Hidden Forces

Shining a light on
Reproductive Coercion
White Paper

MARIE STOPES
AUSTRALIA

Acknowledgement of Country
Marie Stopes Australia acknowledges the Traditional Owners 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 acknowledge the enduring connection to country and that Australia is, was and always will be Aboriginal land.

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MARIE STOPES AUSTRALIA

SEEK HELP

If you, or someone you know, need help, then the following services are available to assist:

- **1800RESPECT** is a 24 hour national sexual assault, family violence counselling line for all Australians experiencing or at risk of family violence and/or sexual assault. Call toll-free on **1800 737 732**
- **Lifeline** is a 24 hour telephone counselling and referral service, and can be contacted on **13 11 14** or lifeline.org.au
- **Kids Helpline** is a 24 hour free counselling service for young people aged between 5 and 25, and can be contacted on **1800 55 1800** or kidshelponline.com.au
- **Aboriginal Family Domestic Violence Hotline** is a dedicated contact line for Aboriginal victims of crime who would like information on victims' rights, how to access counselling and financial assistance. Call **1800 019 120**
- **MensLine Referral Service** is a 24 service from No to Violence that offers assistance, information and counselling to help men who use family violence. Call **1300 766 491** if you would like help with male behavioural and relationship concerns or visit ntv.org.au
- **Safe Relationships Project** provides men and women who are experiencing domestic violence in same sex relationships with support, advocacy, referral and legal information. Call free number 1800 244 481 for help.

- **Beyond Blue** provides information and support to Australians to achieve their best possible mental health. They can be contacted on **1300 22 4636** or beyondblue.org.au
- **Relationships Australia** provides support groups and counselling on relationships, and for abusive and abused partners. To be connected to the nearest Relationships Australia, call 1300 364 277 (for the cost of a local call) or visit relationships.org.au
- **Our Watch** provides materials on how to report on family violence. Visit ourwatch.org.au/news-media/reporting-guidelines

FOREWORD

Everyone has a right to control their reproductive choices. In Australia, like many wealthy nations, such rights are enshrined in various laws and charters.

However, many Australians do not have full control over their reproductive choices. Their choices are constrained by people in their familial and community networks or by structural forces at play in our society.

Reproductive Coercion is gaining greater attention in Australia. Brave people are coming forward to share stories of their lived experience of Reproductive Coercion in order to build greater understanding of this important issue and how it has shaped their lives.

For twenty months, Marie Stopes Australia has coordinated a public consultation process that has culminated in this White Paper on Reproductive Coercion. I am proud of our organisation's leadership in bringing this issue to light. It has been made possible by the generosity of organisations and individuals across Australia who have shared their knowledge, advice and experience of advocacy on this important issue.

This White Paper has emerged following a roundtable of 50 stakeholders, two phases of public submissions, comment on a draft White Paper and targeted engagement of leading academics, healthcare professionals and psychosocial specialists.

We have received 84 submissions that have informed the development of this White Paper. These submissions have provided a wide spectrum of views on this complex issue. Most are supportive of the conclusions of the White Paper, some are not. We have endeavoured to respectfully take account of the views expressed in submissions to inform the development of the final White Paper.

This White Paper is only one part of a broader effort to address Reproductive Coercion. However, we hope that the information presented in it can be used as a resource for those working to address Reproductive Coercion.

As CEO of Marie Stopes Australia, on behalf of our staff and our clients, I would like to personally thank everyone who has contributed to this White Paper, particularly those who have shared their personal stories.

It is encouraging to see that multiple sectors can come together and respectfully share similar and divergent views on this important subject.

Thank you,

Michelle Thompson

CEO Marie Stopes Australia

CONTENTS

ACRONYMS

CALD	Culturally And Linguistically Diverse
CPD	Continuing Professional Development
CEDAW	The UN Committee on the Elimination of Discrimination Against Women
FV	Family Violence
GP	General Practitioner
ICD	International Classification of Diseases
IPV	Intimate Partner Violence
LARC	Long Acting Reversible Contraception
IPSV	Intimate Partner Sexual Violence
PTSD	Post-traumatic Stress Disorder
RC	Reproductive Coercion
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
SV	Sexual Violence

EXECUTIVE SUMMARY

What is Reproductive Coercion?

