into longer-term models of care.[43]
37. Where scope of clinical practice has been extended during the pandemic, support practitioners to gain greater sexual and reproductive health experience. This could support Australia to increase sexual and reproductive healthcare capacity longer term.
38. Increase financial incentives for prescribers and dispensers of medical abortion, in order to increase telehealth access throughout rural, regional and remote areas of Australia. This is particularly relevant for South Australia during and post-abortion decriminalisation.
39. Continue to integrate and support community-led initiatives and services that:
    a. Co-design innovation in sexual and reproductive healthcare
    b. Co-design inclusive sexual and reproductive health information
    c. Provide mental health support
    d. Engage trauma informed approaches to prevention and care
    e. Prevent and respond to sexual, family and domestic violence

f. Consider primary, secondary and tertiary violence prevention mechanisms

g. Prevent and respond to reproductive coercion

h. Consider the intersectional and gendered impacts of disease.

In particular, collaborate with organisations led by and for Aboriginal and Torres Strait Islander communities, people with disability, LGBTIQ+ populations, migrant and refugee communities and sex workers.

40. Invest in community-led academic research that increases our understanding of:

    a. How we can rapidly respond to chronic illness caused by lack of access to sexual and reproductive healthcare

    b. How to increase capacity for trauma informed care in sexual and reproductive health systems during a pandemic

    c. The impact and efficacy of evolving models of care emerging during the pandemic context

    d. The intersections of isolation, violence and the escalation of reproductive coercion in the lead up to, during and post lockdowns

    e. Enabling factors and benefits of sexual and reproductive health consumer leadership in co-design during a pandemic

    f. Where and how virtual care can increase sexual and reproductive access and equity.

41. We need to develop a national list of ultrasound providers. Regional, rural and remote access to ultrasound will require collaboration among community, private and public health providers.

42. Due to lack of abortion access during the pandemic, there will need to be increased investment in organisations that provide support to:

    a. Children with disability and their parents/kinship carers

    b. Children with and without disability who are in out of home care

    c. People seeking adoption, foster care and kinship care services

    d. Families following a stillbirth.

    These individuals and their families should live freely without discrimination or judgement, particularly by social or child safety services.

43. Increase public health education messaging about consent (online and offline), safe sex, emergency contraception, STI prevention, broader contraceptive choices and pregnancy choices.
44. As movement restrictions shift, we need to consider how those key messages are communicated to ensure that health consumers can access accurate movement information and can access clinics without fear of discrimination or persecution.
45. Any enforcement of pandemic related legislation should prevent over policing, support movement for essential services and minimise community fear.
46. In order to prevent violence and support access to telehealth, we need equitable and safe access to personal mobile devices, alongside increasing tech safety and tech confidence for people of all ages.

Legislation and policy should enable healthcare

47. Australia needs a Sexual and Reproductive Health Strategy.
48. Resource, implement and evaluate provision of Federal strategies related to sexual and reproductive health, including the:
    a. Women's Health Strategy 2020-2030
    b. Men's Health Strategy 2020-2030
    c. National Aboriginal and Torres Strait Islander BBV and STI Strategy 2018- 2022
    d. National Digital Health Strategy (2018)
    e. National Disability Strategy 2010-2020
    f. National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families (2016)
    g. National Framework for Universal Child and Family Health Services (2011)
    h. National Hepatitis B Strategy 2018- 2022
    i. National Hepatitis C Strategy 2018- 2022
    j. National HIV Strategy 2018- 2022
    k. National Plan to End Violence Against Women and their Children 2010-2022 (next version in-press)
    l. National Preventative Health Strategy (in-press)
    m. National Sexually Transmissible Infections Strategy 2018- 2022

n. National Strategic Framework for Rural and Remote Health (2011)

49. Legislative, policy and licencing barriers to nurse-led abortion care should be reviewed and reconsidered to enable nurse-led healthcare. Barriers to nurse-led care vary by state and territory.[44]

50. Our obligations for international aid and development remain. We should continue to support countries in Australia's development program to manage ongoing and increased access to sexual and reproductive health care.

Action

We are determined to maintain access to contraceptive and abortion care. We welcome collaboration with Federal, State and Territory governments, professional associations, other non-profit organisations, other private clinical providers and key community stakeholders.

Partnerships

Jamal Hakim, Managing Director

[redacted]

Media

[redacted]

[redacted]

Alternative content access

Bonney Corbin, Head of Policy

[redacted]

[redacted]

Staying connected

Sign up for our health care professional mailing list to receive the regular updates on resources, events and training. Further information for healthcare professionals on COVID-19 and sexual and reproductive health access is available on our website. Follow Marie Stopes Australia on Twitter, Linked In or Facebook.

Please share your feedback by completing our anonymous online survey.

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Hidden forces

A white paper on reproductive coercion in contexts of family and domestic violence

Second edition

MARIE STOPES AUSTRALIA

Acknowledgement

Marie Stopes Australia acknowledges the Traditional Owners and Custodians of the land on which we live and work. We pay our respects to Aboriginal and Torres Strait Islander Elders past, present and emerging. We also acknowledge the enduring connection to their Traditional estates across Australia and to the ongoing passion, responsibility and commitment for their lands, waters, seas, flora and fauna as Traditional Owners and Custodians.

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Contents

1. Acronyms

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
AMA	Australian Medical Association
ANROWS	Australia's National Research Organisation for Women's Safety
ARCHES	Addressing Reproductive Coercion in Health Settings
CEDAW	Committee on the Elimination of Discrimination Against Women
CPD	Continuing Professional Development
DV	Domestic Violence
FV	Family Violence
GP	General Practitioner
ICD	International Classification of Diseases
IPSV	Intimate Partner Sexual Violence
IPV	Intimate Partner Violence
LARC	Long Acting Reversible Contraception
LGBTIQ+	Lesbian, Gay, Bisexual, Trans, Intersex and Queer plus
MCWH	Multicultural Centre for Women's Health
MBS	Medicare Benefits Schedule
NSW	New South Wales
NT	Northern Territory
PTSD	Post-traumatic Stress Disorder
QLD	Queensland
RACGP	Royal Australian College of General Practitioners
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RC	Reproductive Coercion
SA	South Australia
SHEV	Safe Haven Enterprise visa
SHQ	Sexual Health Quarters
SPHERE	Centre of Research Excellence in Sexual and Reproductive Health for Women in Primary Care
SRH	Sexual and Reproductive Health

SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
SV	Sexual Violence
TAS	Tasmania
TPV	Temporary Protection visa
VIC	Victoria
WA	Western Australia
WHO	World Health Organisation

2. Forewords

When I needed to access abortion in 2015 whilst in India for a university subject, my first healthcare provider informed me that abortion was illegal in that country. This was a lie that was based upon her religious convictions. When I realised I was being misled, I felt a sense of betrayal and disempowerment, as well as heartbreaking anger for all the other patients who had been coerced into continuing pregnancies that they did not want to keep, or being forced into finding other unsafe means of terminating their pregnancies. When one person denies another access to healthcare, they meet at the intersections of interpersonal and structural reproductive coercion.

This is not just an issue of the Global South. As Australia gradually decriminalises abortion across various states and territories, abortion should become more accessible, yet women and pregnant people are still being denied abortion care. Some GPs continue to put up signs in practices instructing patients that they will not offer abortion care. Some doctors refuse to offer or support patients to access all pregnancy options: abortion, adoption, care, kinship care and parenting.

In 2020 we have seen the threat and destruction of the Djab Wurrung birthing trees. It has been an act of structural reproductive coercion upon Djab Wurrung birthing culture. Structural reproductive coercion is a colonial legacy in Australia. Aboriginal and Torres Strait Islander women and pregnant people who want to birth on Country and to do so safely, are in many instances are not supported to. They may be forced to travel to regional centres weeks before birthing for medical care, often alone. As a new mother myself, this disturbs me greatly.

Hidden Forces highlights the importance of embedding reproductive coercion in policy and practice. As a progress report, it demonstrates what has been achieved within the past two years. It also proves that there is so much more that we could be doing to prevent both interpersonal and structural aspects of reproductive coercion in Australia.

We know that reproductive coercion is a form of violence experienced by people of all sexualities and genders, people who straight, lesbian, gay, bisexual, pansexual, people who are trans, gender-diverse and agender, yet research remains largely heteronormative and cis-normative. If we want to include everyone who needs access, the perspectives and voices of people with diverse lived experiences need to be centred in the narrative of reproductive coercion.

There is a need to persevere in efforts to include reproductive coercion in screening and sensitive enquiry tools, knowing that a process of refinement and adaptation will be required across different countries, contexts and settings. Further research is required in considering reproductive coercion an early warning sign of an increased risk of escalation of violence, which will enhance prevention mechanisms and strengthen referral pathways to family violence support services.

Discussions about preventing and responding to reproductive coercion in Australia will be ongoing. I look forward to collaboration across communities and sectors during the 2022 review of *Hidden Forces*.

Nishadee Liyanage
Health Consumer Advisor
Marie Stopes Australia

The first edition of *Hidden Forces*, which was published in 2018, raised awareness around reproductive coercion as a form of abuse and violence. Informed by over 80 contributors from a variety of health, education, academic and legal settings, *Hidden Forces* made a series of recommendations for further collaborative action.

As the facilitator of the *Hidden Forces* white paper, Marie Stopes Australia made a number of organisational commitments for change. Continuous improvement in the quality and safety of healthcare requires ongoing policy and practice development to prevent and respond to coercion. This is critically important, as access to sexual and reproductive healthcare is a violence prevention mechanism.

The second edition of *Hidden Forces* provides a two-year progress report. There have been some significant accomplishments in this space; reproductive coercion was embedded in the Women's Health Strategy (2020-2030), and reducing its prevalence was listed as a key measure of success. There is, however, still much to be done. Australia does not have a National Sexual and Reproductive Health Strategy, and reproductive coercion is not yet detailed in the National Plan to Reduce Violence Against Women and Their Children.

Increased and ongoing collaboration is essential in the prevention of, and response to, reproductive coercion. Our understandings of reproductive coercion will continue to develop alongside evolving models of care. A diversity of health consumer perspectives will continue to shape the language we use in clinical and community settings. We need further investment in research and sector-wide capacity building alongside increased access to sexual and reproductive healthcare.

Marie Stopes Australia is committed to ongoing work in this space including a more significant review of *Hidden Forces* in 2022. Until then, we will continue to work collaboratively across sectors to progress the recommendations and commitments of *Hidden Forces*.

I would like to extend thanks to Bonney Corbin, Head of Policy, who led the effort in establishing this second edition. I would also like to extend thanks to everyone who has contributed to this second edition or contributed to the ongoing work in this space. It is only through the ongoing commitment and collaboration of people across sectors and organisations can we realise a reality where bodily autonomy is possible for all people.

Jamal Hakim

Managing Director
Marie Stopes Australia

3. Executive summary

What is reproductive coercion?

Reproductive coercion is behaviour that interferes with the autonomy of a person to make decisions about their reproductive health.[1] Reproductive coercion includes any behaviour that has the intention of controlling or constraining another person's reproductive health decision-making and can take a variety of forms. For example:

- Sabotage of another person's contraception: e.g. deliberately removing or damaging a condom or hiding or disposing of oral contraceptives.
- Pressuring another person into pregnancy.
- Controlling the outcome of another person's pregnancy. For example, forcing another person to continue a pregnancy or forcing another person to terminate a pregnancy.
- Forcing or coercing a person into sterilisation.

Reproductive coercion is a deliberate abuse of power that can be exerted using physical violence, such as sexual assault, but can also occur in the absence of physical violence.[2]

Reproductive coercion is exercised in two domains:

1. The **interpersonal**: the intentional, controlling behaviours that are directly exerted on a person's reproductive health by another person or persons.
2. The **structural**: the social, cultural, economic, legal and political drivers that create an enabling environment that supports or allows reproductive coercion. For example, gender inequality, government policy and legislation, workplace practices, limited access to appropriate healthcare and enabling cultural and social norms.

Why does reproductive coercion matter?

Reproductive coercion is a public health issue that negatively impacts on mental health, sexual and reproductive health and maternal and child health.[3] Reproductive coercion is also often associated with Family Violence (FV), Intimate Partner Violence (IPV) and Sexual Violence (SV).[4] On average, one woman is killed by an abusive male partner in Australia each week.[5] Therefore, in addition to addressing reproductive coercion as an important issue in its own right, there is a compelling public health and safety rationale for exploring how approaches to reproductive coercion can improve prevention and responses to FV, IPV and SV.

About this document

In March 2017, Marie Stopes Australia undertook a process to explore and raise the profile of the largely hidden issue of reproductive coercion. During 2017 and 2018, stakeholder engagement and consultation defined reproductive coercion and examined approaches to addressing reproductive coercion through research, policy and practice.

The result was the first edition of the *Hidden Forces* white paper, which aimed to provide a comprehensive reference resource for those working to address reproductive coercion in Australia and offered recommendations on addressing reproductive coercion collaboratively and across multiple sectors.

In 2020 the first edition was reviewed to provide an update on progress of report recommendations. This second edition subsequently amended sections eight and nine, noting progress within the previous two years, ongoing gaps and additional recommendations for future development.

The language of gender

Marie Stopes Australia provides sexual and reproductive healthcare to people of all genders and non-binary people. Each year, thousands of women and pregnant people across Australia choose to access abortion care through Marie Stopes Australia clinics.

This report references other publications that are predominantly hetero-normative and cis-normative. Subsequently sections of this report may seem to position women as if they are sole service users of abortion care. Women may be primary users, but people of diverse genders and non-binary people access abortion care in Australia.

Women and pregnant people, in all of our diversity, deserve reproductive autonomy. Subsequently there is much work to do to ensure sexual and reproductive healthcare is accessible and equitable for all people in Australia.

Terms of reference

Terms of reference for this enquiry into reproductive coercion were developed following a stakeholder roundtable at the Children by Choice Conference in August 2017. The terms of reference investigated three themes:

1. Existing knowledge, practices and networks that address reproductive coercion.
2. Key approaches to addressing gaps in reproductive coercion research, policy and practice.
3. Future opportunities including collaborations and innovation from other fields and sectors.

Consultation

Following an exploratory roundtable to develop the enquiry's terms of reference, Marie Stopes Australia received submissions from 84 organisations and individuals across two consultation phases.

Themes and issues

Drawing on the submissions and following an extensive literature review, the following themes and issues have been identified and explored in the white paper:

- the importance of a clear, targeted definition of reproductive coercion
- the need to explore how reproductive coercion intersects with FV, IPV and SV.
- the need to simultaneously address gender inequality as an underlying driver of reproductive coercion
- the importance of contextualising reproductive coercion across multiple communities: young people, Aboriginal and Torres Strait Islander communities, culturally and linguistically diverse communities, people living with a disability and men
- the health impacts of reproductive coercion, including mental health, sexual and reproductive health, maternal and child health and homicide
- the role of healthcare professionals in addressing reproductive coercion, including current support structures and tools, international practices and examples of best practice
- the structural drivers of reproductive coercion, including social, cultural, political and economic
- the law, in particular family violence law, as it currently relates to reproductive coercion.

Health sector recommendations and progress

In order to address reproductive coercion on a national level the following recommendations are proposed based on the submissions received and available literature:

- **Recommendation 1:** Develop a qualitative research base to understand diverse lived experiences of reproductive coercion. This recommendation is partially met, some research has begun yet extensive qualitative research will require cross-sector investment and resourcing.
- **Recommendation 2:** Include reproductive coercion questions as part of the Australian Bureau of Statistics (ABS) Personal Safety Survey to gain an understanding of prevalence. This recommendation has not been met, despite advocacy from multiple organisations.

- **Recommendation 3:** Develop a national data set for induced abortions through review of the World Health Organisation's (WHO) International Classification of Diseases (ICD) coding. This recommendation has not been met, ICD-12 development process is yet to begin.
- **Recommendation 4:** Explore the concept of reproductive coercion as an early warning indicator of escalation of IPV. This recommendation is partially met, some research has begun yet extensive qualitative research will require cross-sector investment and resourcing.
- **Recommendation 5:** Embed reproductive coercion in existing and new policies and plans responding to FV, IPV and SV. This recommendation has been partially met. Reproductive coercion is embedded in the Australian Women's Health Strategy (2020-2030). Forced sterilisation is mentioned in the Fourth Action Plan of the first National Plan to Reduce Violence Against Women and their Children. Importantly, there has been no indication of if or how reproductive coercion will be included in the Second National Plan to Reduce Violence Against Women and their Children which is currently in development.
- **Recommendation 6:** Develop a national Sexual and Reproductive Health and Rights Strategy that addresses interpersonal and structural drivers of reproductive coercion. This recommendation has been not been met. Australia still needs a Sexual and Reproductive Health Strategy.
- **Recommendation 7:** Develop a national healthcare professional training program to address reproductive coercion in varied healthcare settings. This recommendation has been partially met. Some online training options offer national access but are tailored to specific jurisdictions or aspects of reproductive coercion. A comprehensive reproductive coercion training program for healthcare professionals is not yet available at the national level.

