Women's Health VICTORIA

August 2018

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Addressing Reproductive Coercion

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Women's Health Victoria's feedback on *Hidden Forces,* Marie Stopes Australia's draft white paper on reproductive coercion

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This submission is endorsed by

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1. Introduction

Women's Health Victoria (WHV) congratulates Marie Stopes Australia (MSA) on the release of your draft white paper *Hidden Forces: Shining a Light on Reproductive Coercion.* WHV was pleased to have raised the issue of reproductive coercion with MSA in 2017 and is delighted to see how far the national conversation on this topic has developed since that time. We support MSA continuing to take a national leadership role as a key provider of sexual and reproductive health services, particularly abortion and contraception, across Australia.

WHV's previous submission to MSA on this topic provided a more detailed exploration of the prevalence and dynamics of reproductive coercion, and how it might be prevented both at the interpersonal and state levels. Our submission was endorsed by 14 other organisations, including a number of Victorian women's health services. In addition, Victoria's rural women's health services made their own joint submission highlighting the evidence and factors that influence the experience of reproductive coercion for women in rural areas.

The draft white paper takes a comprehensive approach, informed by the large number of submissions MSA received from organisations with differing and complementary expertise. As a result, there is now an opportunity to refine the key themes and messages of the white paper, in order to maximise its impact and usefulness both to service providers and policy makers.

This document aims to briefly highlight what we see as the key considerations or principles which we believe should be given clearer prominence in the final version of the white paper. Finally, we have also included some specific recommendations for additional content.

2. The need for a stronger emphasis on reproductive coercion as a form of intimate partner violence

WHV's submission was one of many submissions highlighting that, in addition to interpersonal reproductive coercion by intimate partners in the content of domestic violence, reproductive coercion can also be perpetrated or facilitated by other actors including the state, health professionals, parents and carers. Organisations such as MSA and Victoria's women's health services have a longstanding commitment to advocating for legislative change to ensure that abortion is legal, accessible, affordable and de-stigmatised.

Currently the white paper gives significantly more space to discussion of structural reproductive coercion outside of the intimate partner context (such as abortion legislation) than it does to discussion about the lived reality of reproductive coercion in intimate relationships, and how to best respond to and support those affected. A greater distinction could be made between interpersonal

and structural reproductive coercion in the white paper, whilst acknowledging the links between both forms, and acknowledging that many women will be subjected to both forms at once.

Giving interpersonal reproductive coercion greater attention is important because reproductive coercion is a neglected, prevalent and serious form of violence against women. Violence against women continues to be the leading preventable contributor to death and disability for women of reproductive age in Australia and most often takes place in the context of intimate heterosexual relationships. The current draft paper includes only half a page (in a document of over 50 pages) specifically focusing on the intersection between reproductive coercion and domestic violence/intimate partner violence. This represents a missed opportunity to raise awareness about the particular dynamics and risk factors for domestic violence that are associated with pregnancy, and to obtain 'buy in' from the domestic violence sector who play a critical role in identifying and responding to reproductive coercion. Reproductive coercion should be clearly framed as a form of domestic violence/violence against women which, alongside other tactics, is used by perpetrators to maintain control over their female partners or ex-partners.

In particular, it would be beneficial to see a deeper and more detailed engagement with how pregnancy intersects with intimate partner violence, including pregnancy as a time of increased risk of violence, and the role of sexual and reproductive health, maternal child health and domestic violence service providers (and others), in identifying reproductive coercion, appropriately assessing risk, and providing appropriate referral information, as part of their day to day service provision.

Consideration could also be given to including the voices of women who have experienced reproductive coercion from an intimate partner. Of course, this could be achieved by drawing on existing qualitative literature rather than necessarily asking women to share their stories in detail in the context of receiving sexual and reproductive health services. When discussing various forms of reproductive coercion with service users or others it is important to be aware that the experience of being coerced by a partner into continuing or terminating a pregnancy in the context of a violent or controlling relationship is very distinct from the experience of not being able to access or afford an abortion in your state (even if both amount to reproductive coercion, and share the same drivers – linked to a broader context of gender inequality).

3. The opportunity and need for reproductive coercion to be integrated into local violence against women and primary prevention strategies

The white paper discusses a number of theories and models that can help to inform the way reproductive coercion is conceptualised, such as the inner and outer world dimensions articulated in Harms' model. However, if part of the white paper's purpose is to mobilise community action to address and prevent reproductive coercion as a form of violence against women, clearly linking or contextualising reproductive coercion within existing, well recognised and practical Australian frameworks may be a more effective approach.

For example, we now have a national framework for the prevention of violence against women, *Change the Story*, and in Victoria we have statewide government strategies in place for family violence , gender equity, prevention of family violence and violence against women and sexual and reproductive health. While none of these frameworks specifically identify the issue of reproductive coercion, they are incredibly useful for raising awareness about gender equity and domestic violence, mobilising community action and distinguishing between primary prevention and response. Advocating for the integration of reproductive coercion within these frameworks (or future versions) should be a high priority, particularly given that many service providers, researchers and policy makers are already using the *Change the Story* framework. 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 and maximise 'buy in', providing shared language, concepts, processes, tools and frameworks for service providers.

4. Clearer articulation of the gendered nature of reproductive coercion

As explored in our previous, more detailed submission, it is important to understand and recognise that different groups of women have and may continue to experience reproductive coercion differently. As we wrote in our previous submission:

> 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 regardless of their wishes. 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.

It is critical to acknowledge that interpersonal reproductive coercion most often occurs in the context of domestic violence, where the overwhelming majority of perpetrators are men and the overwhelming majority of victims are women (i.e. in heterosexual presenting relationships). Significant forms of reproductive coercion such as forced pregnancy, forced abortion or forced continuation of a pregnancy are overwhelmingly experienced by women. Often these forms of reproductive coercion have life-long impacts. Reproductive coercion is also gendered because it occurs in a broader social context of gender inequality where women have unequal access to power, resources and opportunities over the course of their lives, and are seen as having the primary responsibility for caring for children.

It is also important to acknowledge the specific impact that reproductive coercion can have on people with intersex variations and transgender people, which can also include forced pregnancy, forced abortion or forced continuation of a pregnancy. All those affected by reproductive coercion should be able to access sensitive and supportive health care that is responsive to individual needs and considerations.

> 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.[1]

The paper rightfully acknowledges the differing experiences and forms of discrimination experienced by LGBTIQ people in regard to sexual and reproductive health. However, highlighting marriage

[1] Excerpt from WHV's previous submission. Women with Disabilities Australia (2016) Position Statement 4: Sexual and Reproductive Rights. Available from: URL http://wwda.org.au/issues/sexualit/sr2016

inequality as the ‘ultimate’ example of reproductive coercion experienced by LGBTIQ people should be reconsidered for the following reasons.

Firstly, as discussed above, it is useful to distinguish between interpersonal reproductive coercion, and structural reproductive coercion. Many lesbian, bisexual and gender non-conforming women have experienced interpersonal reproductive coercion such as forced pregnancy or forced abortion by partners or ex-partners, and/or as a result of sexual assault by a male non-partner. Furthermore, other structural factors, aside from marriage equality, continue to limit LGBTIQ people’s reproductive autonomy.

The challenge is balancing what we know to be the breadth of reproductive coercion (including structural factors such as marriage inequality and legalisation of abortion) without losing a focus on interpersonal reproductive coercion.

Specific recommendations

Formalising the evidence base

As noted in the white paper, there is a lack of coordinated, up to date evidence about the prevalence, nature and dynamics of reproductive coercion in Australia. Indeed, this makes MSA’s leadership on the issue all the more timely and important.

The white paper states that MSA received 19 submissions from academics, service providers and women’s health advocates, each specifically addressing reproductive coercion from various perspectives and with various complementary emphases. WHV suggests that MSA consider bringing together and publishing the submissions in a compendium that accompanies or serves as background to the white paper. A data summary outlining the current evidence that does exist relating to the prevalence of reproductive coercion in Australia would be particularly valuable.

The Law (section 6.4)

Section 6.4 of the white paper titled ‘the Law’ should be more detailed. For example, whilst different legislation exists state by state, it is likely that reproductive coercion would, at least theoretically, be covered under existing family violence law across Australia.

For example, the Victorian Family Violence Protection Act 2008 specifies that family violence includes spiritual, psychological and emotional abuse, which would be pertinent to many women’s experiences of reproductive coercion. Where a perpetrators uses direct physical violence to end a partner’s pregnancy, the use of physical violence would be covered by the Act. However, whether the remedies outlined in the Act, such as apprehended violence orders, are suitable for responding specifically to reproductive coercion is an interesting issue deserving further discussion (access to free, timely health care may be more useful or a higher immediate priority for women in these situations). However, reproductive coercion is unlikely to be the only form of coercion or violence that the woman is experiencing. A holistic, integrated response from services that addresses women’s health and safety needs and supports her full recovery is ideal.

It would be useful for the paper to explore these considerations in more detail. The current mention of attitudes to consent (page 43) shifts the focus to sexual assault rather than reproductive coercion specifically.

The specific history of Marie Stopes

Marie Stopes International is a longstanding world leader in championing women's access to family planning information, contraceptive options and pregnancy termination and there is much to be proud of and celebrate in the history of Marie Stopes International.

However, it may be worth considering acknowledging that Marie Stopes herself was associated with social movements and attitudes that would now be considered highly problematic and linked to reproductive coercion, particularly the eugenics movement of the early twentieth century. Including a reflection on the history of how MSA has engaged with the issue of reproductive coercion, or has considered issues such as intimate partner violence or forced sterilisation in the past, would be an important and authentic addition to the paper. This would also present opportunities for Marie Stopes International to identify and reconcile with groups who may have felt excluded or harmed by past policies.

This might also provide an opportunity for MSA to demonstrate the new actions, policies, and procedures that MSA has put in place, as a key national service provider, in order to more pro-actively screen for, assess and respond to the risk of reproductive coercion as well as all other forms of family violence experienced by MSA service users.

Need for an action plan

The draft white paper and submissions that informed it represent the most comprehensive and up to date examination of the issue of reproductive coercion in Australia. MSA should be congratulated for this achievement. Although the white paper includes a list of specific recommendations, we believe there would be considerable value in the creation of a clear action plan, defining specific actions for all stakeholders (service providers, state and federal and local governments, policy makers and advocates and health professionals). The action plan should include actions such as developing strategic partnerships to support service integration; the development of clear care pathways for women experiencing reproductive coercion and the development of training and integration of reproductive coercion within existing strategies and frameworks for the prevention of violence against women.

Other factors impacting women's reproductive autonomy and access to abortion in Victoria

Notwithstanding the need we have identified to include greater recognition of reproductive coercion as a form of domestic violence and violence against women in the white paper, there are also opportunities to highlight some of the ongoing structural barriers to women's access to sexual and reproductive health services, in particular abortion. These include:

- Ongoing stigma and a lack of knowledge about abortion or abortion services by staff in generalist/community health services including reception staff, ultrasound providers and pharmacists.
- A lack of service provision by public hospitals and a lack of transparency about how to access the services that do exist.
- Lack of affordable and localised abortion provision in settings and areas outside of inner metropolitan cities
- A lack of coordinated, centralised data being collected about conscientious objection and other barriers to access.

Women with disabilities are impacted by all of the structural barriers above, compounded by additional barriers such as a lack of independent access to internet, print and over the phone information.

Concluding remarks

WHV considers that the MSA white paper has the potential to make a significant and timely contribution to discussions and action to address and prevent reproductive coercion, as well as the broader intersection of sexual assault, domestic and family violence and sexual and reproductive health. Our suggestions provide opportunities for the paper to more clearly articulate some of the key issues and considerations which have emerged through the submission process and are critical considerations for policy makers and service providers alike.

We once again congratulate MSA on taking up the issue and 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.