Reproductive Coercion (RC) is behaviour that interferes with the autonomy of a person to make decisions about their reproductive health.[1] RC 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.

RC 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]

RC 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 RC. For example, gender inequality, government policy and legislation, workplace practices, limited access to appropriate healthcare and enabling cultural and social norms.

Why Does RC Matter?

RC is a public health issue that negatively impacts on mental health, sexual and reproductive health and maternal and child health.[3] RC 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 RC as an important issue in its own right, there is a compelling public health and safety rationale for exploring how approaches to RC can improve responses to FV, IPV and SV.

About this White Paper

In March 2017, Marie Stopes Australia began a process to explore and raise the profile of the largely hidden issue of RC. During 2017 and 2018, stakeholder engagement and consultation sought to define RC and examine approaches to addressing RC through research, policy and practice. The result is this White Paper, which aims to provide a comprehensive reference resource for those working to address RC in Australia and offers recommendations on addressing RC collaboratively and across multiple sectors.

Terms of Reference

Terms of Reference for this enquiry into RC 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 RC
2. Key approaches to addressing gaps in RC 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 RC.
- The need to explore how RC intersects with FV, IPV and SV.
- The need to simultaneously address gender inequality and RC.
- The importance of contextualising RC across multiple communities: adolescents, Aboriginal and Torres Strait Islanders, culturally and linguistically diverse communities, people living with a disability and men.

- The health impacts of RC, including mental health, sexual and reproductive health, maternal and child health and homicide.
- The role of healthcare professionals in addressing RC, including current support structures and tools, international practices and examples of best practice.
- The structural drivers of RC, including social, cultural, political and economic.
- The law as it currently relates to RC.

Recommendations

In order to address RC 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 RC.
- **Recommendation 2:** Include RC questions as part of the ABS Personal Safety Survey to gain an understanding of prevalence.
- **Recommendation 3:** Develop a national data set for induced abortions through review of the WHO's ICD coding.
- **Recommendation 4:** Explore the concept of RC as an early warning indicator of escalation of IPV.
- **Recommendation 5:** Embed RC in existing and new policies and plans responding to FV, IPV and SV.
- **Recommendation 6:** Develop a national Sexual and Reproductive Health and Rights Strategy that addresses interpersonal and structural drivers of RC.
- **Recommendation 7:** Develop a national healthcare professional training program to address RC in varied healthcare settings.

Next Steps

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

- **Commitment 1:** Implement internal processes and practices to better support people experiencing RC that come into contact with our services.
- **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 RC.

- **Commitment 3:** Continue to engage in advocacy work that aims to reform and expand sexual and reproductive health rights and services to all Australians.
- **Commitment 4:** Lead the application to the World Health Organisation to amend International Classification of Diseases (ICD) coding to ensure more accurate data capture for abortion care in Australia and across the globe.
- **Commitment 5:** Continue to foster an internal workplace culture that is responsive to FV, IPV, SV and RC by providing staff with up to 10 pays paid FV leave each year.

BACKGROUND

History of RC

RC has only recently been identified as an issue impacting people of reproductive age.[6] The term was first 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 of the research on RC since has come from 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 RC as an issue is starting to be uncovered. There is still much to be learnt about RC, and this White Paper seeks to add to the knowledge about the issue both internationally and in Australia.

What is RC?

RC is behaviour that interferes with the autonomy of a person to make decisions about their reproductive health.[9] RC 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.
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RC 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]

RC 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 RC. For example, gender inequality,

government policy and legislation, workplace practices, limited access to appropriate healthcare and enabling cultural and social norms.

Why Does RC Matter?

Having control of one's sexual and reproductive health is vital to overall health and wellbeing as well as to society in general.[11] 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 RC 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.

RC is a public health issue that negatively impacts on mental health, sexual and reproductive health and maternal and child health.[12]

RC is also often associated with Family Violence (FV), Intimate Partner Violence (IPV) and Sexual Violence (SV).[13] On average in Australia, one woman is killed by an abusive male partner each week.[14] There is therefore a compelling public health and public safety reason to explore the issue of RC 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[15] 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 RC 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 RC.

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 RC, led by Children By Choice, Liz Price
- Policy responses to RC, led by then CEO of White Ribbon, Libby Davies
- Practice initiatives responding to RC, 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 RC. As a sexual and reproductive health provider that operates nationally, Marie Stopes Australia is well placed to identify and respond to instances of RC 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 RC.
2. The role of an advocate to increase awareness, understanding and help foster collaborative action to address RC 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, CEO Marie Stopes Australia

PURPOSE & SCOPE

Aims

The purpose and scope of this White Paper were developed through consultation at the initial roundtable at the Children By Choice conference in August 2017.

This White Paper aims to:

1. Capture the most recent research evidence on RC in Australia and internationally.
2. Identify gaps in our knowledge from an Australia context.
3. Articulate the social and public health aspects of RC.
4. Outline recommendations for addressing RC 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 RC, including:
    - International examples, models and screening tools.
    - Existing local referral pathways and support networks.
    - Existing research (local or international) on RC.

2. Key recommendations regarding actions to address gaps in:
    - Research, including compilation of data to assess the scope, scale and concentration of RC 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 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.

APPROACH TO DEVELOPING THE WHITE PAPER

Guiding Principles

RC is a social and public health problem that requires a whole-of-community, intergenerational response. Responses to RC, 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 this White Paper to fruition.

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

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 this White Paper, which is the culmination of 20 months engagement with individuals affected by RC 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.[16]
2. Responding to RC 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 RC, especially stakeholders involved in:

- Health care delivery, particularly women's health, abortion care and broader sexual and reproductive health services.
- RC 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, RC 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 White Paper Terms of Reference.
2. **May 2018 – August 2018:** Draft RC 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 RC.
- The need to draw together the links between RC, FV, IPV and SV.
- 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 RC[17].
- That RC can be driven from an interpersonal and structural perspective.
- That appropriate risk assessment (including screening tools) is developed for RC.
- That responses to RC be culturally appropriate.
- That RC 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 RC.

The following section of this White Paper explores these themes; drawing on both the submissions received and research literature relating to RC, FV, IPV and SV.

THEMES & ISSUES

The need for a definition of RC

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

Finding a workable definition of RC was the most prominent theme emerging from submissions in both consultation phases. Submissions provided by individuals regarding their experiences of RC 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 RC.[18] Definitional debates are also a key feature in much of the Australian research that has been conducted on RC 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 RC 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 RC should capture:

- The intention of the perpetrator to exert power and control over another individual's reproductive rights.
- The experience of the person who is being coerced.
- The interpersonal nature of RC 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 RC.

If we are to fully explore RC in the Australian context we must examine both the interpersonal dimension and the structural factors that enable or support RC. For this reason, we have identified two dimensions of RC: interpersonal RC, and structural RC. 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 RC.

A definition

RC in this White Paper is defined as any behaviour that interferes with the autonomy of a person to make decisions about their reproductive health.[19] RC 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.

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

Interpersonal RC

Interpersonal RC is the deliberate action by an individual to interfere with the autonomous reproductive health decision-making of another person. Interpersonal RC can involve SV and may take place within the context of FV and IPV. RC may be exerted using physically violent or non-violent tactics.[20] The dominant theme is that power and control are exerted on the person experiencing RC.

Structural Forms of RC

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.[21] Social structures that engender respect and equality are associated with better health and wellbeing outcomes for individuals.[22] 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.[23] Applying a Social Determinants of Health approach to RC is important as it helps to uncover some of the underlying drivers of RC.

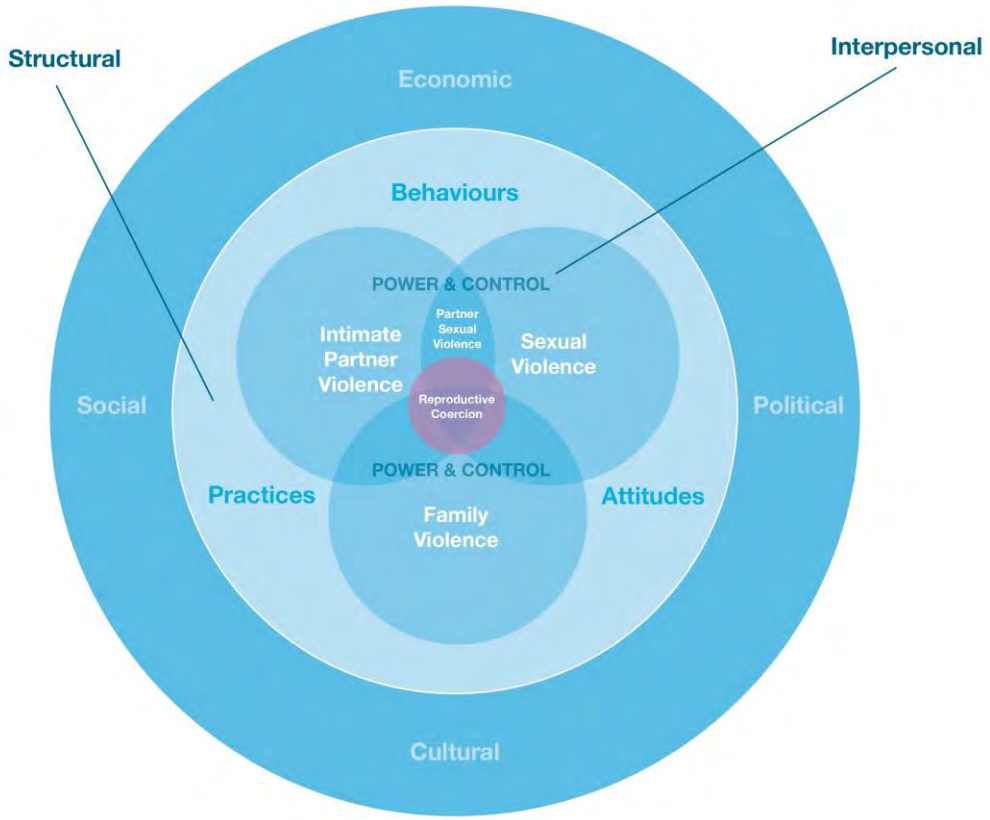
Structural forms of RC are defined as the social, economic, political and cultural norms, practices and policies that interfere with another person's autonomous decision-making in relation to their reproductive health. Examples include:

- 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 RC

The interplay between the interpersonal and structural can best be demonstrated using the model in Figure 1.[24] RC 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 RC 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 RC



Contextualising RC

RC, IPV and SV

While RC intersects with FV, IPV and SV, it is important that RC 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 RC within other forms of interpersonal violence may be due to a range of reasons, including:

- Current stigma that surrounds RC, IPV and SV.
- A lack of understanding of RC that often contributes to RC being viewed as separate from FV, IPV and SV response and prevention measures.
- That RC 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 RC, IPV and FV. North American studies indicate that the vast majority of people who experience RC are women who also experience high rates of FV and IPV.[25] One study shows the rates of IPV and FV at twice the national average when RC is considered.[26]

As a number of submissions stated, RC can and often does appear within the context of IPV.[27] We also know that where a pregnancy is unintended, a woman is four times more likely to experience violence from her partner.[28] On the basis of research and submissions to the current White Paper process, it may be suggested that there is a direct link between RC and pregnancy, particularly unintended pregnancy, and IPV.

It is at the point where a person discloses RC 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 RC.

Marie Stopes Australia accepts and agrees with recommendations from both the research literature and submissions to this White Paper that RC be examined within the context of FV, IPV and SV (including IPSV). Contextualising RC in this way may assist with overcoming the tendency towards conceptual siloes in research agendas, service provision and other RC responses. It is also important that the lived experience of individuals experiencing RC informs the examination of RC 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 privacy**

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

At least two submissions to this White Paper[29] highlighted planned research in this area. Marie Stopes Australia is undertaking research in partnership with the Australian National University (What Women Want in Abortion Care) that will also capture the 'lived experiences' of RC among our research participants. By sharing knowledge generated through these aligned qualitative research projects, we can build a richer picture of the varied lived

experiences of RC that have the potential to inform nuanced and appropriate prevention and response interventions.

SV and Assault

While most of the submissions to the White Paper have detailed the intersection of RC with FV and IPV, there was less discussion of RC 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.[30]

A literature review of RC as sexual assault has shown that while RC 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 defines RC 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.[31]

However, both definitions focus on the intentions of the perpetrator, and much of the behaviours associated with both RC 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 RC are power and control.[32] RC is therefore viewed as closely linked but not identical to SV.

Gender and RC

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

Using a definition of RC that is gender neutral does not preclude the need to apply a gender lens when appropriate. Much of the research on RC in Australia and overseas focuses on cisgender[33] women in heterosexual relationships. Marie Stopes Australia's experience in the area of RC is also predominantly informed by our work with cisgender women in heterosexual relationships, and we will continue to explore and address the influence of gender on RC.

However, we have heeded advice from a number of stakeholders to ensure that the definition of RC is gender neutral, and does not specify the gender or sexual orientation of either partner in a relationship where RC is present. This is particularly important given that a 2014 survey of LGBTQI 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 (WSWM) experienced significantly higher rates of IPV over a lifetime than women who have sex with men (WSM). The same study also showed that WSWM were more likely to be subjected to male-perpetrated RC, high risk sexual behaviour, and unplanned pregnancy and more likely to access regular pregnancy testing without additional corresponding contraceptive measures.[34] The Youth Risk Behaviour Survey, conducted in North America also showed that adolescents who reported same-sex sexual encounters also experienced twice the rate of physical and SV than their peers with opposite sex partners.[35]

Data on the prevalence of RC in the LGBTIQ community is scarce. As part of efforts to address RC in the Australian context, research of the lived experiences of RC should include individuals of diverse sex, sexuality, relationship characteristics and genders, including people of non-binary genders.

Men's experience of RC

In Australia and internationally, RC research and responses focus on male-perpetrator coercion of women's reproductive health decisions. This may be because experiences of IPV, RC and sexual assault are higher among women than they are among men and because most violence against women is perpetrated by men.[36] However, at least two submissions to this White Paper addressed men's experiences of RC by their female partner. There is little research on the male experience of RC although evidence suggests that it does occur and may be equally, or more, prevalent than RC 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 RC. The same study also revealed that 10.4% of men (or 11.7 million) reportedly experienced RC.

Research into the lived experiences of RC 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.

Adolescents and young people

Some research suggests that adolescents are more susceptible to coercion than their older counterparts.[37] Like many other age cohorts, the presence of IPV in adolescent relationship is often correlated with RC and sexual and physical assault.[38] Common examples of RC 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 RC 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, adolescents can also experience RC from other family members such as mothers, particularly in the case of unintended pregnancy.[39]

There is, however, no conclusive evidence that shows younger people or adolescents 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 RC at a rate of 12.5% as opposed to 21.8% for clients in the 20-29 year age bracket.[40] However, a study from North America of 3,539 women accessing family planning clinics in Pennsylvania showed a strong correlation between RC, IPV and sexual assault among young women aged 16-29 years. The likelihood of experiencing RC was also found to be more common

among young women who self-reported lower education levels, 'non-white' ethnicity and previous unintended pregnancy.[41]

Given there is conflicting evidence as to the susceptibility of young people to RC, it is important that this cohort is included in research on the lived experiences of RC. Further, evidence that adolescents often experience RC as their partner's refusal to use a condom suggests a role for RC screening of young people who are regularly accessing termination services, assistance for unintended pregnancies and STI screening and treatment.[42]

Aboriginal and Torres Strait Islander Peoples

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 peoples have been subjected to state-supported structural and interpersonal forms of RC since colonisation.[43] Experiences of RC, 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 Island 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.[44]
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 Island 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 Indigenous women particularly in remote areas.
7. A belief that it is culturally appropriate for Aboriginal and Torres Strait Islander peoples 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 RC have been implemented throughout the history of colonisation and continue to negatively impact the lives of Aboriginal and Torres Strait Islanders. Some academics have suggested that such methods are indicative of a harmful view that Indigenous peoples in Australia are perceived as “less than human”.[45]

Current data shows that Aboriginal and Torres Strait Island 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 (35) 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.[46]

When maternal and infant health is considered, significant disparities in health outcomes between Aboriginal and Torres Strait Islander communities and other Australian

communities exist. These include higher rates of maternal mortality, preterm births, low birth weight and perinatal deaths.[47]

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

RC experienced by Aboriginal and Torres Strait Islander peoples 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 RC in a culturally sensitive way. Such research should seek to give voice to diverse lived experiences of RC 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.[48] Further, the history and ongoing legacy of power and control over Aboriginal and Torres Strait Islander peoples needs to be considered and addressed explicitly in RC 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.[49]

Culturally and Linguistically Diverse People

As a nation made up of people from more than 200 countries, Australia is a culturally diverse place.[50] Research into RC in Culturally and Linguistically Diverse (CALD) communities has shown that coercion often extends beyond the intimate partner as perpetrator to include broader familial structures.[51]

While there is scant research on the experiences of RC and more broadly SV among CALD communities,[52] the limited research available suggests that there are a number of factors that should be considered when exploring the issue of RC and any likely responses and preventative initiatives. These include:

- The importance of shame on an individual, familial and community level[53] can lead to a person's experience being secondary to family and community reputation.[54]

- Language and cultural barriers and a fear of repercussion if RC is reported or raised.[55] [56] [57]
- Uncertain legal status of person experiencing coercion.[58]
- Stress and uncertainty of unemployment and lack of job security.[59]
- Lack of financial resources or access to resources.[60]
- The impact of social isolation.[61] [62]

Recent research indicates that awareness of SV, assault and RC is increasing among some culturally and linguistically diverse communities, although the terminology used to describe phenomena can be confusing for community members.[63] 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.[64] 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 RC in CALD communities.[65] 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 RC or SV. The diversity in interpretation of behaviours and conceptualisation of issues such as RC underscores the need for a richer understanding of the various attitudes and experiences of RC 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.

Volpe et al 2014; Chung 2005

For immigrant and refugee CALD communities in Australia, pre-immigration factors are also likely drivers and enablers of RC, including trauma experienced by both perpetrators and victims of RC.[66] 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.[67]

Structural issues such as Australia's visa policy restrictions also provide an important context within which to explore RC among CALD communities, particularly refugee and recently arrived migrant communities. For example, women who arrive in Australia under a Temporary Protection Visa (TPV) or Safe Haven Visa (SHV) 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.[68]

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 CALD 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.[69] As with other community groups, it is important that these drivers are explored in the context of various lived experiences of RC so that nuanced, culturally respectful and appropriate intervention, response and prevention initiatives can be mounted.

People with a Disability

According to the Australian Bureau of Statistics *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 RC of people with a disability.[70]

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 a 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.[71] 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.[72]

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.[73]

The Inquiry explored multiple examples of RC and the interpersonal and structural forces that interfere with the reproductive health decision-making of people with disabilities 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.[74]

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.[75]

RC 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

RC, 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.[76]

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 RC. Where violence, particularly IPV, occurs alongside

RC, 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.[77]

RC 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 RC include mental health, sexual and reproductive health and maternal and child health impacts,[78] underscoring the important role of healthcare and other service providers working in these fields in identifying instances of RC. 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[79] and our economy[80] so, too would RC. 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 RC, very few outlined the specific public health risks of RC, which may reflect a lack of research into the phenomena. Given the close association between RC and other significant public health issues, such as, FV, IPV and SV, it would appear important that the likely risks associated with RC 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 RC.

Mental Health Impacts

FV, IPV and SV are associated with poor mental health outcomes.[81] Emerging research also suggests a link between poor mental health outcomes and RC. In a study of women in Cote D'Ivoire who reported being subjected to RC, 22% of women reported suffering PTSD.[82] 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.[83]

Research into the mental health impacts of IPV in the United States 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.[84]
- Depression.[85]
- Anxiety disorders.[86]
- Substance abuse disorders, including higher rates of consumption of nicotine, alcohol and other drugs.[87]
- Suicidal tendencies and learned helplessness as a result of perceiving little or no control over their life or relationship.[88]

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.[89]

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.[90]

Further, refusal to use condoms by a partner perpetrating RC 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.[91] People experiencing IPV and/or RC may not seek treatment for STIs given the control exerted on them by the perpetrating partner.[92] Left untreated, STIs can lead to pelvic inflammatory disease, infertility, cancer, poor neonatal health outcomes and potential pregnancy complications.[93]

Unintended pregnancy risks are also higher for people who experience RC and/ or IPV.[94] Research from the United States showed that 1 in 4 women accessing family planning clinics had experienced some form of coercion or IPV.[95] In Australia, data on women accessing counselling services provided by Children By Choice showed that clients experiencing RC or IPV were more likely to present for a termination at a later gestation than

those who did not experience violence.[96] 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 RC 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 RC.
- A suite of discrete contraceptive options and accompanying contraceptive counselling to be available to clients at risk of RC.

There are a number of warning signs that can indicate RC, 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.[97]
- Multiple, frequent diagnoses of STIs.[98]
- Frequent requests for emergency contraception or pregnancy testing[99]; and
- Multiple abortions over a short space of time.[100]

Maternal and Perinatal Health Impacts

Little research has been conducted specifically on the impact of RC 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.[101]
- Less likely to make the decision about when to have a baby.[102]
- More likely to seek an abortion.[103]
- At increased risk of STIs including HIV, urinary tract infections, substance abuse, depression and other mental-health issues,[104] with serious implications for maternal and perinatal health.
- More likely to experience pre-eclampsia, preterm delivery, foetal distress and antepartum haemorrhage during pregnancy.

- More likely to have a low birthweight baby.[105]
- Less likely to be able to initiate and sustain breastfeeding of an infant.[106]
- At greater risk of maternal death, death of the foetus or both from trauma.[107]

Studies suggest that pregnancy can also be a time of increased risk of IPV[108] and that women experiencing an unplanned pregnancy are at even greater risk of IPV.[109] 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.[110]

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.[111] While screening for violence in maternal health settings occurs to varying degrees across Australia, RC may be too subtle to identify if it takes place without physical violence.

Homicide

While there is no specific research on possible associations between RC and homicide, there are clear links between IPV, FV and homicide. In the United States, over the course of a ten-year period across 18 States, half of all homicides involving a female victim were related to IPV.[112] In Australia, according to the Australian Institute of Criminology, one woman per week is killed by a current or former partner.[113] 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 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.[114] Given that RC 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*. The review found that of the 105 cases where a female was killed by a male perpetrator, over 12% involved sexual abuse.[115] 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 RC, 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.[116] 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 RC 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.[117]

The role of Healthcare Professionals in Addressing RC

Importance of Healthcare Professionals

Healthcare professionals play a critical role in identifying and responding to RC.[118] 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 RC during their careers.

In primary health care settings, healthcare professionals are exposed to diverse sub-groups of the general population.[119] 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.[120]

While healthcare providers are well placed to respond to RC, there is limited research on how best to address the issue of RC within healthcare settings and with healthcare professionals.[121] The limited research available does suggest a range of barriers to healthcare workers screening for and responding to RC, including:

- Insufficient time particularly in busy healthcare settings.[122]
- Health worker discomfort with the subject.[123]
- Health worker not feeling adequately equipped or prepared for disclosures.[124]
- Lack of known referral pathways for disclosures and patients/ clients seeking help.[125]

Initiatives to engage health workers in RC 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 RC. There are, however, limited tools and no specific guidelines for how to identify and address the issue of RC 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 RC in healthcare settings. In North America, research suggests that screening tools for IPV and RC have had limited uptake, including in sexual and reproductive health settings where there is generally greater investment in screening initiatives.[126] Similarly, education of healthcare professionals coupled with screening has also shown limited effectiveness in improving screening and interventions for IPV.[127] 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 RC.[128] A recent study assessing different methods of healthcare provider education on IPV and RC indicated that knowledge-based training significantly improved communications to patients/ clients about IPV and RC.[129] 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 RC 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, RC. The table at Annex 1 provides an overview of identified resources and initiatives. Forthcoming research on RC 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 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)?; and,
- Would you like help with any of this now?[130]

There are currently no standalone screening tools for RC apart from the program, *Screening to Safety*, developed by Children By Choice. RC is not included in almost all of the current healthcare practitioner tools. Given that behaviours associated with RC may be a sign of potential escalation in violence (and potential lethality),[131] 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 RC in an abortion care settings. Given that the current research from North America shows a strong correlation between people accessing family planning clinics and RC, including abortion care settings, a strong case is made to focus on this healthcare setting.[132]

International Examples of Healthcare Practitioner Resources

One of the most comprehensive healthcare practitioner resources on RC is *the Futures Without Violence Guide for Obstetric, Gynaecologic, Reproductive Health Care Settings* developed by the American College of Obstetricians and Gynaecologists.[133] 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 RC. The guide also provides training links to assist with developing a trauma-informed approach to addressing the issue of RC.

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,[134] which could be a useful resource in development of RC 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 RC.[135] Clearly, even in North America, further work is required to fully and effectively engage health practitioners in screening for and responding to RC.

Engaging Healthcare Practitioners in Australia

In order for healthcare professionals to develop a richer understanding of RC, 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 highlight the need for training to build on existing clinical knowledge and experience related to FV, IPV and RC. Such training would ideally address the use of RC 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[136] within the context of a sexual and reproductive health clinic to test and trial best practice approaches to addressing RC. 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 RC may redirect limited resources away from the FV sector. Given that RC 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 RC. Rather than diverting resources from the FV sector, early identification of RC 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 RC 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.[137] Research from North America has highlighted the importance of healthcare practitioners adopting a trauma-informed approach to discussing and addressing RC with clients. Trauma-informed practice emphasises a non-judgemental approach that ensures a safe, calm and empowering environment is available to the person disclosing RC.

The ARCHES (Addressing Reproductive Coercion in Health Settings) 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; and,
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.[138]

Structural Issues and Drivers of RC

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 RC is based on how RC 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 RC and FV, IPV and SV, it is important that we look at the structural elements that create a permissive environment for behaviours associated with RC.

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

Social Drivers

A number of submissions to the White Paper cautioned against taking a gendered approach to what is largely an unexplored area of interpersonal power and control. While we acknowledge that the study of RC and measures to address it need to take into account the broad spectrum of situations and experiences, this section considers gendered frameworks, models and research that nevertheless, provide a basis for tackling RC on a society-wide level.[139]

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."[140] Further we identify gender as a 'symbolic institution'

where roles are 'performed' and these roles can have a causal link to violence and coercion.[141]

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.[142] 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.[143]

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'.[144] 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.[145] 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.[146]

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.[147]

Addressing Social Drivers

Addressing RC in a social context is complex and requires a significant, intergenerational response.[148] Like FV, IPV and SV, addressing rigid gender roles and challenging the social norms that can enable RC is the first step.

Gender stereotyping is reinforced through media, imagery and language from a very young age.[149] 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.[150] 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 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 adolescence, ideas about gender roles within sexual relationships can influence their susceptibility to RC.[151] Therefore programs that teach respectful relationships and encourage health literacy, self-esteem and shared decision-making about sexual and reproductive health and rights are important.[152]

The media also plays a significant role in both condoning and challenging gender stereotypes[153]. 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.[154][155] 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.[156] Guidelines have also been developed to assist journalist better report on gender issues and challenge gender stereotypes.[157]

There is no one action alone that will address social drivers of RC. 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.[158]

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.

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 RC 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.[159]

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 RC driven by the culture of the community, there are also economic drivers that perpetuate and compound RC[160]. 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".[161] