

Women's Health Victoria submission on addressing reproductive coercion

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This submission is endorsed by:



Reproductive coercion

Submission prepared by Women's Health Victoria

Introduction

Women's Health Victoria (WHV) congratulates Marie Stopes Australia (MSA) on prioritising this important, though often little understood, form of violence against women.

WHV has been proud to work closely with MSA on some recent initiatives to draw attention to the issue of reproductive coercion, and what can be done to address and prevent it in Australia. Such initiatives have included a presentation made by WHV to key MSA staff in 2017, participating in the excellent conference discussion hosted by MSA as part of the Children by Choice conference held in Brisbane in August 2017, and involvement in the resultant media coverage.

This submission provides an opportunity to explore the issue of reproductive coercion, and how it may be prevented, in greater depth. As a health promotion organisation, WHV has particular expertise to offer in relation to primary prevention, gender equity and strengthening service delivery for women.

More specifically, this submission focuses on:

- Understanding the prevalence and dynamics of reproductive coercion, including how reproductive coercion can be experienced differently by different groups of women
- Understanding how reproductive coercion can be prevented and addressed in Australia, including the need to integrate reproductive coercion into existing gender equity, sexual and reproductive health and prevention of violence against women strategies
- What MSA can do to address reproductive coercion as well as other forms of violence against women, including screening and risk assessment, data collection and advocacy.

We would also draw your attention to the submission prepared by the Victorian rural women's health services, who have worked together to identify the specific issues affecting the experience of reproductive coercion for women in regional and rural areas.

We look forward to further collaboration and discussion with MSA and other cross sector experts and stakeholders on this important though neglected area of women's health.

About Women's Health Victoria and women's health services

WHV is a statewide women's health promotion, information and advocacy service. We work collaboratively with women, health professionals, policy makers and community organisations to influence systems, policies and services to be more gender equitable to support better outcomes for women.

As a statewide body, WHV works with the nine regional and two other statewide services that make up the Women's Health Association of Victoria (WHAHV).¹ The women's health services network offers a unique approach to women's health across the state by providing an infrastructure which focuses on gender equality, health promotion and improving women's health outcomes.

Preventing violence against women and improving sexual and reproductive health outcomes have been longstanding priorities for all Victorian women's health services, including WHV, for many years. Together, women's health services have led statewide and regional efforts, contributing to the evidence base for effective interventions and the development of key frameworks and strategies in relation to the prevention of violence against women, gender equity and sexual and reproductive health.

Working from a statewide perspective, with a mandate to focus on both violence against women and sexual and reproductive health, WHV is well positioned to identify key service and policy gaps for women. This enabled us to identify and prioritise the issue of reproductive coercion and raise it with MSA, as Australia's leading provider of key sexual and reproductive health services for women, in particular, abortion and contraception.

1. Prevalence and dynamics of reproductive coercion

Reproductive coercion is most often described as a form of intimate partner violence whereby the perpetrator (most often a male) uses manipulation, sabotage or coercion to deny women reproductive autonomy and the ability to leave a violent relationship. Common forms of reproductive coercion include sabotaging birth control, refusing to use contraception while coercing sex, forcing a woman to continue a pregnancy (coerced pregnancy) or to have an abortion. Women and girls with disabilities are subjected to fertility control in the form of forced contraception.²

Like other forms of intimate partner violence against women, reproductive coercion is used as a tool of control, used to increase dependency and limit a woman's ability to have contact with others, leave a relationship or engage in study or paid work outside the home. Reproductive coercion therefore intersects with other forms of violence against women including financial abuse and emotional abuse. Reproductive coercion can be the only form of violence a woman experiences, or it can part of a much larger, ongoing experience of violence, including sexual, physical or psychological violence. The underlying driver for all forms of violence against women is gender inequality. See [Change the Story](#) for more information about the drivers of violence against women.

Pregnancy and early years of motherhood are periods of increased risk for experiencing assault from a partner for the first time, or an increase in the form or intensity of violence.³

Lou, 34, was pregnant to her violent ex-partner. For weeks he oscillated between two extremes: one day threatening Lou with violence if she continued the pregnancy and saying

¹ The three statewide services are *Women's Health Victoria*, the *Multicultural Centre for Women's Health* and the *Royal Women's Hospital*. The nine regional services are *Women's Health and Wellbeing Barwon South West*, *Women's Health Grampians*, *Women's Health Loddon Mallee*, *Women's Health Goulburn North East*, *Gippsland Women's Health Service*, *Women's Health West*, *Women's Health in the North*, *Women's Health East* and *Women's Health in the South East*.

² Women with Disabilities Australia (2016) Position Statement 4: Sexual and Reproductive Rights. Available from: URL <http://wwda.org.au/issues/sexualit/sr2016>

³ Australian Institute of Family Studies (2015) Domestic and Family Violence in Pregnancy and Early Pregnancy. Available from: [URL](#)

he'd pay for her to access an abortion, and the next withdrawing the money and pleading with her to make a family with him. The day before her appointment for an abortion, he gave a final refusal to help her pay for it but said he would punch her in the stomach until she miscarried unless she got it "sorted".

-'Lou' contacted Children by Choice for assistance in 2014.⁴

Importantly, the term 'reproductive coercion' can also be used to describe when women are forced into particular reproductive outcomes by other actors, such as parents, health professionals, or the state (this distinction is explored in more detail below). It can also take the form of denying women access to safe, affordable and legal abortion services, forced contraception and forced sterilisation.

More research and regular data collection is needed before we can accurately judge the prevalence of reproductive coercion in Australia. However, we do have a clear picture of the prevalence of violence against women, of which reproductive coercion is a common form. We know that pregnancy is a time of heightened risk for intimate partner and family violence, and that violence often begins during pregnancy. We also know that forced contraception can mask abuse in families, institutional settings or in the wider community, resulting in underreporting and a failure to recognise and respond to such abuse.

Intimate partner violence against women is characterised by the male partner wishing to exert control and dominance over the female partner. During pregnancy women often begin to receive more attention from friends, family and health professionals. Gender expectations and stereotypes are also heightened at this time. In this context, it is speculated that perpetrators use reproductive coercion to re-exert their control and dominance over their female partners.

Women's Health Goulburn North East undertook ground breaking research into rape in the context of domestic violence as early as 2008, specifically focusing on the experiences of rural women, Aboriginal women and partner rape. The report confirmed that pregnancy was a time of increased risk for experiencing violence from a partner, including sexual violence and rape.⁵

While more research is needed, intimate partner violence is associated with a range of poor sexual and reproductive health outcomes for women. These include being at a greater risk of unintended pregnancy, repeat abortions, second-trimester abortions, and sexually transmitted infections (STI).⁶ Women who experience violence in their relationships are more likely to be coerced into risky behaviours such as inconsistent condom use, which puts them at greater risk of STI. Additionally, women exposed to intimate partner violence are less likely to disclose an STI to a partner due to fear.⁷

Key data summary

- Violence against women is the leading contributor to ill-health, disability and death for Australian women aged between 18-44 years. Its contribution to the overall burden of disease is greater than tobacco use, high cholesterol or use of illicit drugs
- 1 in 3 Australian women has experienced physical violence from a current or ex-partner and women are *at least* 3 times more likely than men to experience intimate partner violence, and 5 times more likely to require medical attention or hospitalisation

⁴ Children by Choice (2014) Domestic Violence in Australia: Submission to Finance and Public Administrative References Committee. Available from: [URL](#)

⁵ Women's Health Goulburn North East (2008) Raped by a Partner: A Research Report. Available from: [URL](#)

⁶ Planned Parenthood Federation of America (2012) Intimate Partner Violence and Reproductive Coercion Fact Sheet. Available from: [URL](#)

⁷ Planned Parenthood Federation of America (2012) Intimate Partner Violence and Reproductive Coercion Fact Sheet. Available from: [URL](#)

- Women with a disability experience higher rates of violence than both men with a disability and women without a disability
- Immigrant and refugee women experience a broad range of different forms of family violence, including violence that is associated with, and exacerbated by, some of the social and structural consequences of migration and settlement, for example, precarious visa status.
- Violence against immigrant and refugee women tends to be long-term, and in some cases includes multi-perpetrator violence from members of the extended family or close community. In multi-perpetrator violence family members encourage or support the male partner's control and abuse of female partners (Chaudhuri et al 2014).
- Aboriginal and Torres Strait Islander women experience higher rates and more severe forms of violence⁸ and are at a greater risk of experiencing domestic and family violence during pregnancy⁹
- Young women aged 18-24 experience significantly higher rates of physical and sexual violence than women in older age groups. Young women experience the highest rates of violence of any age group.¹⁰
- Pregnancy is a particular risk factor for violence: almost one in four women (22%) experiencing partner violence have experienced it during pregnancy, and 13% of those women were pregnant when the violence started (Australian Bureau of Statistics 2013).
- A 2010 study found that 35% of women attending a family planning clinic in the USA had experienced reproductive control, which included contraception sabotage and pregnancy coercion.¹¹
- 2015 research in Queensland has found that 'almost 40% of clients reporting sexual violence also report domestic violence, highlighting the prevalence of forced sex within ongoing relationships that are also abusive in other ways'.¹²

In 2015 WHV prepared a research summary of relevant current literature and resources related to identifying and responding to reproductive coercion, including some examples of resources for health professionals. You can access our 'Connector' on Reproductive Coercion [here](#).

Reproductive coercion exists at the 'intersection' between sexual assault, domestic violence and sexual and reproductive health. Responding to the health impacts of reproductive coercion – whether in terms of decision making in relation to pregnancy, accessing abortion or choosing contraception – has traditionally fallen to the sexual and reproductive health service system, rather than the family violence service system. Similarly, if reproductive coercion occurs in the context of sexual assault, the response may come primarily from the sexual assault service system. The need for an integrated response to reproductive coercion is explored in greater detail in section 3.

2. Reproductive coercion outside of intimate partner violence

⁸ Our Watch, VicHealth and ANROWS (2015) Change the Story: A shared framework for the primary prevention of violence against women and their children in Australia. Available from: [URL](#)

⁹ Taft, A, Watson, L., & Lee, C. (2004). Violence against young Australian women and association with reproductive events: A cross sectional analysis of a national population sample. *Australian and New Zealand Journal of Public Health*, 28(4), 324-329.

¹⁰ Our Watch, VicHealth and ANROWS (2015) Change the Story: A shared framework for the primary prevention of violence against women and their children in Australia. Available from: [URL](#)

¹¹ Australian Institute of Family Studies (2015) Domestic and Family Violence in Pregnancy and Early Pregnancy. Available from: [URL](#)

¹² Children by Choice (2017) Violence and Pregnancy. Available from: [URL](#)

Reproductive coercion means denying women autonomy over their reproduction, including forcing a woman to become pregnant or continue a pregnancy against her will, or forced abortion. While this submission focuses on reproductive coercion at the individual level (usually between intimate partners), other actors (including extended family members and health professionals) can prevent women from having reproductive autonomy, including through forced contraception, forced sterilisation, infanticide and the forced removal of babies and children from their mothers. Indeed, for most of history most women had no, or very little, control over their fertility.

Both historically and today, particular groups have been the target of reproductive coercion from health professionals and/or the state. Such groups include but are not limited to: single/unwed mothers, women and girls with disabilities, Aboriginal women and girls, intersex people and women from newly arrived, refugee and migrant backgrounds. Such experiences include the forced removal of babies from Aboriginal women and communities resulting in the Stolen Generation, forced marriage and forced sterilisation. Women with Disabilities Victoria is aware that women with cognitive disabilities are commonly administered contraception without evidence of supported decision making. More broadly, limited access to affordable contraception and abortion continues to force many women to continue pregnancies. This is particularly true for women in rural areas and women with low income.

3. How can reproductive coercion be prevented and addressed?

Whether perpetrated by the state, health professionals or intimate partners, reproductive coercion constitutes a form of violence against women, with profound consequences for women's health, autonomy, and ability to participate in society.

Despite this, reproductive coercion has been neglected in terms of policy development and law reform, perhaps because it sits at the intersection between domestic violence, sexual and reproductive health, and sexual assault, each sector having its own distinct and separate history of policy development and service delivery.

"If a woman is trying to access a refuge in the middle of the night it doesn't feel like the right time to ask her about her contraception because her first priority is emergency accommodation.

In a reproductive or sexual health setting someone who does STI screenings or Pap smears is focused on providing that specific clinical service.

Sexual assault support workers might be providing support to women who experienced assault many years ago, so it doesn't feel like the right time to ask about reproductive coercion."¹³

For example, in Victoria we now have statewide government strategies in place for [violence against women](#), [gender equity](#), [prevention of violence against women](#) and [sexual and reproductive health](#) respectively. Each of these strategies represents a considerable step forward, yet none specifically addresses or identifies the issue of reproductive coercion.

These frameworks, in addition to the national framework for the prevention of violence women, [Change the Story](#), are incredibly useful for addressing and preventing other forms of violence against women. Integrating strategies to address reproductive coercion within these existing frameworks would be an efficient way to 'mainstream' awareness of reproductive coercion at the national and state level. At the same time, new, specific and tailored interventions and resources, specifically targeted at reproductive coercion, will also be required.

¹³ Excerpt from: Gina Rushton (2017) This is how violence is cutting off reproductive choices, BuzzFeed. Available from: [URL](#)

In order to prevent all forms of violence against women, we need to challenge the underlying drivers. Generally, this means:

1. Challenging condoning of violence against women
2. Promoting women's independence and decision making
3. Challenging gender stereotypes and roles
4. Strengthening positive, equal and respectful relationships¹⁴

In relation to reproductive coercion, the underlying drivers are the same, but relate more specifically to women's reproduction. It is important to address the attitudes, norms and structures that specifically enable reproductive coercion as a form of violence against women. For example:

- **Challenging condoning of reproductive coercion** by challenging attitudes and beliefs that minimise forms of reproductive coercion, such as 'stealthing' (removing a condom without a partner's knowledge), or that deny women's physical autonomy (for example, the attitude that the male partner is entitled to just as much of a say as the pregnant woman as to whether or not the pregnancy will continue).
- **Promoting women's independence and decision making** by decriminalising abortion across Australia, increasing access to timely abortion and contraception and incorporating and normalising positive messages such as 'her body, her choice' in education programs and campaigns. Specific strategies should be developed to ensure health professionals enable and reinforce women's independence and autonomy in relation to pregnancy and contraception.
- **Strengthening positive, equal and respectful relationships** by integrating discussion about family planning, sex, consent and equitable parenting into existing respectful relationships and sexual health education programs, as well as early parenting programs, and ensuring such programs are inclusive.

Notably, the Victorian Royal Commission into Family Violence also made specific recommendations in relation to the integration of the sexual assault and family violence service systems. Specifically, the Royal Commission highlighted the need for funding to facilitate collaboration across specialist family violence and sexual assault services to ensure an integrated response. An integrated response would include: promoting and, if necessary, resourcing shared casework models; establishing secondary consultation pathways; developing guidelines and protocols for facilitating information sharing; and participating in joint education and training.¹⁵ There is an opportunity to leverage this work to explore how relevant services can work together to provide an effective and consistent response to reproductive coercion.

Adapting and tailoring existing gender equity, sexual and reproductive health and prevention of violence against women strategies to incorporate reproductive coercion (from primary prevention, to early intervention, response and recovery) are key strategic actions that should be taken to address reproductive coercion. Funding and advocacy involving government as well as service providers will be required for the development of new resources and training for workers across all sectors to support them to integrate consideration of reproductive coercion within their current practice and processes. This could be supported by the development of cross sector 'communities of practice' brought together specifically to support an integrated approach to reproductive coercion.

Other key strategies include:

- Fostering cross sector 'buy in' by developing shared language, concepts, processes, tools and frameworks for service providers
- The establishment of coordinated processes for data collection
- Resourcing women's health services in Victoria, and equivalent or related organisations in other states, to advocate with their partners and local networks, and to develop training and resources for health professionals with particular emphasis on development of resources

¹⁴ Our Watch, VicHealth and ANROWS (2015) Change the Story: A shared framework for the primary prevention of violence against women and their children in Australia. Available from: [URL](#)

¹⁵ Royal Commission into Family Violence (2016) Summary and Recommendations. Available from: [URL](#)

appropriate to increasing understanding of, and support for, Aboriginal women, women with disabilities and women from newly arrived and migrant backgrounds. The Multicultural Centre for Women's Health (MCWH) has been conducting research in this space and is keen to contribute to data collection and evidence-based interventions.¹⁶

- Establishing partnerships between service providers and academics to develop a robust evidence base for best practice, evaluation and to measure change over time
- Acknowledging and leveraging the leadership and expertise developed by women's services such as Children by Choice and Women's Health Victoria who have been advocating for increased attention to the issue of reproductive coercion for many years

4. What can Marie Stopes Australia do?

The Victorian Royal Commission into Family Violence found that health professionals are in a unique position to identify and respond to family violence and violence against women. In particular, the [Commission's Final Report](#) identified that some victims will not contemplate engaging with a family violence service but will interact with health professionals at times of heightened risk, for example, during pregnancy. Furthermore, failing to identify signs of family violence or minimising disclosures by patients can have a profound impact on victims and deter them from seeking help in the future.¹⁷

The Commission made several recommendations for the health sector going forward, including whole of workforce family violence risk assessment training and fostering coordinated, cross sector interventions.¹⁸

As Australia's leading provider of comprehensive sexual and reproductive health services for women, particularly in relation to contraception and abortion services, Marie Stopes Australia is pre-eminently placed to introduce strategies to both prevent and respond to violence against women, and reproductive coercion specifically. The fact that MSA is also an international leader means that it is well placed to leverage and share findings and interventions developed and tested in Australia, and to contribute to the international evidence base.

Below are some practical suggestions MSA may like to consider, across the spectrum from primary prevention, to early intervention and response.

Primary Prevention - addressing gender inequality as the underlying driver of all forms of violence against women to stop violence before it occurs.

- Embed gender equity and the prevention of violence against women in the workplace culture and processes of MSA, both in terms of its internal culture and its interactions with women. A range of programs for the primary prevention of violence against women are offered by women's health services that can assist MSA to undertake this work.
- Be guided by the voices and experiences of service users and cautious of others assuming decision making roles. In particular, develop awareness of the inequities experienced by groups of women particularly at risk of loss of autonomy over their bodies, for example women with disabilities.
- Collect data so that we are able to more accurately gauge the prevalence of reproductive coercion and measure change over time
- Provide training to staff and health professionals about the centrality of women's reproductive autonomy, with a focus on challenging discriminatory or harmful attitudes that may lead health professionals to stereotype or target specific groups of women, such as women with disabilities, for specific interventions.

¹⁶ MCWH undertook a nationally funded research project in partnership with University of Melbourne and University of Tasmania to better understand immigrant and refugee women's experiences of family violence in Australia. Findings from this study included testimony relating to sexual and reproductive coercion. MCWH is now further analysing the research data for findings specific to sexual and reproductive coercion, with a view to developing a more detailed position, recommendations and understanding of the specific issues involved and barriers to support.

¹⁷ Royal Commission into Family Violence (2016) Summary and Recommendations. Available from: [URL](#)

¹⁸ Royal Commission into Family Violence (2016) Summary and Recommendations. Available from: [URL](#)

Early Intervention – changing the trajectory for people at risk

- Introduce simple, routine, non-invasive screening questions into your intake process for all service users. For example, *'Is there anything else I should know about how you came to your decision?'* *'Are there other factors impacting your choices and decisions that we haven't talked about?'* or *'Do you feel safe and supported in your decision?'*
- Ensure all resources and screening questions are sensitive and responsive to all women, particularly women with disabilities, Aboriginal women, young women and women from migrant and refugee backgrounds
- Use existing tools, such as the resources developed by Children by Choice for health professionals, and develop and test new tools and resources as needs or gaps are identified.
- Include basic training about violence against women, risk assessment and reproductive coercion in induction processes for all staff (and board members)
- Develop and maintain critical cross referral and support pathways for women, in recognition that pregnancy is a high-risk time for violence.

Response – supporting survivors and holding perpetrators to account

- Introduce policies and processes to support women/service users impacted by reproductive coercion. For example, women experiencing reproductive coercion may appear disorganised or unsure, they may arrive late to appointments or not have all the money they need. These women can often be perceived negatively by health professionals and staff. MSA should consider what extra steps could be taken or supports offered to women in these circumstances, including possible fee reductions, etc.
- All MSA staff should be able to recognise and respond appropriately and supportively to women experiencing violence, including reproductive coercion, or who may have experienced it in the past. As mentioned above, one in three women in Australia have experienced violence from a male partner or ex-partner. The experience of intimate partner violence can have lifelong effects. The experience of unplanned pregnancy and pregnancy termination is often difficult and complex, and women may be at their most vulnerable and in need of understanding when interacting with MSA
- Ensure that training and processes are in place to ensure that all MSA staff are equipped to assess and respond to immediate safety risks for patients and staff
- MSA will also come into contact with perpetrators. Staff should be supported to manage risk and perpetrators appropriately and should avoid unintentionally colluding with perpetrators. Organisations such as the Men's Referral Service and No to Violence have significant expertise to offer in this area.