Marie Stopes Australia commitments and progress.

Marie Stopes Australia has also made a number of key internal commitments to address the issue of reproductive coercion. These commitments are:

- **Commitment 1:** Implement internal processes and practices to better support people experiencing reproductive coercion that come into contact with our services. This commitment is met, though improvements will be ongoing and continuous.
- **Commitment 2:** Engage in further research as part of a collaborative effort to progress understanding of the prevalence, lived experiences of and most appropriate responses to reproductive coercion. This commitment is partially met, research partnerships have been established and data analysis is in progress.
- **Commitment 3:** Continue to engage in advocacy work that aims to reform and expand sexual and reproductive health rights and services to all Australians. This commitment is ongoing as much advocacy action remains.
- **Commitment 4:** Lead the application to the WHO to amend ICD coding to ensure more accurate data capture for abortion care in Australia and across the globe. This commitment has not been met; ICD-12 consultation process is yet to begin.
- **Commitment 5:** Continue to foster an internal workplace culture that is responsive to FV, IPV, SV and reproductive coercion by providing staff with up to 10 pays paid FV leave each year. This commitment has been met.

4. Background

History of reproductive coercion

Reproductive coercion is a term that has been used intermittently since the 1960s. It is has been used in various contexts to refer to the structural and interpersonal abuse of power over sexual and reproductive health rights.[6] The term has been used by researchers in North America to describe a series of pregnancy controlling behaviours such as 'birth control sabotage' linked to the issue of IPV.[7] Much academic research on reproductive coercion since has been published in North America, however the term has also become more prevalent in research work here in Australia.[8]

With the increasingly urgent and warranted focus on FV, particularly IPV, the profile and understanding of reproductive coercion as an issue is starting to be uncovered. There is still much to be learnt about reproductive coercion, and this white paper seeks to add to the knowledge about the issue both internationally and in Australia.

What is reproductive coercion?

Reproductive coercion is behaviour that interferes with the autonomy of a person to make decisions about their reproductive health.[9] Reproductive coercion includes any behaviour that has the intention of controlling or constraining another person's reproductive health decision-making and can take a variety of forms. For example:

- sabotage of another person's contraception: e.g. deliberately removing or damaging a condom, or hiding or disposing of oral contraceptives
- pressuring another person into pregnancy
- controlling the outcome of another person's pregnancy. For example, forcing another person to continue a pregnancy or forcing another person to terminate a pregnancy
- forcing or coercing a person into sterilisation.

Reproductive coercion is a deliberate abuse of power that can be exerted using physical violence, such as sexual assault, but can also occur in the absence of physical violence.[10]

Reproductive coercion is exercised in two domains:

1. The **interpersonal**: the intentional, controlling behaviours that are directly exerted on a person's reproductive health by another person or persons.
2. The **structural**: the social, cultural, economic, legal and political drivers that create an enabling environment that supports or allows reproductive coercion. For example, gender inequality, government policy and legislation, workplace practices, limited access to appropriate healthcare and enabling cultural and social norms.

Violence against women

Reproductive coercion is one of the forms of violence against women. Violence against women was defined by the United Nations in the 1993 Declaration on the Elimination of Violence Against Women as:

"…any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

Violence against women shall be understood to encompass, but not be limited to, the following:

> *(a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;*
>
> *(b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;*
>
> *(c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs."*[11]

This definition has been adopted by the WHO, the Australian Government through the National Plan to Reduce Violence Against Women and their Children (2010-2022) and Our Watch.[12]

Reproductive coercion is not uniquely experienced by women. Reproductive coercion can be experienced by people of all genders, trans and non-binary people. Reproductive coercion is also a form of gender-based violence, affected by the presence and interplay of intersectional femininities and/or masculinities. For further information, read 'contextualising reproductive coercion' in section seven of this paper.

Why does reproductive coercion matter?

Having control of one's sexual and reproductive health is vital to overall health and wellbeing as well as to society in general.[13] In May 2018, the Guttmacher-Lancet Commission released a global action plan detailing the importance of sexual and reproductive health and rights to overall health, wellbeing and prosperity. The report was a ground-breaking attempt to show the importance of overlooked aspects of reproductive health and rights including access to basic services such as abortion care, contraception and the need for health literacy, to overall health, wellbeing and community prosperity.

At its heart, the Guttmacher-Lancet Commission underscored the need for all people to be able to control their sexual and reproductive health decisions.

Addressing reproductive coercion is a vital part of the global effort to promote good overall health and wellbeing and this is why it warrants further study and resources to address its root causes.

Reproductive coercion is a public health issue that negatively impacts on mental health, sexual and reproductive health and maternal and child health.[14]

Reproductive coercion is also often associated with Family Violence (FV), Intimate Partner Violence (IPV) and Sexual Violence (SV).[15] On average in Australia, one woman is killed by an abusive male partner each week.[16] There is, therefore, a compelling public health and public safety reason to explore the issue of reproductive coercion and how it can create a better understanding and response to FV, IPV and SV.

Background to this white paper

The 2016 Royal Commission into Family Violence in Victoria[17] marked a turning point in the way Australia responds to FV. On 26 May 2017, Marie Stopes Australia received a briefing from Women's Health Victoria on the findings of the Royal Commission, which highlighted the omission of reproductive coercion from the scope of the Royal Commission. The briefing inspired an organisation-wide effort to address and undertake advocacy regarding this hidden issue that is so closely aligned to FV, IPV and SV.

In August 2017, at the Children by Choice conference in Brisbane, Marie Stopes Australia brought together health practitioners, policy makers, politicians, academics, lawyers and journalists from across Australia with the aim of identifying critical gaps in Australian research, policy and practice responses to reproductive coercion.

Chaired by social commentator, writer and lecturer Jane Caro, subject matter experts took guests through a facilitated discussion to identify and map key interventions and gaps in:

- research on reproductive coercion, led by Children by Choice, Liz Price
- policy responses to reproductive coercion, led by then CEO of White Ribbon, Libby Davies
- practice initiatives responding to reproductive coercion, led by Marie Stopes Australia Medical Director, Dr Philip Goldstone.

The discussion from the roundtable informed the development of terms of reference for the white paper and the subsequent consultation process.

“As a provider of abortion care, the fundamental question we ask when we see each patient is this: is my patient in control of the decision she has made?

Most of the time the answer is yes.

However there are times when it is clear that there is coercion at play.”

Dr Philip Goldstone, Medical Director Marie Stopes Australia

At the roundtable, Marie Stopes Australia publicly committed to continuing to lead a national exploration of the issue of reproductive coercion. As a sexual and reproductive health provider that operates nationally, Marie Stopes Australia is well placed to identify and respond to instances of reproductive coercion particularly where forced pregnancy or forced abortions are concerned, but also in relation to contraception tampering. In the development of this white paper, Marie Stopes Australia plays two roles:

1. The role of a healthcare provider that has a responsibility to respond to instances of reproductive coercion.
2. The role of an advocate to increase awareness, understanding and help foster collaborative action to address reproductive coercion across multiple sectors.

“If we are to truly help Australians take control of their sexual and reproductive health and rights, we need to intimately understand the forces that can interfere with autonomy and rights. We need to do our best to make sure we know how to remove barriers and support people so the decisions they make are theirs and theirs alone. This is the heart of our advocacy work.”

Michelle Thompson, Former CEO Marie Stopes Australia

5. Purpose and scope

Aims

The purpose and scope of this *Hidden Forces* white paper were developed through consultation at the initial roundtable at the Children by Choice conference in August 2017.

This *Hidden Forces* white paper aims to:

1. Capture the most recent research evidence on reproductive coercion in Australia and internationally.
2. Identify gaps in our knowledge from an Australia context.
3. Articulate the social and public health aspects of reproductive coercion.
4. Outline recommendations for addressing reproductive coercion from an interpersonal and structural perspective.

Terms of reference

The terms of reference called for public submissions and a review of the literature focused on three key areas:

1. Existing knowledge, practices and networks that address reproductive coercion, including:
   - international examples, models and screening tools
   - existing local referral pathways and support networks
   - existing research (local or international) on reproductive coercion.

2. Key recommendations regarding actions to address gaps in:
   - research, including compilation of data to assess the scope, scale and concentration of reproductive coercion across the nation
   - policy that is evidence-based and provides for practical actions that will address the issue throughout the health system and community sector
   - service delivery, particularly in relation to abortion providers, so that women and pregnant people requiring assistance have clear, supportive and consistently high quality referral pathways.

3. Future opportunities, including:
   - cross-sectoral collaboration
   - application of innovative models and approaches from other fields.

6. Approach to developing *Hidden Forces*

Guiding principles

Reproductive coercion is a social and public health problem that requires a whole-of-community, intergenerational response. Responses to reproductive coercion, like responses to FV, IPV and SV, also require co-operation between multiple organisations across multiple sectors. Diverse individual and organisational stakeholders have co-operated to bring *Hidden Forces* to fruition.

Hidden Forces therefore seeks to draw together many forms of knowledge and evidence in order to shine a light on reproductive coercion in Australia, consolidate the current body of knowledge and make recommendations on strategies to improve our understanding of responses to and prevention of reproductive coercion.

Prevention and intervention are most relevant, effective and sustainable when communities are involved in their development. Marie Stopes Australia acknowledges the generosity of all organisations and individuals who have contributed to *Hidden Forces*, which is the culmination of 20 months engagement with individuals affected by reproductive coercion and other key stakeholders.

Two important guiding principles therefore informed the development of this white paper:

1. Each individual has a right to make decisions about their reproductive health free from coercion.[18]
2. Responding to reproductive coercion will require organisations to think and work in new ways so as to effectively address the issue.

Everyone has a right to make decisions that govern their bodies, free of stigma, discrimination, and coercion.

Accelerate Progress: Sexual and reproductive health & rights for all: report from the Guttmacher-Lancet Commission

White paper consultation

To develop this white paper, Marie Stopes Australia has reached outside of our own experiences and sought submissions from stakeholders with knowledge of and/or a demonstrated strong interest in supporting people experiencing reproductive coercion, especially stakeholders involved in:

- health care delivery, particularly women's health, abortion care and broader sexual and reproductive health services
- reproductive coercion prevention and response sectors including social workers, policy makers and advocates
- academics and researchers with a professional interest in women's health, prevention of violence against women, reproductive coercion and law reform.

The development of the white paper comprised two consultation stages:

1. **November 2017 – March 2018**: Initial submissions from stakeholders and individuals guided by the terms of reference.
2. **May 2018 – August 2018:** Draft *Hidden Forces* white paper circulated for comment.

Marie Stopes Australia received 84 submissions from academics, health professionals, counselling service providers, FV response and advocacy organisations and lawyers. The submissions raised a number of themes including:

- the importance of a clear definition of reproductive coercion
- the need to draw together the links between reproductive coercion, FV, IPV and SVs
- requirement for cross-sector collaboration between FV, IPV, SV and health professionals and organisations (particularly abortion and contraception providers and maternal health services)
- the need for further research to determine prevalence and gain an understanding of the 'lived experiences' of reproductive coercion[19]
- that reproductive coercion can be driven from an interpersonal and structural perspective
- that appropriate risk assessment (including screening tools) is developed for reproductive coercion
- that responses to reproductive coercion be culturally appropriate
- that reproductive coercion be part of policy consideration for sexual and reproductive health nationally
- the critical role that healthcare professionals, particularly those working in maternal and child health and sexual and reproductive health, play in responding to reproductive coercion.

The following section of this white paper explores these themes; drawing on both the submissions received and research literature relating to reproductive coercion, FV, IPV and SV.

7. Themes and issues

The need for a definition of reproductive coercion

To fully understand, respond to and prevent reproductive coercion, we first need to clearly define what reproductive coercion is. A useful definition is one that clearly articulates the characteristics of reproductive coercion and that reflects broad consensus among health practitioners, academics and others involved in responding to reproductive coercion. A useful definition will guide further research to further illuminate the phenomena of reproductive coercion and will be used in the development of targeted responses to reproductive coercion.

Finding a workable definition of reproductive coercion was the most prominent theme emerging from submissions in both consultation phases. Submissions provided by individuals regarding their experiences of reproductive coercion emphasised the importance of being able to have a name for what they experienced and a definition that enabled them to describe their experiences of reproductive coercion.[20] Definitional debates are also a key feature in much of the Australian research that has been conducted on reproductive coercion to date.

"I always felt what was happening to me was wrong but I just didn't know why it upset me so much. He wasn't beating me, he wasn't mean to me. He just would not wear a condom. In every way we had an equal say in our relationship, apart from contraception. To name what happened to me helps."

Sasha* Sydney

Name has been changed for privacy.

Nearly all submissions highlighted the need to develop a definition of reproductive coercion that explicitly considers the interrelationship with FV and IPV. It is noteworthy that SV was referred to in a minority of submissions.

Submissions also highlighted that a useful definition of reproductive coercion should capture:

- the experience of the person who is being coerced
- the intention of the perpetrator to exert power and control over another individual's reproductive rights
- the interpersonal nature of reproductive coercion and close links to IPV, FV and SV.

Many submissions also noted that there are significant structural forces at play that can and do interfere with a person's autonomous decision-making regarding reproductive health, including abortion law, access to maternity care, and gender inequality. These structural forces limit reproductive health decision-making directly, or encourage the development of attitudes and behaviours that promote and allow reproductive coercion in healthcare settings.

If we are to fully explore reproductive coercion in the Australian context, we must examine both the interpersonal dimension and the structural factors that enable or support reproductive coercion. For this reason, this paper has identified two dimensions of reproductive coercion: interpersonal reproductive coercion, and structural reproductive coercion. While both the interpersonal and the structural intersect with each other, the structural forms of coercion reinforce harmful attitudes contributing to an environment that helps to create interpersonal reproductive coercion.

A definition

Reproductive coercion in this white paper is defined as any behaviour that interferes with the autonomy of a person to make decisions about their reproductive health.[21] Reproductive coercion includes any behaviour that has the intention of controlling or constraining another person's reproductive health decision-making and can take a variety of forms:

- sabotage of another person's contraception: e.g. deliberately removing or damaging a condom or hiding or disposing of oral contraceptives
- pressuring another person into pregnancy
- controlling the outcome of another person's pregnancy. For example, forcing another person to continue a pregnancy or forcing another person to terminate a pregnancy
- forcing or coercing a person into sterilisation.

Reproductive coercion is exercised in two domains, the **interpersonal** and the **structural.**

Interpersonal reproductive coercion

Interpersonal reproductive coercion is the deliberate action by an individual to interfere with the autonomous reproductive health decision-making of another person. Interpersonal reproductive coercion can involve SV and may take place within the context of FV and IPV. Reproductive coercion may be exerted using physically violent or non-violent tactics.[22] The dominant theme is that power and control are exerted on the person experiencing reproductive coercion.

Structural forms of reproductive coercion

Research on the social determinants of health suggest that prevailing social, economic and political policies can and do have an impact on the health and wellbeing of individuals.[23] Social structures that engender respect and equality are associated with better health and wellbeing outcomes for individuals.[24] For instance, international evidence shows that where women's economic, social and political rights are protected and resources and power are equally distributed between women and men, there are lower rates of violence against women.[25] Applying a social determinants of health approach to reproductive coercion is important as it helps to uncover some of the underlying drivers of reproductive coercion.

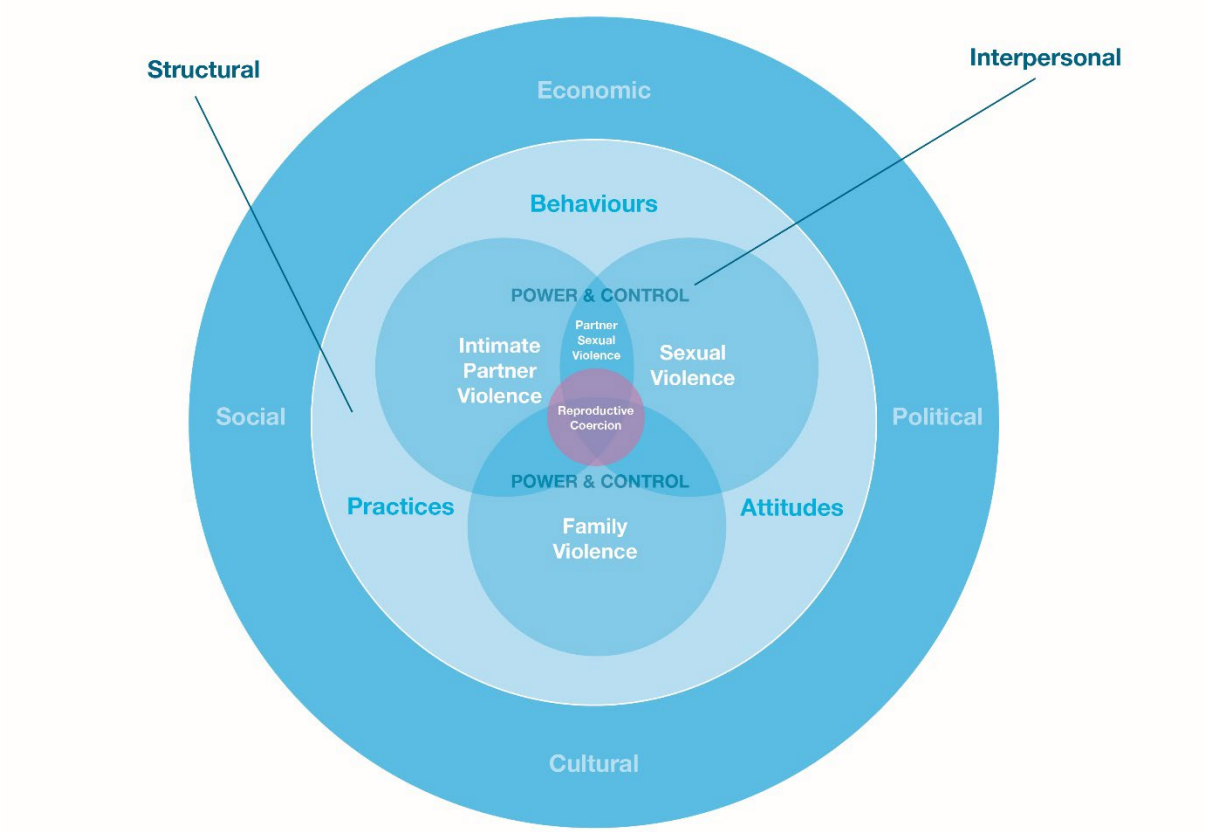
Structural forms of reproductive coercion are defined as the social, economic, political and cultural norms, practices and policies that interfere with another person's autonomous decision-making in relation to their reproductive health. Examples include:

- government policies that impede access to sexual and reproductive health services, including contraception, abortion, and maternity services
- economic policies, such as 'baby bonus' tax initiatives that can drive coercive behaviour
- cultural institutions and beliefs that condemn contraception or abortion
- gender inequality or community attitudes that promote or enable attitudes supporting violence
- cultural norms of 'motherhood' and 'fatherhood' that can create pressure to have or not have children.

Interplay between interpersonal and structural reproductive coercion

The interplay between the interpersonal and structural can best be demonstrated using the model in Figure 1.[26] Reproductive coercion intersects with FV, IPV, SV and Intimate Partner Sexual Violence (IPSV) – sexual violence that takes place within an IPV setting – with power and control being key elements of all of these forms of violence and coercion. Some societal norms regarding behaviours, practices and attitudes support or enable a perpetrator of reproductive coercion to exert power or control over another person. These societal behaviours, practices and attitudes are, in turn, shaped by the social, economic, political and cultural environment.

Figure 1. Interplay between interpersonal and structural reproductive coercion



Contextualising reproductive coercion

Reproductive coercion, IPV and SV

While reproductive coercion intersects with FV, IPV and SV, it is important that reproductive coercion is understood in its own right. Three people who told their personal stories as part of the consultation process chose not to classify what happened to them in the context of FV, IPV and SV. This reluctance to contextualise reproductive coercion within other forms of interpersonal violence may be due to a range of reasons, including:

- current stigma that surrounds reproductive coercion, IPV and SV
- a lack of understanding of reproductive coercion that often contributes to reproductive coercion being viewed as separate from FV, IPV and SV response and prevention measures
- that reproductive coercion can take place without the use of physical violence and other behaviours traditionally identified as FV, IPV and SV.

Research suggests a direct link between the occurrence of reproductive coercion, IPV and FV. North American studies indicate that the vast majority of people who experience reproductive coercion are women who also experience high rates of FV and IPV.[27] One study shows the rates of IPV and FV at twice the national average when reproductive coercion is considered.[28]

As a number of submissions stated, reproductive coercion can and often does appear within the context of IPV.[29] We also know that where a pregnancy is unintended, a woman is four times more likely to experience violence from her partner.[30] On the basis of research and submissions to the current white paper process, it may be suggested that there is a direct link between reproductive coercion and pregnancy, particularly unintended pregnancy, and IPV.

It is at the point where a person discloses reproductive coercion that organisations and healthcare providers, particularly those working in maternity services and abortion care services can play a critical role in identifying and assisting the person experiencing reproductive coercion.

Marie Stopes Australia accepts and agrees with recommendations from both the research literature and submissions to this white paper that reproductive coercion be examined within the context of FV, IPV and SV (including IPSV). Contextualising reproductive coercion in this way may assist with overcoming the tendency towards conceptual siloes in research agendas, service provision and other reproductive coercion responses. It is also important that the lived experience of individuals experiencing reproductive coercion informs the examination of reproductive coercion so that the research and service response recommendations reflect this experiential knowledge and are respectful of individual experiences.

"I did not feel in control but I would not say he assaulted me. He wasn't violent."

Melanie*, NSW

***Name has been changed for their privacy.**

For these reasons, it is important that we respectfully, safely and appropriately qualitatively analyse the multifaceted nature of lived experiences of reproductive coercion. This will provide an acceptable, evidence-based approach to preventing and responding to reproductive coercion.

At least two submissions to this white paper[31] highlighted planned research in this area. Marie Stopes Australia is undertaking research in partnership with the Australian National University (ANU) titled 'Personalising Abortion Care' that will also capture the lived experiences of reproductive coercion among research participants. By sharing knowledge generated through these aligned qualitative research projects, we can build a richer picture of the varied lived experiences of reproductive coercion that have the potential to inform nuanced and appropriate prevention and response interventions.

Sexual violence and assault

While most of the submissions to *Hidden Forces* have detailed the intersection of reproductive coercion with FV and IPV, there was less discussion of reproductive coercion as a form of SV or sexual assault. The Centre Against Sexual Assault (CASA) House in Melbourne defines sexual assault as:

"...any sexual behaviour that makes a person feel uncomfortable, frightened or threatened. It is sexual activity to which a person does not consent. The use of emotional or physical violence to force another person to engage in sexual activity also constitutes sexual assault. Sexual assault can take various forms, some of which are criminal offences:

- touching, fondling, kissing
- being made to look at, or pose for, pornographic photos
- voyeurism
- exhibitionism
- sexual harassment
- verbal harassment/innuendo
- rape
- incest/intrafamilial child sexual assault
- stalking."[32]

A literature review of reproductive coercion as sexual assault has shown that while reproductive coercion is closely associated with sexual assault, or sexual coercion as it is often termed, there may be subtle distinctions between the two. For example, the American College of Obstetricians and Gynaecologists (ACOG) defines reproductive coercion in the context of pregnancy as controlling behaviours, including threats of violence, with the intention of coercing another person to continue or end a pregnancy. Sexual coercion is defined as behaviours that coerced a partner into having sex or interfere with the sexual health of a partner.[33] However, both definitions focus on the intentions of the perpetrator, and much of the behaviours associated with both reproductive coercion and sexual coercion are similar in that they seek to control a partner. Not all sexual assault or sexual coercion leads to an unintended pregnancy. The outcome of the coercion should not be its defining characteristic. The defining characteristic should be the intention of the perpetrator. The most prominent intentions of perpetrators in terms of FV, IPV and SV are power and control.

Equally the most important characteristics of reproductive coercion are power and control.[34] Reproductive coercion is therefore viewed as closely linked but not identical to SV.

Gender and reproductive coercion

The gendered nature of reproductive coercion was a point of contention in the consultation process. Some submissions proposed a definition of reproductive coercion that recognised the gendered nature of reproductive coercion. However, other submissions argued that a definition of reproductive coercion, and the research and interventions that use that definition, need to be mindful of gender and relationship diversity.

Using a definition of reproductive coercion that is gender neutral does not preclude the need to apply a gender lens when appropriate. Much of the research on reproductive coercion in Australia and overseas focuses on cis[35] women in heterosexual relationships. We will continue to explore and address the intersectionality of reproductive coercion.

However, we have heeded advice from a number of stakeholders to ensure that the definition of reproductive coercion is gender neutral, and does not specify the gender or sexual orientation of either partner in a relationship where reproductive coercion is present. This is particularly important given that a 2014 survey of LGBTIQ+ people in Australia revealed that more than half of the respondents (54.7%) had previously been in one or more emotionally abusive relationships and that more than a third (34.8%) had been psychically or sexually assaulted by a partner.

North American research also found that women who have sex with women and men experienced significantly higher rates of IPV over a lifetime than women who have sex with men. The same study also showed that women who have sex with women were more likely to be subjected to men-perpetrated reproductive coercion, high risk sexual behaviour, and unplanned pregnancy and more likely to access regular pregnancy testing without additional corresponding contraceptive measures.[36] The Youth Risk Behaviour Survey, conducted in North America, also showed that young people who reported same-sex sexual encounters also experienced twice the rate of physical and SV than their peers in heterosexual relationships.[37]

Data on the prevalence of women who have sex with women in the LGBTIQ+ community is scarce. As part of efforts to address reproductive coercion in the Australian context, research of the lived experiences of reproductive coercion should include LGBTIQ+ perspectives, researchers and health consumers.

Men’s experience of reproductive coercion

In Australia and internationally, reproductive coercion research and responses focus on male-perpetrator coercion of women’s reproductive health decisions. This may be because experiences of IPV, reproductive coercion and sexual assault are higher among women than they are among men and because most violence against women is perpetrated by men.[38] However, at least two submissions to this white paper addressed men’s experiences of reproductive coercion by their female partner.

There is little research on the male experience of reproductive coercion although evidence suggests that it does occur and may be equally, or more, prevalent than reproductive coercion perpetrated by men against women. A North American 2010 nation-wide survey of IPV by the Centre for Disease Control revealed that 8.6% of women (or 10.3 million) had experienced reproductive coercion. The same study also revealed that 10.4% of men (or 11.7 million) reportedly experienced reproductive coercion.

Research into the lived experiences of reproductive coercion should also include men as experiencers of coercion to assist in comparing the gendered nature of such experiences and to target intervention, response and prevention measures.

Young people

Some research suggests that young people are more susceptible to coercion than their older counterparts.[39] Like many other age cohorts, the presence of IPV in young people's relationships often correlated with reproductive coercion and sexual and physical assault.[40] Common examples of reproductive coercion among young people include being coerced to not use a condom during sex, either by means of force or by using love and fidelity as a means of coercion. For example, a coercive partner telling their partner "if you loved me you would… [have sex without a condom]" or accusing their partner of infidelity if they request the use of a condom. Another commonly reported example of reproductive coercion among young people involves a coercive partner deliberately failing to withdraw before ejaculation during sexual intercourse, despite agreeing on this method of contraception. In addition to intimate partners, young people can also experience reproductive coercion from other family members such as mothers, particularly in the case of unintended pregnancy.[41]

There is, however, no conclusive evidence that shows younger people or young people are more likely to experience coercion. Research in Australia by Children by Choice has shown that clients accessing the support services under 20 years of age experienced reproductive coercion at a rate of 12.5% as opposed to 21.8% for clients in the 20-29 year age bracket.[42] However, a study from North America of 3,539 women accessing family planning clinics in Pennsylvania showed a strong correlation between reproductive coercion, IPV and sexual assault among young women aged 16-29 years. The likelihood of experiencing reproductive coercion was also found to be more common among young women who self-reported lower education levels, 'non-white' ethnicity and previous unintended pregnancy.[43]

Given there is conflicting evidence as to the susceptibility of young people to reproductive coercion, it is important that this cohort is included in research on the lived experiences of reproductive coercion. Further, evidence that young people often experience reproductive coercion as their partner's refusal to use a condom suggests a role for reproductive coercion screening of young people who are regularly accessing termination services, assistance for unintended pregnancies and STI screening and treatment.[44]

Aboriginal and Torres Strait Islander people

"There can be no greater institutional violence against the reproductive health of an Aboriginal and Torres Strait Islander woman than to implement legislation to render parents powerless to know of their children's whereabouts and incapable of protecting them from exploitation and abuse."

Professor Kerry Arabena

Aboriginal and Torres Strait Islander people have been subjected to state-supported structural and interpersonal forms of reproductive coercion since colonisation.[45] Experiences of reproductive coercion are the source of significant trauma for Aboriginal and Torres Strait Islander people, both historically and in the present day. Methods of control of the sexual and reproductive health and rights of Aboriginal and Torres Strait Islander people since colonisation have been mapped by on one of Australia's leading Indigenous health experts, Professor Kerry Arabena:

1. Indigenous people were perceived as property of the colonialists. Policy and practice tended to view Indigenous women as providers of sexual services and SV and assault against Aboriginal and Torres Strait Islander people was not criminalised.
2. Indigenous people were stereotyped as sexually depraved and this view dominated medical research and practice in the early 19th century. Sexually transmitted infections (STIs) were viewed as proof of this depravity, even though STIs were introduced and spread by European colonisers.[46]
3. Aboriginal people were perceived to be 'dying out' with the spread of STIs and other diseases providing a rationale for both 'protection' and a view that Aboriginal and Torres Strait Islander people could be 'bred out' through the forced removal of Aboriginal and Torres Strait Islander children.
4. Government policies served to regulate, separate, remove and institutionalise Aboriginal and Torres Strait Island children. Professor Kerry Arabena of Melbourne University describes that "for an Indigenous woman to be reproductively healthy during this phase of Australian history was to result in your children being taken away".
5. Assumption of Western ideals of motherhood and Western medical intervention in birthing assumed that Aboriginal and Torres Strait Islander people needed to be taught to be competent mothers. The application of Western standards to Indigenous parenthood has provided an opportunity to question the capacity of Indigenous peoples to properly care for themselves and their children.

6. Indigenous people do not have the same autonomy over their reproductive health that non-Indigenous people have and women do not have same level of access to safe legal abortion options than non-Indigenous women. Developments that have enabled non-Indigenous women to access terminations have not been afforded to Aboriginal and Torres Strait Islander women particularly in remote areas.
7. A belief that it is culturally appropriate for Aboriginal and Torres Strait Islander people to have children when they are young. Non-Indigenous people are, increasingly delaying marriage and starting a family in order to participate in the modern Australian economy. For Aboriginal and Torres Strait Islander people, particularly young people, this belief is making it increasingly more difficult for them to have access to education, employment and to participate in the modern Australian economy.

These methods of reproductive coercion have been implemented throughout the history of colonisation and continue to negatively impact the lives of Aboriginal and Torres Strait Islander people. Some academics have suggested that such methods are indicative of a harmful view that Aboriginal and Torres Strait Islander people in Australia are perceived as "less than human".[47]

Current data shows that Aboriginal and Torres Strait Islander communities are deeply impacted by FV and IPV. According to data from Our Watch, when compared with other Australian women, Aboriginal and Torres Strait Islander women are:

- thirty-five times more likely to be hospitalised as a result of FV
- five times more likely to be victims of homicide related to FV
- five times as likely to experience physical violence
- three times as likely to experience sexual assault.[48]

When maternal and infant health is considered, significant disparities in health outcomes between Aboriginal and Torres Strait Islander communities and non-Indigenous communities exist. These include higher rates of maternal mortality, preterm births, low birth weight and perinatal deaths.[49]

Given that much of the current data shows significant disparities in health outcomes of Aboriginal and Torres Strait Islander communities and non-Indigenous communities, it is likely that rates of reproductive coercion may also be disproportionally higher. This assumption requires validation through appropriately designed research into the true prevalence and experiences of reproductive coercion in the Aboriginal and Torres Strait Islander communities.

Reproductive coercion experienced by Aboriginal and Torres Strait Islander people needs to be explored so we can begin to understand the trauma, including intergenerational trauma, these experiences have caused and how we are to prevent and respond to reproductive coercion in a culturally sensitive way. Such research should seek to give voice to diverse lived experiences of reproductive coercion of Aboriginal and Torres Strait Islander peoples and seek to represent the diversity of

Aboriginal and Torres Strait Islander communities. Such lived experiences will likely show a plethora of nuances that may require multiple response and prevention measures.[50] Further, the history and ongoing legacy of power and control over Aboriginal and Torres Strait Islander people needs to be considered and addressed explicitly in reproductive coercion intervention, response and prevention measures if they are to be effective, including through measures to address ongoing trauma and distrust of Government services and non-Indigenous service providers.[51]

People of migrant and refugee backgrounds

As a nation made up of people from more than 200 countries, Australia is a culturally diverse place.[52] Research into reproductive coercion with and within migrant and refugee populations has shown that coercion often extends beyond the intimate partner as perpetrator to include broader familial structures.[53]

While there is scant research on the experiences of reproductive coercion and more broadly SV among migrant and refugee communities,[54] the limited research available suggests that there are a number of factors that should be considered when exploring the issue of reproductive coercion and any likely responses and preventative initiatives. These include:

- the importance of shame on an individual, familial and community level[55] can lead to a person's experience being secondary to family and community reputation[56]
- language and cultural barriers and a fear of repercussion if reproductive coercion is reported or raised.[57] [58] [59]
- uncertain legal status of person experiencing coercion[60]
- stress and uncertainty of unemployment and lack of job security[61]
- lack of financial resources or access to resources[62]
- the impact of social isolation.[63] [64]

Recent research indicates that awareness of SV, assault and reproductive coercion is increasing among some culturally and linguistically diverse communities, although the terminology used to describe phenomena can be confusing for community members.[65] For example, recent research exploring the issue of sexual coercion among young African women in Australia revealed that while many of the participants understood and could relate to the term 'coercion', the term 'sexual violence' was viewed as referring to sexual violence perpetrated by a stranger and not by an intimate relationship.[66] This study also found that controlling behaviours by an intimate partner was considered a normal part of marriage and romance and that study participants stay in coercive relationships in the hope that their partner will change.

Indeed, the importance of terminology is a recurring theme in the literature on reproductive coercion in migrant and refugee communities.[67] A review of the research conducted by Australia's National Research Organisation on Women's Safety (ANROWS) has revealed that communities have differing views as to what constitutes violence, abuse and coercion.

Controlling behaviours in one community may be defined as ‘normal’, yet in others they may be classified as reproductive coercion or SV. The diversity in interpretation of behaviours and conceptualisation of issues such as reproductive coercion underscores the need for a richer understanding of the various attitudes and experiences of reproductive coercion across diverse communities.

Ideas about abusive or controlling behaviour being a sign of romantic love and the sanctity of marriage prevented young women from identifying their experiences as abusive and/or disclosing that abuse.

Vope et al 2014; Chung 2005

For migrant and refugee communities in Australia, pre-immigration factors are also likely drivers and enablers of reproductive coercion, including trauma experienced by both perpetrators and victims of reproductive coercion.[68] Research suggests that experiences of pre-migration trauma, particularly exposure to violence, combined with patriarchal power structures and certain gender norms are likely to drive coercive or controlling behaviour by the perpetrator.[69]

Structural issues such as Australia’s visa policy restrictions also provide an important context within which to explore reproductive coercion among migrant and refugee communities, particularly refugee and recently arrived migrant communities. For example, women who arrive in Australia under a Temporary Protection Visa (TPV) or Safe Haven Enterprise visa (SHEV) are not able to access support services including health services such as contraception, maternal health and abortion services. A lack of knowledge of Australian laws and available support services can also play a role in the experience of refugee and migrant communities which effectively denies individuals access to the law and sources of support and treatment. Women on TPVs may therefore be forced to remain in a controlling and/or abusive relationships.[70]

Athieng* came to Australia from Sudan with her husband and two children three years ago. Her husband was violent and she made the difficult and complicated decision to leave him. Weeks after leaving her husband, Athieng, living with her two children in a small rural town in Northern Australia, discovered she was pregnant. She could not have the child as she was already struggling financially and emotionally. When Athieng went to a doctor to ask for a termination she was told by the doctor that abortion was illegal across Australia. Athieng felt trapped. It was only after several weeks that Athieng was told by a women's health advocate that she could legally access an abortion in Australia. By that stage Athieng's gestation was beyond the legal gestation limit for a termination where she lived. Through support from the Marie Stopes Australia Choice Fund and other women's health organisations Athieng was supported to access an abortion in Victoria.

Case study from Marie Stopes Australia Choice Fund 2017

***Name has been changed for privacy**

There are many interpersonal (particularly familial) and structural (including cultural) factors that interfere with the autonomous reproductive health decision-making of people from migrant and refugee communities that require further exploration. For community members who have migrated to Australia, these include the influence of visa restrictions, legal complexities of citizenship and the external stressors of the immigration experience, and how these complexities can be exploited by perpetrators of coercion or violence to intimidate their partners into remaining silent.[71] As with other community groups, it is important that these drivers are explored in the context of various lived experiences of reproductive coercion so that nuanced, culturally respectful and appropriate intervention, response and prevention initiatives can be mounted.

People with disability

According to the ABS 2015 Survey of Disability, Ageing and Carers, 18.3% of the Australian population have a disability. However, very little data exists on the experiences and prevalence of sexual assault and reproductive coercion of people with disability.[72]

Many of the submissions in both consultation phases of the white paper reinforced that people with a disability have an equal right to a healthy sexual and reproductive life as people without a disability. However, their ability to make decisions about their reproductive health is, to varying degrees, impacted by a range of interpersonal and structural forces.

All of the submissions that discussed the issues for people with disability highlighted the importance of inclusions of people with a disability in decisions about their own reproductive and sexual health.

On an interpersonal level, parents, carers and guardians have a critical role to play in supported decision-making. Interplay between the roles of guardians, carers and parents and varying guardianship laws across Australia can often create overt or subtle coercion on the reproductive decision-making of people with a disability.[73] Much of the legislation regarding decision-making in Australian states and territories is based on substitution of decision-maker rather supporting the person with a disability as decision-maker. However, there are a number of best practice examples from health jurisdictions across Australia that seeks to put the person with a disability at the centre of reproductive decision-making. SHINE SA has developed a useful analysis of programs and initiatives that seek to help people with a disability exercise decision-making about their sexual and reproductive health and rights.[74]

The interplay between the interpersonal and structural forces that impact on the reproductive health decisions of people with a disability was explored in depth in the 2013 Australian Senate Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia. Submissions to the Inquiry documented numerous stories of coercion in relation to contraception and sterilisation, frequently without informed consent and including instances where decisions about the person's reproductive health was made by a third party, such as a family member or foster carer.[75]

The Inquiry explored multiple examples of reproductive coercion and the interpersonal and structural forces that interfere with the reproductive health decision-making of people with disability in Australia.

For example:

- forced and/ or coerced sterilisation
- forced contraception and menstrual suppression
- gender-based violence that disproportionately affects women with disabilities
- denial of maternity, parenting and parental rights
- denial of legal capacity and decision-making
- lack of access to sexual and reproductive health services and programs
- lack of access to education on sexual and reproductive health rights
- lack of access to the justice system.[76]

Unfortunately, recommendations from the 2013 Senate Inquiry that included State and Territory legislation change, medical workforce training and the adoption of uniform protection laws for people with a disability, have not been implemented. The UN Committee on the Elimination of Discrimination Against Women (CEDAW) has also recommended that Australia should abolish forced and coerced sterilisation of women and girls with disability, and people with intersex characteristics.[77]

Reproductive coercion as a public health issue

"Looking back on some of my patients, there were some who experienced unusually high levels of depression, anxiety and somatic symptoms that were difficult to explain. Having become aware of the issue of RC, it is highly possible that they were experiencing some form of coercion to continue the pregnancy."

Obstetrician and Gynaecologist, Melbourne 2018

Reproductive coercion, like FV, IPV and SV, is a public health issue. Lack of control over reproductive health decision and the presence of violence and coercion can lead to significant health problems including chronic pain, gastrointestinal and gynaecological issues, STIs, depression, anxiety, post-traumatic stress disorder (PTSD), self-harm and suicide ideation. There are also significant risks to infants in cases of coerced or forced pregnancies.[78]

Healthcare settings and services, including maternal and child health services, accident and emergency departments, family planning services including abortion providers, fertility clinics, gynaecologist and obstetricians, and General Practitioners (GPs) – have a critical role to play in identifying and treating reproductive coercion. Where violence, particularly IPV, occurs alongside reproductive coercion, the person experiencing coercion is more likely to seek treatment for physical injuries and trauma than psychological trauma, meaning that healthcare settings and healthcare professionals are in a unique position to identify coercion and abuse.[79]

Reproductive coercion that takes place in the absence of violence may prove more challenging to identify. What we do know from current research is that the health impacts of reproductive coercion include mental health, sexual and reproductive health and maternal and child health impacts,[80] underscoring the important role of healthcare and other service providers working in these fields in identifying instances of reproductive coercion. The role of the healthcare provider will be explored in more detail later in this white paper.

In a broader sense, it is fair to assume that given FV, IPV and SV all have an impact on our health system[81] and our economy[82] so, too would reproductive coercion. However, it is difficult to quantify such an impact or impacts given the lack of current research in Australia.

While many of the submissions to this white paper outlined the need to have appropriate psychosocial support for people experiencing reproductive coercion, very few outlined the specific public health risks of reproductive coercion which may reflect a lack of research into the phenomena. Given the close association between reproductive coercion and other significant public health issues, such as, FV, IPV and SV, it would appear important that the likely risks associated with reproductive coercion are also examined.

Due to the lack of direct research evidence, much of the following sections will draw on research into the public health impacts of IPV to explore health risks that may also be associated with reproductive coercion.

Mental health impacts

FV, IPV and SV are associated with poor mental health outcomes.[83] Emerging research also suggests a link between poor mental health outcomes and reproductive coercion. In a study of women in Cote D'Ivoire who reported being subjected to reproductive coercion, 22% of women reported suffering PTSD.[84] Furthermore, long-term exposure to abuse, violence and control can result in complex PTSD that, above and beyond symptoms of 'regular' PTSD, can include dissociation, explosive anger, distrust, obsession with revenge, drug and alcohol abuse, chronic despair and self-harm.[85]

Research into the mental health impacts of IPV in the United States of America also shows that victims of IPV are more likely to experience:

- severe mood disorders: one study found an eightfold increase in the risk of severe mood disorders in those who were slapped, kicked, bitten or hit at least once per month[86]
- depression[87]
- anxiety disorders[88]
- substance abuse disorders, including higher rates of consumption of nicotine, alcohol and other drugs[89]
- suicidal tendencies and learned helplessness as a result of perceiving little or no control over their life or relationship[90]

Depression and prolonged exposure to high stress are also independent risk factors for heart disease, stroke, diabetes, osteoporosis and cancer. People who have a history of trauma, particularly women, are also more likely to experience a broad range of physical health problems, chronic pain and use more medication and health services than those with no history of abuse.[91]

Sexual and reproductive health problems

Research into the health impacts of IPV shows a direct link between the experience of IPV and increased risks of gynaecological problems. These problems include STIs, vaginal bleeding or infection, fibroids, decreased sexual drive, genital irritation, pain during intercourse, chronic pelvic pain and urinary tract infections.[92]

Further, refusal to use condoms by a partner perpetrating reproductive coercion and/or IPV, also leads to higher risk of STIs including HIV. Research with women in heterosexual relationship suggests that those who experience IPV are at increased risk of STIs including HIV, and urinary tract infections.[93] People experiencing IPV and/or reproductive coercion may not seek treatment for STIs given the control exerted on them by the perpetrating partner.[94] Left untreated, STIs can lead to pelvic inflammatory disease, infertility, cancer, poor neonatal health outcomes and potential pregnancy complications.[95]

Unintended pregnancy risks are also higher for people who experience reproductive coercion and/ or IPV.[96] Research from the United States of America showed that 1 in 4 women accessing family planning clinics had experienced some form of coercion or IPV.[97] In Australia, data on women accessing counselling services provided by Children by Choice showed that clients experiencing reproductive coercion or IPV were more likely to present for a termination at a later gestation than those who did not experience violence.[98] Delays in presentation can cause further financial and emotional stress and can carry greater health risk.

The increased sexual and reproductive health risks associated with reproductive coercion and IPV underscores the need for:

- sexual and reproductive health specialists (particularly abortion care and other family planning providers) to receive adequate training to identify potential clients at risk of reproductive coercion
- a suite of discrete contraceptive options and accompanying contraceptive counselling to be available to clients at risk of reproductive coercion.

There are a number of warning signs that can indicate reproductive coercion, particularly if IPV has not been disclosed or identified. These signs include:

- inability to follow a contraceptive regime including frequent skipping of contraceptive pill, irregular use of condoms, removal of long-acting reversible contraceptive (LARC) devices for no apparent physical reason[99]
- multiple, frequent diagnoses of STIs[100]
- frequent requests for emergency contraception or pregnancy testing[101]
- multiple abortions over a short space of time.[102]

Maternal and perinatal health impacts

Little research has been conducted specifically on the impact of reproductive coercion on maternal and perinatal health. For this reason, this white paper draws on research on IPV and its impact on maternal and perinatal health.

Research indicates that heterosexual women who experience IPV are:

- less likely to have planned their pregnancy[103]
- less likely to make the decision about when to have a baby[104]
- more likely to seek an abortion[105]
- at increased risk of STIs including HIV, urinary tract infections, substance abuse, depression and other mental-health issues,[106] with serious implications for maternal and perinatal health
- more likely to experience pre-eclampsia, preterm delivery, fetal distress and antepartum haemorrhage during pregnancy
- more likely to have a low birthweight baby[107]
- less likely to be able to initiate and sustain breastfeeding of an infant[108]
- at greater risk of maternal death, death of the foetus or both from trauma[109]

Studies suggest that pregnancy can also be a time of increased risk of IPV[110] and that women experiencing an unplanned pregnancy are at even greater risk of IPV.[111] IPV in pregnancy is also relatively common. For instance, in Australia, research suggests that over 5% of first-time mothers are fearful of their partner during pregnancy.[112]

Unplanned pregnancy, in and of itself, can also pose a risk to the health of mother and child. These risks include low birthweight, higher infant mortality, poor child health and development outcomes, and maternal depression.[113] While screening for violence in maternal health settings occurs to varying degrees across Australia, reproductive coercion may be too subtle to identify if it takes place without physical violence.

Homicide

While there is no specific research on possible associations between reproductive coercion and homicide, there are clear links between IPV, FV and homicide. In the United States of America, over the course of a ten-year period across 18 States, half of all homicides involving a female victim were related to IPV.[114] In Australia, according to the Australian Institute of Criminology, one woman per week is killed by a current or former partner.[115] There is, however, a dearth of data on the number of people killed outside cisgender heterosexual relationships as a result of IPV.

In 2017, the Queensland Domestic and Family Violence Death Review and Advisory Board released a report (the Queensland Review) that analysed 263 deaths over a ten-year period. A significant proportion of these deaths involved IPV and coercive or controlling behaviours were evident in almost all cases. The report also observed that unless concurrent reports of physical violence were made, reported coercive behaviour was not necessarily identified. Covert forms of coercion and control were often not noticed by services due to their subtly and the lack of physical violence. In the majority of intimate partner homicides, obsessive behaviour and sexual jealousy were identified as important precursors.

The Queensland Review provides useful insights into indicators of potential escalation in controlling behaviour. The Review also found that while crisis-based responses during high risk situations were imperative, opportunities to identify and respond to low to medium risk situations were important so as to avoid escalation in coercive and controlling behaviours. The Review put forward a number of recommendations including the need to share information at the early detection stage and to extend response initiatives such as workplace responses to FV.[116] Given that reproductive coercion can take place in the absence of physical violence, early detection, especially before possible escalation, is challenging.

On a national level, in May 2018 the Death Review Network released the Australian Domestic and Family Violence Death Review. It found that of the 105 cases where a female was killed by a male perpetrator, over 12% involved sexual abuse.[117] Coercive behaviour such as that outlined in the Queensland Review was not considered to the same degree in this report.

The presence of psychosocial abuse, such as reproductive coercion, in the absence of physical violence may provide an early indicator of escalation of violence as psychosocial abuse is often found to precede and co-occur with IPV.[118] For this reason, healthcare professionals, particularly in the gynaecological, obstetric, maternal, neonatal and sexual and reproductive healthcare (including abortion providers) spheres have a particularly important role to play in early detection and hence prevention of IPV. The incorporation of reproductive coercion behaviours into law enforcement screening practices may assist with risk assessment and early detection of situations that have the capacity to escalate to more violent and even lethal levels.[119]

The role of healthcare professionals in addressing reproductive coercion

Importance of healthcare professionals

Healthcare professionals play a critical role in identifying and responding to reproductive coercion.[120] Healthcare professionals working in general practice, gynaecology and obstetrics, sexual and reproductive health clinics and specialists including abortion providers and STI treatment facilities, fertility specialists, emergency departments and maternal and neonatal health settings will almost certainly be exposed to reproductive coercion during their careers.[121]

According to the ABS census data for 2016, eight in ten Australians have visited a GP in the past year. Additionally, research indicates that people experiencing IPV, particularly women, access healthcare more often than people who do not experience IPV.[122]

While healthcare providers are well placed to respond to reproductive coercion, there is limited research on how best to address the issue of reproductive coercion within healthcare settings and with healthcare professionals.[123] The limited research available does suggest a range of barriers to healthcare workers screening for and responding to reproductive coercion, including:

- insufficient time particularly in busy healthcare settings[124]
- health worker discomfort with the subject[125]
- health worker not feeling adequately equipped or prepared for disclosures[126]
- lack of known referral pathways for disclosures and patients/ clients seeking help.[127]

Initiatives to engage health workers in reproductive coercion screening and responses will need to account for these challenges.

Current support for healthcare professionals

Many of the submissions to the white paper highlighted the important role that healthcare professionals play in addressing reproductive coercion. There are, however, limited tools and no specific guidelines for how to identify and address the issue of reproductive coercion in healthcare settings in Australia.

As part of this white paper we will explore tools available for health professionals in Australia and overseas, as these provide a good starting point to develop further resources.

Risk assessment, screening, provider education and healthcare provider response support

There is relatively little research on the effectiveness of screening tools and their application for interventions that address reproductive coercion in healthcare settings. In North America, research suggests that screening tools for IPV and reproductive coercion have had limited uptake, including in sexual and reproductive health settings where there is generally greater investment in screening initiatives.[128] Similarly, education of healthcare professionals coupled with screening has also shown limited effectiveness in improving screening and interventions for IPV.[129] However, this education was focused on the screening tool rather than equipping healthcare professionals with the skills to have a conversation with a client experiencing IPV and/or reproductive coercion.[130] A recent study assessing different methods of healthcare provider education on IPV and reproductive coercion indicated that knowledge-based training significantly improved communications to patients/ clients about IPV and reproductive coercion.[131] These findings underscore the importance of ensuring screening measures are accompanied with appropriate knowledge-based training that equips providers to confidently and sensitively address IPV and reproductive coercion with clients.

In Australia, a number of initiatives exist to help healthcare providers identify, and respond to FV, IPV, SV and, to a lesser degree, reproductive coercion. The table at Annex 1 provides an overview of identified resources and initiatives. Forthcoming research on reproductive coercion screening and response in healthcare settings by the University of Melbourne, the Centre of Research Excellence in Sexual and Reproductive Health for Women and Sexual Health Quarters (SHQ) will also add to this body of knowledge.

All states and territories apart from the Australian Capital Territory (ACT) have healthcare practitioner guidance regarding identifying FV. While screening questions vary across jurisdictions, common questions include:

- Within the last year, have you (ever) been hit, slapped or hurt in other ways by your partner or ex-partner? OR (In the last year,) has (your partner or) someone in your family or household ever pushed, hit, kicked, punched or otherwise hurt you?
- Are you (ever) afraid of your partner or ex-partner (or someone in your family)?
- (In the last year) has (your partner or) someone in your family or household ever (often) put you down, humiliated you or tried to control what you can or cannot do?
- (In the last year), has your partner or ex-partner (ever hurt or) threatened to hurt you (in any way)?
- Would you like help with any of this now?[132]

There are currently no standalone screening tools for reproductive coercion apart from the program, Screening to Safety, developed by Children by Choice. Reproductive coercion is not included in almost all of the current healthcare practitioner tools. Given that behaviours associated with reproductive coercion may be a sign of potential escalation in violence (and potential lethality),[133] it is worthwhile including screening questions and guidance into existing resources.

While many of the resources provide support for healthcare professionals in antenatal and neonatal settings and to some degree, General Practice, the Screening to Safety program is the only set of resources that specifically addresses the issue of IPV and reproductive coercion in abortion care settings. Given that the current research from North America shows a strong correlation between people accessing family planning clinics and reproductive coercion, including abortion care settings, a strong case is made to focus on this healthcare setting.[134]

International examples of healthcare practitioner resources

One of the most comprehensive healthcare practitioner resources on reproductive coercion is the Futures Without Violence Guide for Obstetric, Gynaecologic, Reproductive Health Care Settings developed by the American College of Obstetricians and Gynaecologists.[135] The guide has been developed for use in a number of settings including:

- family planning clinics
- obstetrics, gynaecology and other women's health settings
- antenatal care settings
- STI/HIV clinics and prevention programs
- abortion clinics
- other sexual and reproductive health service clinics, including contraceptive care providers.

The strong focus on sexual and reproductive health in this guide allows for a more nuanced, targeted approach to identifying and responding to reproductive coercion. The guide also provides training links to assist with developing a trauma-informed approach to addressing the issue of reproductive coercion.

The Feminist Women's Health Center, The National Coalition Against Domestic Violence, and the National Organization for Men Against Sexism – all North American based organisations – have also developed a practitioner tool to help 'bridge the gap' between the health and domestic violence sectors,[136] which could be a useful resource in development of reproductive coercion guidance and tools for Australia.

While North America may be ahead of Australia in terms of the development of specific screening and response resources for healthcare practitioners, research indicates that staff at family planning clinics in the United States are still not using available screening tools and techniques in their practice and that healthcare practitioners have expressed a need for specific knowledge-based training about reproductive coercion.[137]

Engaging healthcare practitioners in Australia

In order for healthcare professionals to develop a richer understanding of reproductive coercion, how it manifests and ways that it can be addressed in the context of FV, IPV or as stand-alone issue, learnings from the evaluation of the North American programs are beneficial to consider. Specifically, the evaluation of these screening initiatives highlights the need for training to build on existing clinical knowledge and experience related to FV, IPV and reproductive coercion. Such training would ideally address the use of reproductive coercion as a potential sign of escalation of violence and describe referral pathways to services that best assist with intervention and ongoing support.

Ideally, screening and training resources should be developed using an Implementation Science Framework[138] within the context of a sexual and reproductive health clinic to test and trial best practice approaches to addressing reproductive coercion. This would allow for the development of screening and training resources based on the latest research as well as using the existing knowledge of clinicians within the clinic setting.

A small number of submissions voice concern that development of resources in the area of reproductive coercion may redirect limited resources away from the FV sector. Given that reproductive coercion may be an early warning sign of an increased risk of escalation of violence, it is important that such resources are complementary, coordinated and create a web of support for people experience reproductive coercion. Rather than diverting resources from the FV sector, early identification of reproductive coercion has the potential to identify markers for FV (and IPV and SV) and appropriate referral pathways to FV agencies.

A submission from the Australian Medical Association highlighted the need to engage with relevant medical colleges, including the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the Royal Australian College of General Practitioners and the Royal Australasian College of Physicians, in the development of reproductive coercion guidelines. This submission also highlighted the importance of engagement with universities through the relevant Schools of Medicine.

Trauma-informed practice

Screening for IPV alone has yielded mixed results in terms of decreasing the prevalence of IPV.[139] Research from North America has highlighted the importance of healthcare practitioners adopting a trauma-informed approach to discussing and addressing reproductive coercion with clients.

Trauma-informed practice emphasises a non-judgemental approach that ensures a safe, calm and empowering environment is available to the person disclosing reproductive coercion.

The Addressing Reproductive Coercion in Health Settings (ARCHES) intervention program in the United States is a pilot program implemented in a number of family planning clinics that includes:

1. universal assessment and education for all clients accessing services
2. harm reduction counselling
3. supportive referrals to relevant services.

Evaluation of the ARCHES program has shown that the assessment, education and counselling components provided clients with an increased sense of care and attention during their contact with health practitioners. The evaluation also showed that the program increased client knowledge of violence-related resources and encouraged confidence to enact harm-reducing behaviours.[140]

Structural issues and drivers of reproductive coercion

A complex array of sociological, psychological, and epidemiological factors are at play in the phenomenon of RC. The influence of cultural norms, gender roles and expectations, and interpretations of masculinity impact how men and women experience and understand decisions and pressure regarding reproductive health.

Dr Karen Trister Grace (2016)

Conceptualising the structural drivers

Much of the research on reproductive coercion is based on how reproductive coercion plays out on an interpersonal level. As outlined in earlier sections, this white paper acknowledges the importance of the interpersonal, particularly as it relates to perpetrator intensions to exert power and control. However, given the close connection between reproductive coercion and FV, IPV and SV, it is important that we look at the structural elements that create a permissive environment for behaviours associated with reproductive coercion.

It is equally important to investigate the policy frameworks that can help drive deep systemic and intergenerational change required to address reproductive coercion. Much of the work in this section draws on existing research from the reproductive coercion sector as well as the latest work on structural factors that impact on individual reproductive health decisions.

Social drivers

Some submissions to the first edition of *Hidden Forces* cautioned against taking a gendered approach to what is largely an unexplored area of interpersonal power and control. Reproductive coercion and measures to address it need to take into account the broad spectrum of situations and experiences, including gendered frameworks, models and research that provide a basis for tackling reproductive coercion on a society-wide level.[141]

For the purposes of this white paper, we identify gender as a "constitutive element of social relations based upon perceived (socially constructed and culturally variable) differences between females and males, and as a primary way of signifying (and naturalizing) relationships of power and hierarchy."[142] Further, we identify gender as a 'symbolic institution' where roles are 'performed' and these roles can have a causal link to violence and coercion.[143]

Societies with rigid gender roles, and particularly those with clearly defined roles for women as child-bearers and for men as 'breadwinners', tend to experience higher rates of violence against women.[144] There is a significant body of research that suggests a strong causal link between rigid masculine gender roles and coercive, violent and sometimes rape-related behaviours. These attitudes and behaviours can lead to a sense of entitlement which, in turn, can manifest as use of force.[145]

Anna would describe her relationship as healthy and equal. There were no issues of power and control, until it came to the subject of family planning.

Anna's husband has always wanted to have children as has Anna. But first she wanted to establish her career.

"As our relationship progressed, he became more demanding of me having children. When I reached 30 it intensified, when I achieved a promotion at work, his demands further increased. His behaviour really took me by surprise and made me feel like I had no choice. I had to get pregnant."

Anna says that as her husband's demands intensified, she changed her behaviour. "I would take the pill without him knowing because I just wasn't ready for children," she says.

When Anna did stop using contraception she said that her husband directed everything. "He wanted to have sex every day, sometimes several times a day. I was tired. I felt like I was on this merry-go-round and that the best thing for me to do was to just be compliant." When Anna did become pregnant, she described it as feeling overshadowed by the rage and aggression of her husband.

Anna miscarried and had a long, difficult and painful recovery. "To begin with my husband was great. But then he became single-mindedly focused on trying for another baby," Anna says. "My body and my mind were just not ready for another pregnancy. I felt like I had lost all safety in my body.

"He made me feel like I was not a person of worth. My biggest value to him was to give him a child.

"We are separated right now and he maintains that I am the bad one. I am the only one who can fix this by giving him children."

Anna*, NSW

***Name has been changed for privacy**

Boys will be boys, but we have so far collectively failed to let you all be anything other than the most rigid, damaging and reductive form of boy.

Clementine Ford, Boys Will Be Boys, 2018

Few of the people who came forward with their stories for this white paper would describe their partners as 'rigid in their masculine roles'.[146] In fact most of them have described their relationships as loving and equal in decision-making in almost all aspects of their lives, apart from when it came to sex and reproduction. The portrayal of gender roles through media and popular culture, through public discourse and the everyday interactions within our community can, however, create constant, unconscious and underlying reinforcement of these roles.[147] This constant reinforcement through stereotypes allows unconscious bias to drive deep-seated gender inequalities that can condone attitudes leading to violence and coercion. Rigid masculine and feminine gender roles are driven from external or structural forces, such as media and social commentary, and also by interpersonal relationships and reinforcement from partners, parents, teachers, siblings, peers and others.[148]

A number of submissions highlighted the impact of the media in the reinforcement of rigid gender roles, including:

- the impact of pornography and the normalising of male pleasure over female pleasure
- the normalising of motherhood as the ultimate feminine role and core to female identity
- the portrayals of heterosexual sexual encounters in the media that normalise lack of contraception and contraception negotiation.[149]

Addressing social drivers

Addressing reproductive coercion in a social context is complex and requires a significant, intergenerational response.[150] Like FV, IPV and SV, addressing rigid gender roles and challenging the social norms that can enable reproductive coercion is the first step.

Gender stereotyping is reinforced through media, imagery and language from a very young age.[151] It starts in the early years of childhood with the reinforcement of rigid notions of what it is to be male or female; blue or pink; dolls or trucks; soft or strong.[152] The formation of these stereotypes becomes embedded and grows strong throughout the years. Portraying less dichotomised, traditional versions of gender roles will provide children with an opportunity to grow up with more open ideas about gender roles.

School-based programs that focus on respectful relationships can provide an opportunity to help children develop more open ideas about gender and the nature of power and control in a relationship. Research from North America reveals that by the time a child reaches puberty, ideas about gender roles within sexual relationships can influence their susceptibility to reproductive coercion.[153] Therefore programs that teach relationships and sexuality education alongside respectful relationships and encourage health literacy, self-esteem and shared decision-making about sexual and reproductive health and rights are important.[154]

The media also plays a significant role in both condoning and challenging gender stereotypes[155]. Gender stereotyping in advertising is an issue that is currently being addressed by advertising regulation bodies in Australia and the United Kingdom. Advertising regulatory bodies in both countries have produced guidelines and codes of ethics that directly challenge, and in some cases ban, advertising that perpetuates negative and rigid gender stereotyping.[156][157] In the wake of #MeToo and #TimesUp campaigns, a number of film bodies are also attempting to address the issue of gender stereotyping and representation of diversity in the film industry.[158] Guidelines have also been developed to assist journalist better report on gender issues and challenge gender stereotypes.[159]

There is no one action alone that will address social drivers of reproductive coercion. However when implemented together and coordinated through existing social infrastructure such as not-for-profit organisations, businesses and governments, and implemented across multiple settings such as schools and public spaces, these efforts can help to drive social change.[160]

Cultural drivers

"I grew up in an ultra-orthodox closed Jewish community. From a young age I was taught that my only purpose in life as an ultra-orthodox Jewish woman was to give birth to the next generation of law abiding ultra-orthodox Jews. My education was heavily based on the idea that the only purpose of having children was to further this mission.

We had absolutely no sexual education at school and were forbidden to read any book that was not vetted. Books we could read contained no information that would even suggest what a normal relationship between adult partners should look like. The lack of education meant I had no exposure to material that would inform me of my rights.

At 18 the knowledge I had about my body and my rights were that of a 4-year-old. I was arranged to marry a young man and prior to my wedding I was given bridal lessons about how I was to have sexual relations with my partner. The rules around our sex life were long and detailed and we were instructed to ask our Rabbi about any questions we may have over time. I understood that if there were any issues with pregnancy, birth control or giving birth, the Rabbi would make the final decision on how to proceed.

The rules detailed the times I could or could not be with my partner and how to transition between these two times; I was not allowed to be with my husband during my period or the 7 days after I finished my period. I was considered 'unclean' during this time and could not be seen naked by my husband. This included my uncovered hair so I wore wigs. I could not even pass something directly to him with the worry that I would mistakenly touch him. For 7 days after my period I needed to check my 'cleanliness' status with special cloths twice a day to ensure I had no blood. If I found blood I would have to start counting the 7 'clean' days again.

Sometimes when a small amount of blood was found the question of whether it constituted enough of a problem to begin counting again would be up to the Rabbi to decide. My underwear or special cloth was taken to the Rabbi and he would inspect it and then make his ruling.

[continued next page]

All other decisions regarding the reproductive process were also decided by the Rabbi.

I was not able to get pregnant naturally and we asked the Rabbi for permission to get fertility treatments. I could not go on birth control without gaining permission from the Rabbi. After I gave birth to my daughter and struggled with postpartum depression I asked my husband to ask our Rabbi for permission to go on birth control. My husband refused to ask, and this played a part in the breakdown of our marriage. All of my reproductive decisions ultimately were made by the Rabbi and a lack of education meant I believed this was the norm.

The culture I lived in meant I had very little to no understanding about the rights I had to my own body and reproductive decisions. The closed community meant that I had little exposure to the world outside my community and the lack of education meant that I didn't even understand I had any rights."

Helen*, Victoria

***Name has been changed for privacy**

The reinforcement of power and control over Helen's reproductive health passed through generations and was perpetuated by the institutions of her community, particularly education and religious institutions. Such control over her reproductive health, and other aspects of her life was, for Helen, normalised. Education, Helen says, was a catalyst to question and challenge the power and control structures of her community. Helen is no longer part of the closed community in which she grew up, but when asked what support would have helped, she says education about her rights, especially her right to bodily autonomy.

While there is little literature on the cultural drivers of reproductive coercion specifically, there are a number of studies that illustrate the ways in which cultural factors can influence and condone IPV and SV. These cultural drivers include beliefs that:

- condone male violence, particularly in heterosexual relationships
- focus on collectivism and reinforce hierarchies of power that must be protected for the 'good of the group'
- are patriarchal and thus reinforce male dominance over female structures.[161]

A contributor to this white paper, Ella, recalled her experience growing up in a high control Jehovah's Witness community.

"The Jehovah's Witness religion I grew up in made me feel immense pressure to maintain my virginity. I dreaded the prospect of being trapped by a lifelong commitment to a husband in a community that would dictate what we did in the bedroom and I started to realise that I did not belong because I didn't want to be married or have children in that stifling community.

To live a free and fulfilled life, I had to leave, which resulted in loss of my social and familial networks. This decision delayed my normal development. I subsequently didn't feel that I had grown up until I was in my thirties."

Ella*, Victoria

***Name has been changed for privacy**

When recalling her experience of life in a high control Jehovah's Witness community, Ella also highlighted that women in particular not only experience reproductive coercion driven by the culture of the community, there are also economic drivers that perpetuate and compound reproductive coercion[162]. Ella outlined that decisions of when to start and end reproduction rests with the typically male provider as the woman is expected to be silent or "in subjection".[163] Ella describes how lack of income,[164] coupled with lack of control over one's own body results in fear, obligation and guilt and increases reliance on the public health system. In her recovery, she needed psychological counselling, visits to specialist physiotherapists to relax her shallow breathing and to women's hospitals for a vulvar disorder caused by hyper-contraction.[165]

"If you wanted to have an abortion you would need to hide it from your community for fear of being shunned. This is a huge burden on your mental health. While I didn't have an abortion I was always prepared to, and this made me feel guilty throughout my child-bearing years.

If you are a woman in a high control community like this, you have limited access to income, you don't have a voice and you don't have control over your body. Trying to seek health support, particularly mental health support is difficult socially and economically."

Ella, Victoria

Ella and Helen's stories highlight the ability of cultural influences such as religion, particularly in closed or high control communities, to significantly influence autonomous decision-making about reproductive health.

Supporting people like Ella and Helen when they decide to leave any such community is important, particularly in relation to ensuring access to sexual and reproductive health and rights education that they may not have received previously.[166]

Like the social drivers of RC, addressing cultural drivers of reproductive coercion requires education linked to a whole-of-community response to reproductive coercion. These are similar to responses that underpin prevention efforts for FV, IPV and SV.[167]

Religion also plays a critical role in addressing structural drivers of reproductive coercion. While religious institutions are often perceived as barriers to reproductive autonomy,[168] a number of religious organisations champion reproductive justice and access to contraception and abortion.[169] Where available, engaging faith-based organisations that encourage autonomous reproductive health decision-making will also be an important part of preventing and responding to reproductive coercion.[170]

When addressing cultural drivers that are specific to religion, engaging community religious leaders in these efforts is essential. However, it is not without its challenges. When asked about engaging religious leaders from her former community, Ella highlighted that all leaders from her community were male and to attempt to engage them was futile.

"Engagement with an equal balance of males and females would have to be legislated for the Jehovah's Witnesses to participate as they would consider this as diluting their leadership. Without legislating their involvement, the leaders would simply ignore invitations to participate in a discourse. We saw this during the Royal Commission into Institutional Response to Child Sexual Abuse."[1]

Ella, Victoria

Economic drivers

While there is little data about the economic drivers of reproductive coercion specifically, there is a strong body of research that correlates reduction in violence against women to gender pay parity.[171] [172] The evidence shows that not only does a decrease in the gender pay gap reduce violence against women, addressing the gender pay gap also improves health and wellbeing of those experiencing violence, the broader family unit and the community.[173]

The tax system can also be an economic driver of IPV, FV and reproductive coercion as it can be used as a means of power and control. While the tax system is mostly used as a means of interpersonal reproductive coercion,[174] it can also exert power and control from a structural perspective. In April 2017, the British Government introduced what has become known as the "rape clause".[175]

This tax credit reform states that a mother in the UK is unable to claim tax credits for any child following the first two unless they can demonstrate that conception was a result of "a sexual act which [they] didn't or couldn't consent to" or that the mother was at the time of conception "in an abusive relationship, undergoing control or coercion by the other parent of the child".[176] Further, the exemption does not apply if the mother is living with the other parent of the child, regardless of whether coercion and abuse are continuing.[177] In response to this reform, the Child Poverty Action Group's solicitor, Carla Clark, argued that the policy "places women, in particular, in the invidious position of deciding whether to continue with an unplanned pregnancy or to have an abortion".[178]

While the "rape clause" is an obvious form of the tax system exhibiting structural coercion, there are other, less obvious forms of structural coercion linked to tax systems. Many tax systems across the world exhibit gender bias.[179] In Australia, the federal opposition recently claimed that the Australian Government's 2018 tax cuts would be twice as beneficial to men as they are to women.[180]

The idea of gender bias in taxation is not new and has been the subject of much recent debate amongst economists globally.[181] In Australia, however, this issue has not gained much public attention. However, given that an association between higher rates of violence, particularly IPV, and inequality in the distribution of economic resources between men and women, and given current public debates around pay parity in Australia,[182] reviewing current wages and taxation for gender bias makes sense from a violence reduction and public health perspective.

Policy and legislative drivers

Policy and legislation play a critical role in reproductive health.[183] Some policy and legislation may inadvertently interfere with a person's ability to make autonomous reproductive health decisions. For example, a policy that results in the closure of a public maternal health unit may have the aim of saving public money but may also limit the pregnancy care options for local people. Equally, policies and laws can be designed for the purpose of interfering with individual decision-making about reproductive health, for example laws that criminalise abortion.

The impact of policy and legislation on autonomous decision-making about reproductive health can best be demonstrated by the current state of sexual and reproductive healthcare planning in Australia. Australia is a complex environment when it comes to health policy and service provision as these activities are predominantly managed through a network of different state and territory jurisdictions.[184]

There is currently no nation-wide, overarching sexual and reproductive health strategy, contributing to significant inequities in access to services between health jurisdictions. Further, there is a lack of intersection between sexual and reproductive health services and other health services which inhibits continuity of care.[185]

Given that access to sexual and reproductive health services plays a significant role in reproductive autonomy and overall health and wellbeing, it is important that people have access to appropriate services no matter where they live or their circumstances without judgement or discrimination.[186] However some sexual and reproductive health services, such as abortion care, attract considerable political debate and controversy which, in turn, can limit access.

In late 2017, the last affordable surgical abortion clinic in Tasmania closed. The closure left Tasmanian women with little to no access to surgical abortions other than travelling to the mainland. The closure and subsequent lack of access has significantly impacted the reproductive decision-making of many Tasmanian women.

Angela's story

"I believe that the lack of action from the Tasmanian Government in late 2017 -2018 regarding access to affordable and safe surgical terminations in Tasmania heavily influenced a personal reproductive decision, and in particular executing that decision, where I hit multiple barriers (costs, access, mental health etc) and ultimately couldn't access the service in Tasmania.

Making the decision should have been the hardest part of this, not navigating a pathway full of barriers, heavily politicised, let alone having to leave the state to ultimately access the service.

While health professionals wanted to help me, they weren't able to due to lack of information, the policy environment as it stood at that time, the fact the government was in caretaker, the absence of a Chinese wall between the health service and the political sphere.

I felt I had to re-make that decision at every stage of the process – including to the 6 different health professionals I spoke to as I went through the pathway.

The Tasmanian legislation doesn't require a doctor's referral to get a surgical termination, yet the policy and public lines from the government spokesperson during this time told us we needed to. This adds another barrier and cost.

On return, screenshot of my tweets regarding the need to resolve this issue were sent to my former employer by a then staff member of the Premier's Office with an intention to silence my voice.

What this government policy did to me was make me feel invisible, unheard, not understood, not cared about, I felt ashamed, I felt misunderstood, I felt targeted if I spoke out, I felt like I was taboo, I felt lied to, I felt isolated, I felt alone, I felt un-represented.

I also felt determined to fill that information void with my lived experience. I felt like I had the right connections to fix this, to work with the decision makers to really understand what is going on."

Angela Williamson, Tasmania

Establishing another surgical abortion service in Tasmania has taken more than 10 months.[187] Data from Marie Stopes Australia reveals that, on average, at least ten Tasmanian women per month travelled interstate to access surgical services between January 2018 and November 2018. The laws and lack of public support for critical sexual and reproductive health services including support to end or to continue a pregnancy, directly interferes with autonomous decision-making of reproductive health. Further, the lack of public health funding attributed to sexual and reproductive health, including abortion care and contraception, on a national level reveals deep inequities in access depending on where a person lives.[188] At the time of publication, there were still a number of access issues.[189]

As highlighted in a number of submissions, a national strategy that addresses the sexual and reproductive health needs of Australians will help to provide more equitable access to support and services across the country. This means equitable access to services that provide contraception, abortion care, sexual and reproductive health literacy, fertility treatment and sexual health screening and treatment will help to increase reproductive healthcare options[190] and support autonomous reproductive health decision-making for all Australians.

A national strategy that provides national consistency in abortion laws and funding will help to increase access to vital services for people who are experiencing pregnancy coercion.[191] The current laws and overall inconsistency in publicly funded abortion services limits an individual's ability to make autonomous decisions about their own reproductive health.[192]

With the current review of the Medical Benefits Scheme (MBS), there is an opportunity to also review MBS item numbers and subsequent rebates for certain procedures that are either not currently covered by the MBS or have inadequate rebates.[193] These procedures include insertion of LARC, Termination of Pregnancy services and insertion of LARC following a Termination of Pregnancy. The effect of such reforms would increase access and availability of these reproductive health services. For people experiencing reproductive coercion, the ability to access these services in the right place at the right time is critical.[194]

Given the importance of sexual and reproductive health to overall health,[195] there is an opportunity to address the complex and changing sexual and reproductive health needs of individuals over time through a GP-coordinated sexual and reproductive health plan. A sexual and reproductive healthcare plan could be rolled out in the same way that mental health care plans have been rolled out across primary health care settings.

A sexual and reproductive healthcare plan could provide access to services such as contraception, sexual health screening and treatment, abortion care and fertility treatment.

The law

As part of the consultation process for this white paper, a number of submissions questioned whether current laws can appropriately respond to instances of reproductive coercion. While there is no specific law that currently addresses reproductive coercion in Australia,[196] there are, several laws that deal with consent that are applicable to reproductive coercion.[197] For example, the following actions relevant to reproductive coercion are addressed in criminal law:

- Rape: reproductive coercion can be classified as rape depending on the circumstances and whether those circumstances do not constitute consent.[198]
- Causing (serious) injury intentionally or causing (serious injury) recklessly: an argument can be made that an unplanned or forced pregnancy constitutes injury (as injury does not have to be permanent) although it would be difficult to argue that an unplanned or forced pregnancy would cause serious injury.[199]
- Assault: 'Stealthing'[200] may be classified as assault where the application of force is the sexual act and the injury is the forced pregnancy.[201]
- Procuring sexual act by fraud: stealthing in particular may constitute a false or misleading representation and so this form of reproductive coercion can be viewed in the context of this criminal act.[202]
- Family Violence Act: reproductive coercion fits within the Family Protection Act 2008 and the definition of what constitutes FV. The act provides a specific example of "sexually assaulting a family member or engaging in another form of sexually coercive behaviour".[203]
- Child Welfare Legislation: this may have the consequence of tying a husband and wife together where the birth of a child has been the result of Family Protection Act.[204]

Although Family Protection Act is not specifically mentioned in the above criminal laws, these criminal laws could arguably be applied to certain behaviours that are examples of Family Protection Act.[205]

A final word needs to be said on the legal aspects of reproductive coercion as it relates to the roll out of My Health Record. A number of legitimate and significant concerns have been raised by organisations responding to IPV, SV and FV about access to records by abusive partners.[206] Any health record that could detail access to STI test results, contraception and abortion procedures impacts on the issue of reproductive coercion in that people experiencing reproductive coercion who choose to access these services should do so without any fear that an abusive partner can gain access to such sensitive health services.

My Health Record does not change the current position regarding access to a person's health information - in that broadly speaking a partner cannot access their partner's health information without the former's consent - but it did initially raise concerns because of the ability for both parents to access their children's records. In the case of domestic violence, this has the potential to pose a serious risk because it would enable a partner to access data such as the child (and mother's) residential address. Some pleasing amendments were passed through the Senate on 15 November 2018 which strengthen the privacy around electronic health records. These include amendments which provide that a parent will not be deemed to be an authorised representative of their child where the life, health or safety of the healthcare recipient or another person would be put at risk if the person was the authorised representative, and that the Australian Digital Health Agency will no longer be required to notify a parent that they have been removed as an authorised representative. These amendments were tabled before the House of Representatives on Monday, 26 November 2018.

8. Health sector recommendations and progress

This section focuses on recommendations to further investigate and address reproductive coercion in Australia. The recommendations draw on the submissions and current literature considered in the white paper consultation process and discussed in the previous sections of this report.

Recommendations were written in 2018 and presented according to the three areas of enquiry set out in the original terms of reference, namely research, policy and practice. Following each recommendation is a brief progress report which has been added in 2020.

Research recommendations

Exploring the lived experiences of reproductive coercion

People experience reproductive coercion in various ways. These experiences are driven by both interpersonal and structural factors and the interplay between the two. In order to gain a richer understanding of reproductive coercion and to develop appropriate, respectful, and effective prevention and response measures, and the various lived experiences of reproductive coercion must be explored. No one person or entity can explore these lived experiences and so exploration needs to be undertaken in a collaborative manner with multiple partners.

Recommendation 1

A qualitative research base should be established that captures the multiple lived experiences of reproductive coercion and provides for a richer understanding of the most appropriate prevention and response measures. This should be achieved through:

- a cooperative research network, established to share findings and compare and contrast lived experiences
- key research stakeholders sharing research findings under the auspice of this cooperative research network. Key research stakeholders include ANROWS, ANU (in partnership with Marie Stopes Australia), University of Melbourne's Safer Families Centre of Research Excellence, Monash University's SPHERE, Children by Choice, University of Queensland and Griffith University
- regularly publishing research findings in peer-reviewed journals, in traditional media and presenting findings at conferences to facilitate the sharing of knowledge across stakeholders and their aligned industries
- collaborative research projects that seek to include, in respectful ways, the breadth and depth of experiences in diverse communities across Australia.

Progress on developing qualitative research base

This recommendation has been partially met. A number of research networks are planning to or in the process of researching qualitative data relevant to reproductive coercion. Over the past two years in Australia, a small number of papers have been published, and key academics have begun smaller-scale qualitative studies.[207] There is still much work to do both on a national context and within diverse population groups that experience intersections of oppression.

In the past two years, there have been limited opportunities for reproductive coercion focussed research. Due to the nature of qualitative research, future progress will require substantial resourcing. Reproductive coercion must be included in the Second National Plan to Reduce Violence Against Women and their Children to increase incentives for research investment.

Determining the prevalence of reproductive coercion

As highlighted in a number of submissions, there is currently no data on the prevalence of reproductive coercion in Australia. The ABS Personal Safety Survey provides an ideal means by which to gather this important information. Quantifying the prevalence of reproductive coercion on a national level will help to shed light on reproductive coercion as an issue and create impetus for its consideration in the suite of research, policy and practice initiatives to address FV, IPV and SV.

Recommendation 2

That reproductive coercion questions be included as part of the ABS Personal Safety Survey in order to gain a national picture of the prevalence of reproductive coercion. Such questions could focus on:

- contraception control/and or sabotage
- forced abortion and pregnancy.

Research from North America indicates that individuals attending clinics that provide abortions report higher prevalence of reproductive coercion and IPV.[208]

Currently, there is no clear national data set for induced abortion procedures in Australia.[209] Given the intersection of unplanned pregnancy, abortion services and reproductive coercion, gaining an understanding of the number of induced abortions across Australia will be useful in exploring the prevalence of reproductive coercion.

Progress on prevalence mapping

This recommendation has not been met. Our Watch has echoed the call for the ABS Personal Safety Survey to be reviewed with the integration of reproductive coercion questions in their Tracking Progress in Prevention report.[210]

The National Women's Health Strategy (2020-2030) has listed “reduction in the rate of reproductive coercion” as a key measure of success in addressing the health impacts of violence against women and girls.[211] As a key measurable, the Australian Government has committed to designing and implementing a prevalence measure over the next 10 years.

At this stage, it is unclear as to what the prevalence measure will involve and how this will be resourced.

Recommendation 3

That a standard national data set for induced abortions be established. This can be achieved through:

- Review of induced abortion coding in the WHO ICD. ICD coding is used in the Australian healthcare system to code procedures and interventions and is therefore important from an epidemiological perspective in understanding the prevalence of induced abortions in Australia.

Progress on ICD coding amendments

This recommendation has not been met. Due to the timing of ICD coding reviews, there have been no opportunities to advance this over the past two years. The current ICD-11 was published in early 2019 and will come into effect in 2022.

ICD-12 will be the next opportunity for coding review, during which Australian members of the ICD Review Steering Group should be encouraged and supported to open dialogue on sexual and reproductive health reforms.

Exploration of reproductive coercion as an early indicator of escalation of violence

Reproductive coercion may be an early indicator or marker of escalation of IPV[212] and this link should be further explored in order to improve early warning and responses to IPV. Behaviours such as contraceptive sabotage may be an important aspect to consider in FV, IPV and SV risk assessment to decrease the risk of fatalities.

Recommendation 4

That reproductive coercion is explored as an early warning indicator of escalation of violence in risk assessment tools for IPV, FV and SV:

- This exploration can take the form of a pilot study on the effectiveness of including identification of reproductive coercion as part of an existing FV, IPV or SV risk assessment tool.

Progress on research into reproductive coercion and escalation of violence

This recommendation has not been met. Reproductive coercion is increasingly recognised as a possible early indicator of escalation of violence, however there is yet to be investment in research in this space.[213]

Policy recommendations

Embedding reproductive coercion in FV, IPV and SV Policy

There are a number of policy initiatives that respond to FV, IPV and SV, including the National Plan to Reduce Violence Against Women and Their Children. Given the close links between FV, IPV, SV and sexual and reproductive health, reproductive coercion should be embedded in these policies.

Recommendation 5

That reproductive coercion be embedded in the development of FV, IPV and SV policies and action plans and included as part of the review of existing FV, IPV and SV policies and action plans including:

- The next iteration of the National Plan to Reduce Violence Against Women and Their Children.
- The Women's Health Plan that is currently out for consultation by the Commonwealth Government[214].
- Any reviews or policy development for FV, IPV and SV across all state and territory jurisdictions.

Progress on embedding reproductive coercion in policy

This recommendation has been partially met. National Women's Health Strategy (2020-2030) has platformed reproductive coercion a key measure of success in addressing the health impacts of violence against women and girls.[215] 'Priority area 5 – Health impacts of violence against women and girls' proposes a series of interlinked priorities and actions.

The First National Plan to Reduce Violence Against Women and their Children 2010-2022 ('the National Plan') does not include explicitly reference reproductive coercion. The Fourth Action Plan of the National Plan does briefly reference and define forced sterilisation in the context of women with disability.

This was a small yet significant acknowledgement women with disabilities' historical experiences of eugenics and ongoing experiences of discrimination and injustice.

State and territory policy review and policy development has largely been informed by the National Plan. Without comprehensive reference to reproductive coercion in the National Plan, integration into various state and territory policy has been limited.

The Second National Plan to Reduce Violence Against Women and their Children (beyond 2022) is currently in development and the inclusion of reproductive coercion including or in addition to forced sterilisation is yet to be confirmed. In order to strengthen the National Women's Health Strategy, and to formalise links between women's health and violence against women, it is essential that reproductive coercion be included in the Second National Plan, including alignment with the National Women's Health Strategy.

Development of a national strategy

A number of submissions raised the need for a national Sexual and Reproductive Health and Rights (SRHR) Strategy and international evidence suggests that implementation of a national-level SRHR Strategy has positive impacts on overall community health and wellbeing[216]. A national SRHR Strategy not only provides an important opportunity to better coordinate, fund and deliver sexual and reproductive health services. It also provides an opportunity to address the interpersonal and structural drivers of reproductive coercion.

Recommendation 6

That a national SRHR Strategy is developed that addresses all aspects of sexual and reproductive health and rights, including addressing the drivers of reproductive coercion from an interpersonal and structural perspective. Addressing these drivers as part of the SRHR Strategy includes:

- provision for further research into prevalence and drivers of reproductive coercion
- plan for the expanded provision of sexual and reproductive health services including contraception, sexual health screening and treatment, abortion care and access to specialised SRH counselling. Specific attention should be paid to priority populations including low socio-economic communities, culturally and linguistically diverse communities, Aboriginal and Torres Strait Islander communities, young people, people with a disability and their carers, regional and remote communities and LGBTIQ+ communities
- training for healthcare professionals in SRHR services and support
- SRHR education across educational institutions (school to tertiary institutions)
- consideration of an action plan based on research findings into prevalence and qualitative analysis of lived experiences of reproductive coercion.

Progress on a national SRHR Strategy

This recommendation has not been met. In 2019 both Labor and the Greens parties made federal election commitments to support a National Sexual and Reproductive Health Strategy. The Morrison Government has since confirmed that a National Sexual and Reproductive Health Strategy cannot be prioritised. Australia still needs a National Sexual and Reproductive Health Strategy, particularly now that we are in a pandemic.[217]

Practice recommendations

Equipping healthcare professionals

Reproductive coercion is a public health issue that can impact on mental health, sexual and reproductive health and maternal and child health. As outlined in the submissions and the literature review, reproductive coercion can take place in the absence of physical violence. Healthcare professionals, particularly GPs, can play a key role in identifying and responding to reproductive coercion. However, in order to do so effectively, healthcare professionals require training in reproductive coercion identification, risk assessment and response.

Recommendation 7

Develop a national healthcare professional training program in collaboration with relevant Medical Colleges, University Medical Schools and SRH providers that:

- includes an approach to reproductive coercion risk assessment
- is developed for healthcare settings and professions that are likely to come into contact with people experiencing reproductive coercion. These include obstetrics and gynaecology settings, GPs, abortion and contraception care providers, maternal and child health settings
- teaches a trauma-informed approach to reproductive coercion response
- provides Continuing Professional Development (CPD) points so as to create an incentive for healthcare professionals to undertake the training
- provides a network function for healthcare professionals to share de-identified knowledge and expertise among peers in a safe and confidential manner.

Progress on a national training program

This recommendation has been partially met. A comprehensive reproductive coercion training program for healthcare professionals is not yet available at the national level.

Some individuals and organisations have developed training in various locations or regions; however, it is reliant on local leadership by sexual and reproductive health advocates working within NGOs, academic institutions or health and hospital systems.

Some online training options offer national access but are tailored to specific jurisdictions or aspects of reproductive coercion. For any of these programs to be accessible nationally, they will need further resourcing and investment.

9. Commitments from Marie Stopes Australia

A national response to reproductive coercion, including the implementation of recommendations outlined in this white paper requires a collaborative approach across multiple sectors, including health, FV, IPV and SV institutions involved in the response, research, education and government.

Marie Stopes Australia hopes that the knowledge and expertise synthesised within this white paper from key stakeholder provides an opportunity to raise the profile of reproductive coercion as a public health concern.

As the coordinator of this knowledge-gathering process, and as a key sexual and reproductive health provider, it is important that Marie Stopes Australia commits to and reports on action. While practice may shift over time, this area of work will be ongoing. Evolving models of care must continually integrate new knowledge and evidence of best practice for coercion prevention and response.

Continuous improvement

Marie Stopes Australia commits to implementing internal processes and practices to better support people accessing the organisation's services who may be experiencing reproductive coercion. This commitment includes:

- commencing 2019, Marie Stopes Australia will roll-out trauma-informed training across the organisation to equip all relevant staff with risk assessment and response tools to support clients experiencing reproductive coercion
- through the roll-out of the second edition of the National Safety and Quality Health Service Standards, Marie Stopes Australia will review informed consent and other relevant policies with consumers to continually improve the organisation's risk assessment approach to reproductive coercion
- continuing to raise funds and support clients at risk of reproductive coercion through the organisations Choice Philanthropic Fund[218]
- foster an internal workplace culture responsive to FV, IPV, SV and reproductive coercion by supporting staff who may be experiencing any of these issues personally by providing staff with up to 10 days paid FV leave each year.

Progress on continuous improvement commitments

Marie Stopes Australia reviewed existing approaches to trauma-informed care used in various clinical and counselling settings across Australia, considering the gaps, areas of risk and opportunities for change. This involved introductory level training with almost 100 staff, including the executive, and interviews with key leadership roles. It became apparent that rather than rolling-out training and developing standardised approaches, trauma-informed care needed to be embedded throughout the structure of the organisation.

Marie Stopes Australia developed a theory of change model alongside a longer-term framework for implementation, monitoring and evaluation. The next steps are to secure resourcing for a trauma-informed care program lead that will be located within the Community of Excellence to facilitate the broader process of properly embedding principles of trauma-informed care. Ideally, this would be partnered with an academic research project that can gather evidence and evaluate the model for translation in other Marie Stopes International settings.

In line with the National Safety and Quality Health Service Standards, a comprehensive care plan review mapped the client journey to consider opportunities for continuous improvement. In terms of reproductive coercion prevention and response, it considered existing or potential points for sensitive enquiry. It found that in some situations, clients were being questioned too frequently about the risk of coercion. Amendments were made to administrative processes and patient flow to enhance sensitive enquiry mechanisms and reduce risk of over-screening.

Marie Stopes Australia undertook a policy audit of all organisational policies and mapped which ones needed review in order to embed trauma-informed care and integrate person and community-centred care. Key policies underwent a more detailed review, including informed consent policies and anti-discrimination policies. A Reflect Reconciliation Action Plan was completed, and an Aboriginal and Torres Strait Islander cultural protocol policy was developed in consultation with key community stakeholders. Health consumer advisory policies and procedures were updated and consumer advisory roles were formalised within the organisational committee structure alongside the executive team.

In early 2019 there was an internal review of bookings procedures to reduce risk of coercion by second or third parties during telephone bookings. The review findings were implemented in late 2019.

In 2020 Marie Stopes Australia commissioned two independent reviews of the call centre and the client journey respectively which evaluated relevant policies, procedures and practice, including interviews with clients and staff. One of the 2020 reviews focused on client flow, and the other on identifying any real or perceived reproductive coercion in the call centre setting - with both intersecting prior to making recommendations.

The reproductive coercion review paid particular attention to any practice that may inadvertently increase the risk of coercion or be perceived as coercive. The reviews concluded that existing practices were not coercive nor did they increase the risk of coercion. Recommendations included enhanced models of pre-care via telehealth and further investment in counselling to enable faster escalation processes. Revised procedures were suggested with refreshed quality measurement tools that better measure impact, remove any perceptions of coercion with traditional call centre metrics, and are more likely to inform continuous improvement mechanisms. Recommendations from both reviews will be implemented in late 2020 and throughout 2021.

The Choice Fund has been used to support women and pregnant people to access their choice of contraceptive and/or abortion care when they cannot otherwise afford it. Over the two years from 2018 to 2019, 1,477 clients were financially supported through this fund. In 2018 20% of Choice Fund beneficiaries were experiencing domestic or family violence, and 9% were experiencing sexual violence. In 2019 this dropped to 4% experiencing family or domestic violence and 1% experiencing sexual violence. This was not aligned with one of the Fund's intentions to support people experiencing violence to access their choice of healthcare. In addition to needing to consider funding criteria, by 2019, the level of financial support reached $561,000 of services, which was unsustainable for the organisation.

In 2020 Marie Stopes Australia undertook a review of the Choice Fund and introduced new funding criteria in an effort to increase equity for those experiencing violence to access sexual and reproductive healthcare. In 2021 we will be able to evaluate the new financial support criteria.

Given the financial barriers to sexual and reproductive healthcare, an initiative like the Choice Fund cannot be the answer to SRH access and equity in Australia. Marie Stopes Australia will continue to lobby for investment in sexual and reproductive healthcare provision, such as MBS item numbers for medical abortion via telehealth and aspects of nurse-led care.

In 2018 Marie Stopes Australia revised leave policy that provides up to ten days paid leave for staff experiencing family or domestic violence.

Build and share evidence

Marie Stopes Australia is committed to engaging in further research as part of a collaborative effort to progress understandings of the prevalence, lived experiences of, and most appropriate response to reproductive coercion, including through:

- including reproductive coercion as part of the current ANU and Marie Stopes Australia research collaboration on Personalising Abortion Care[219]
- using world-leading research methodologies to bring together research partners and data in sexual and reproductive health and rights

- sharing knowledge across the sexual and reproductive health profession through training and presentations at key events and conferences
- engaging with the FV, IPV and SV sectors through network events such as conferences, and sharing knowledge gained through the organisation's work to address reproductive coercion in healthcare settings.

Progress on contributing to the evidence base

Since the first edition of *Hidden Forces* was published, Marie Stopes Australia has participated in a number of related events including conferences, roundtables, advisory meetings and consultations. The paper had 6,106 downloads in the first year of publication, accessed by 1,054 unique visitors.

Conferences presentations included Australasian Society of HIV Medicine (ASHM) Children by Choice, Jean Hailes and the Multicultural Centre for Women's Health (MCWH) conferences. Marie Stopes Australia facilitated a reproductive coercion themed Access and Equity Forum hosted by Women's Health Victoria and Women's Health in the North.

The ANU Personalising Abortion Care program is currently designing a cohort study of clients which includes reference to reproductive coercion. Findings from the research are expected to inform sensitive enquiry mechanisms and support clinical communications with clients.

Marie Stopes Australia is working in a partnership between University of Melbourne, Griffith University, University of Queensland, Children by Choice to consider trends in reproductive coercion. Findings from this research are expected to inform sensitive enquiry mechanisms and increase understandings where prevention and intervention opportunities may arise.

Over the past two years, it has become clear that contributing to the evidence base can only be done in partnership with other service providers, academics and community-based advocacy organisations. Thank you to all of the organisations who have collaborated to build and share evidence on reproductive coercion, most of whom have done so without access to research grants. Additional resourcing and investment in reproductive coercion research will be required to continue to build understandings of effective reproductive coercion prevention and response mechanisms.

Advocate for change

That Marie Stopes Australia continues to engage in advocacy work that aims to reform and expand SRHR services and support across Australia through:

- Political advocacy work that builds the case for reproductive coercion, and more broadly SRHR, as a key health priority for governments across Australia.
- Lobbying for key reforms including the development of a national SRHR Strategy and federal reform to increase access to services, including abortion care and contraception.
- Continuing to publicly advocate for further law reform to ensure abortion is decriminalised across Australia and is considered a key healthcare issue as opposed to a criminal matter.
- A submission to the WHO to amend the ICD coding that will enable better data capture of abortion procedures across health systems globally. Outline the need for the coding amendment to assist in the understanding of the prevalence of abortion and how countries can use the data to better plan provision of services. Identify the link between abortion access and reproductive coercion so as to better target intervention and response efforts.

Progress on advocating for change

Over the two years, Marie Stopes Australia continued to advocate for sexual and reproductive health, rights and justice. During that time, Marie Stopes Australia staff contributed to 200 media interviews, over 20 conference presentations, 6 academic papers, 12 policy submissions and 2 policy papers. It is a collaborative effort; advocacy work is undertaken across the health sector and with various community stakeholders who have been seminal in various campaigns focused on women's rights and equality, human rights, LGBTIQ+ rights, decolonisation and safe access to healthcare for all.

Since *Hidden Forces* was published, law reforms have been extensive. Abortion has been decriminalised in NSW and the ACT. Safe access zones have been implemented in NSW and SA. WA is now the only state without safe access zones, and SA is the only state where abortion remains in the criminal code. Both states have upcoming opportunities for law reform, with national decriminalisation and national safe access possible in the coming year.

Following law reforms for decriminalisation and safe access, there is still much work to be done to ensure access and equity for all people in Australia. The need for regional and remote access prompts ongoing investigation into various forms of care including nurse and midwifery-led care, Aboriginal and Torres Strait Islander health worker led-care, community-led care and self-administered care. These evolving models of care will require ongoing legislative and policy reforms.

The current ICD-11 was published in early 2019 and will come into effect in 2022. ICD-12 will be the next opportunity for coding review.

Marie Stopes Australia will offer support to Australian members of the ICD Review Steering Group to open dialogue on sexual and reproductive health reforms.

Reproductive coercion is not yet recognised in the National Plan to Reduce Violence Against Women in their Children. As the Second National Plan will be drafted in the coming year, it is critical that the Australian Government commits to embedding reproductive coercion prevention and response in our violence prevention and response policy and practice.

Reproductive coercion is a concept that is constantly evolving. Our understandings of reproductive abuse, coercion, autonomy and justice are expanding, alongside evolving models of clinical care. Marie Stopes Australia commits to reviewing the content of *Hidden Forces* in 2022. The review will include further consultation with community organisations and community groups who have been long term advocates for self-determination in healthcare, sexual and reproductive autonomy and health systems reforms.

10. Acknowledgements

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Professor Caroline de Costa AM MBBS BA PhD MPH FRANZCOG FRCOG

CASA House: The Royal Women's Hospital

Catholic Women's League Australian Inc.

Dr Catriona Melville, Marie Stopes Australia

Children by Choice

Dani Fried

Domestic Violence Australia

Domestic Violence Victoria

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National Aboriginal and Torres Strait Islander Women's Alliance (NATSIWA)

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True Relationships & Reproductive Health (Queensland)

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Victorian Rural Women's Health Organisations

White Ribbon Australia

Women's Health and Wellbeing Barwon South West

Women's Health Goulburn North East

Women's Health Grampians

Women's Health in the North

Women's Health in the South East

Women's Health Loddon Mallee

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Women with Disabilities ACT

Women with Disabilities Victoria

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11. Support

This report includes references to structural reproductive coercion. If you need support, please speak to a supportive person in your networks or consider one of the following support options:

- 1800 Respect, for professionals who work in areas of sexual, family or domestic violence and for survivors of violence: 1800 737 732.
- beyondblue aims to increase awareness of depression and anxiety and to reduce stigma. Call 1300 22 4636.
- Blue Knot Foundation Helpline (formerly ASCA Professional Support Line) provides help, information, support or referral for adult survivors of childhood trauma and abuse, their partners, family and friends, health professionals and anyone in the workplace working with people who have experienced childhood trauma and abuse. Call 1300 657 380.
- Butterfly Foundation's National Helpline provides information, counselling and referral for people with disordered eating and related issues. Call 1800 33 4673.
- Lifeline provides 24-hour crisis counselling, support groups and suicide prevention services. Call 13 11 14.
- MensLine Australia is a professional telephone and online support and information service for men. Call 1300 78 99 78.
- MindSpot is a free telephone and online service for people with stress, worry, anxiety, low mood or depression. It provides online assessment and treatment for anxiety and depression. Call 1800 61 44 34.
- QLife provides nationwide telephone and web-based services to support LGBTI people of all ages. Call 1800 184 527.
- PANDA (Perinatal Anxiety & Depression Australia) provides a national telephone information, counselling and referral service staffed by trained volunteers, professional counsellors and supervising staff. Many helpline counsellors have had their own experience of perinatal depression or anxiety. Call 1300 726 306.
- SANE Australia provides support, training and education to enable mental health and wellbeing. Call 1800 18 7263.
- Your General Practitioner.

Annex 1. Reproductive coercion, IPV, FV, SV resources for Australian healthcare practitioners

Tool / program	Details	Purpose	Direct reference to RC	Jurisdiction	Link
Screening to Safety	Developed by Children By Choice for Abortion care providers	Screening, clinic staff education and support materials	Yes, provides materials for contraceptive counselling.	QLD	https://www.childrenbychoice.org.au/forprofessionals/recognisingviolenceandcoercion/screening-to-safety
Strengthening Hospital Responses to Family Violence	Victorian Government initiative led by Royal Women's Hospital and Bendigo Health	Framework for helping hospitals to respond to RC	No	VIC	https://www.thewomens.org.au/health-professionals/clinical-resources/strengthening-hospitals-response-to-family-violence
Responding to Family and Domestic Violence Program	Education, policy, screening and education program administered by Women's Health Clinical Support Programs, Women and Newborn Health Service	Guidelines, screening and training for all WA Health staff	No	WA	https://ww2.health.wa.gov.au/Articles/F_I/Family-and-domestic-violence-guideline-reference-manual-policy-education-and-training
Domestic Violence Routine Screening Program	A screening tool for healthcare workers with questions about domestic and reproductive coercion being asked at the initial antenatal visit developed by NSW Health	Routine screening for domestic and reproductive coercion in healthcare settings	No	NSW	https://www.health.nsw.gov.au/parvan/DV/Pages/dvrs.aspx
Common Risk Assessment Framework (CRAF)	Risk assessment tool that provides guidance on screening questions and possible prompts for practitioners in a variety of settings developed by the Department of Health and Human Services, Victoria	To assist professionals and practitioners to identify risks associated with reproductive coercion to respond appropriately.	No	VIC	https://providers.dhhs.vic.gov.au/family-violence-risk-assessment-and-risk-management-framework
Domestic Violence Risk Assessment Questionnaire	Risk assessment questionnaire most often used in maternity hospitals developed by Queensland Health	Routine screening tool for hospitals with psychosocial questionnaire attached (Safe Start).	No	QLD	https://www.health.qld.gov.au/__data/assets/pdf_file/0032/712688/qh-gdl-456.pdf
Domestic Violence Safety Assessment Tool	Risk assessment tool for professionals and practitioners other than NSW police force	Risk assessment and screening tool for people experiencing IPV	No	NSW	http://www.domesticviolence.nsw.gov.au/__data/assets/file/0020/301178/DVSAT.pdf

Antenatal Risk Questionnaire	Risk assessment tool that determines likelihood of perinatal health morbidity	Questionnaire designed to highlight risk factors thought to increase the risk that women may develop perinatal mental health morbidity	No	SA	http://cope.org.au/wp-content/uploads/2017/11/ANRQ-_Questionnaire.pdf
Domestic and Family Violence Survey	The survey tool is used for women 18 years and over at antenatal clinics and Home Birth Services with de-identified data provided to the government. Mandatory reporting of domestic and reproductive coercion is in place in the NT	To screen for domestic and reproductive coercion in antenatal settings	No	NT	https://territoryfamilies.nt.gov.au/domestic-violence/domestic-and-family-violence-reduction-strategy
ObstetrixTas	ObstetrixTas is the computerised information system used in Tasmania that also contains a number of domestic violence related questions	To screen for domestic and reproductive coercion as part of antenatal consultations in public hospitals	No	TAS	http://www.dpac.tas.gov.au/__data/assets/pdf_file/0007/404566/180572_DPAC_Responding_and_Reporting_Document_2018_wcag.pdf
MBS Item no. 16522	New MBS item number that, among other things, provides for complex consultation where domestic is disclosed	Provides MBS provisions for complex consultation to assist with domestic violence screening	No	National	http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-ObstetricsServices
Abuse & Violence: Working with our patients in general practice (White Book)	Clinical guidelines developed by the Royal Australian College of General Practitioners (RACGP) to assist GPs with identifying and responding to all forms of reproductive coercion	Clinical guidelines to assist GPs to identify and respond to abuse and violence experienced by patients	No	National	https://www.racgp.org.au/your-practice/guidelines/whitebook/
Supporting Patients Experiencing Family Violence, A Resource for Medical Practitioners	A resource for Medical Practitioners produced by the Australian Medical Association (AMA) and the Law Council of Australia that outlines how to identify and respond to reproductive coercion experienced by patients. Includes mandatory reporting requirements across Australia	Provides information to assist with identifying reproductive coercion and suggested referral services	No	National	https://ama.com.au/article/ama-family-violence-resource

Health practitioner resource hub for unintended pregnancy and abortion - reproductive coercion	A page of resources collated by the University of Melbourne Centre for Excellence in Rural Health (CERSH)	A series of links and resources including four webinars by Children by Choice	Yes	VIC	https://www.cersh.com.au/resource-hub/training-and-support/reproductive-coercion/
Our Site- a website by and for women and girls (15+) with disability	Information for women with disabilities, this page specifically related to healthcare rights	A useful resource which may assist with ethical decision making and informed consent processes	No	National	https://oursite.wwda.org.au/life-choices/healthcare
Addressing reproductive coercion: Access and Equity lll	A two part webinar series developed by Women's Health Victoria and Women's Health in the North	These webinars are aimed at both prevention and response service professionals working in the violence against women and sexual and reproductive health sectors in Victoria.	Yes	National	https://whv.org.au/resources/whv-publications/forum-proceedings-addressing-reproductive-coercion-access-and-equity-iii or https://www.whin.org.au/resources/sexual-and-reproductive-health-resources/
The National Safety and Quality Health Service (NSQHS) Standards.	Quality and safety standards assist with the prevention of reproductive coercion in clinical settings, particularly clinical governance, partnering with consumers, communicating for safety and comprehensive care.	The Australian Commission on Safety and Quality in Health Care (the Commission) has developed resources to assist health service organisations align their patient safety and quality improvement programs.	No	National	https://www.safetyandquality.gov.au/standards/nsqhs-standards

Endnotes

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[16] Meyer S. After a deadly month for domestic violence, the message doesn't appear to be getting through. The Conversation, 1 Nov 2018 https://theconversation.com/after-a-deadly-month-for-domestic-violence-the-message-doesnt-appear-to-be-getting-through-105568

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[18] Starrs AM, Ezeh AC, Barker G et al., Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission, The Lancet, 2018.

[19] A number of submission raised the issue that reproductive coercion can be driven by and experienced by people from differing backgrounds, cultures and varied relationships.

[20] Verbal submissions of experiences of reproductive coercion

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[192] Marie Stopes Australia has heard numerous accounts from patients who have been unable to access termination of pregnancy services in States where it is criminalised. As part of the community consultation for the Termination of Pregnancy Bill 2018 in Queensland, a number of women told of the barriers they experienced due to criminality of abortion: https://www.theguardian.com/world/2018/oct/14/you-were-shamed-punished-queensland-changes-its-mind-on-abortion

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[197] The submission from HWL Ebsworth Lawyers specifically focused on the issue of consent as it relates to reproductive coercion. Taking the Victorian laws as an example there are a number of existing laws that can respond to the issue of reproductive coercion from the perspective of the victim/ perpetrator.

[198] Under the Crimes Act 1958 (Vic) consent is not given is the person submitting to the act is forced or fears force; fears harm to themselves or someone else; is unlawfully detained; asleep or unconscious; affected by drugs or alcohol; the person is mistaken about the nature of the sexual act; the person does not say or do anything to indicate consent; or the person later withdraws consent.

[199] The Victorian Crimes Act defines injury as "physical injury or hard to mental health whether temporary or permanent". According to the submission from HWL Ebsworth, pregnancy and birth can be classified as harm in a civil claim. There is also a common law acceptance that pregnancy and birth can constitute an injury (see Cattanach v Melchoir [2003] HCA 38 at 148

[200] Stealthing is the deliberate removal of a condom during sex without the consent of the partner.

[201] The Victorian Crimes Act defines assault as the indirect or direct application of force to a person (body, clothing etc) where the application of force is without lawful excuse; and with intent to inflict or being reckless as to the infliction of bodily pain, injury etc. In the case of stealthing, the application of force is the sexual act and the injury is forced pregnancy.

[202] Under the Victorian Crimes Act, a person commits an offence is they make a false or misleading representation; know that the representation is false or misleading (or probably know); as a result of the representation the victim takes part in the sexual act; intends that this will occur as a result of their representation.

[203] The Family Protection Act defines FV as behaviour that is, among other things, physically or sexually abusive; coercive or in any other way controls or dominates the family member and causes them to feel fear for their safety and wellbeing.

[204] The Status of Children Act 1974 (Vic) states that "a child born to a woman during her marriage or within ten months after the marriage has been dissolved by death or otherwise, shall, in absence of evidence to the contrary, be presumed to be the child of its mother and her husband, or former husband, as the case may be." According to the submission by HWL Ebsworth, the original intent of the law was to establish parental rights. However in the case of reproductive coercion (or IPV and FV) it can bond an abusive partner to the mother.

[205] HWL Ebsworth's submission highlights that this can either be done by an amendment to the definition of injury, or it may happen on its own by the framing of reproductive coercion as a criminal offence using the existing relevant laws.

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[207] A number of researchers are progressing qualitative work in Australia directly or indirectly in this area, including Professor Kerry Arabena, Professor Kathleen Baird, Professor Kirsten Black, Brenna Bernardino, Tina Dixson, Professor Heather Douglas, Dr William Liley, Lydia Mainey, Sarah Ratcliffe, Dr Nicola Sheeran, Dr Anne Stephens, Dr Georgina Sutherland, Professor Angela Taft, Dr Laura Tarzia, and Molly Wellington. Papers published in 2019 and 2020 that involve Australian qualitative research include:

Buchanan, F., & Humphreys, C. (2020). Coercive Control During Pregnancy, Birthing and Postpartum: Women's Experiences and Perspectives on Health Practitioners' Responses. *Journal of Family Violence*, 1-11.

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Acknowledgment to Women With Disabilities Australia (WWDA) and other women with disability advocacy organisations. They continue to platform the voices of women with disabilities who have experienced forced contraception, forced sterilisation and broader forms of reproductive coercion

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[212] The Queensland Death Review indicates that the presence of coercive controlling behaviour was an early symptom of many of the fatal DV instances considered in the review. As such it is worth exploring if and what behaviours associated with reproductive coercion can be used as an early indicator of escalating violence.

[213] Douglas, H., Sheeran, N., & Tarzia, L. (2020). Reproductive Coercion and Legal Recognition: Views of Domestic Violence Support Workers and Lawyers. *International Journal for Crime, Justice and Social Democracy*, *9*(3).

[214] The National Women's Heath Strategy 2020-2030 is currently in draft form for stakeholder consultation. The draft plan includes a section on Sexual and Reproductive Health and a section related to IPV. Reproductive coercion should be considered within these two sections of the plan.

[215] The Australian Government Department of Health. National Women's Health Strategy. 2019; 43.

[216] The Lancet Guttmacher Commission report, Accelerating progress – sexual and reproductive health and rights for all, highlights the importance of national sexual and reproductive health plans in order to address sexual and reproductive health, gender equality, women's health and wellbeing, maternal, newborn, child and adolescent health as well as to promote overall health and wellbeing.

[217] Marie Stopes Australia. Situational Report on Sexual and Reproductive Health Rights. https://resources.mariestopes.org.au/SRHRinAustralia.pdf. Accessed 12 November 2020.

[218] The Marie Stopes Australia Choice Fund is a philanthropic fund set up by Marie Stopes Australia in October 2017 to support women accessing abortion and contraception care who are experiencing severe financial and other hardship: https://www.mariestopes.org.au/donate/. For further information on the Choice Fund, read the Marie Stopes Australia Impact Reports: https://www.mariestopes.org.au/about-us/our-impact/

[219] This research collaboration aims to amplify the voice of the client, with the objective of building strong-evidence based improvements for their abortion care experience and outcomes. This research program has three stages: qualitative investigation of women and pregnant people's expectations and experiences of abortion care; development of predictive pathways that personalises abortion care to client needs; and translation of this research into practice within an Implementation Science Framework.

Further information and feedback

If you would like to know more about the work that we do at Marie Stopes Australia, you can follow us on social media or get in touch via the following channels.

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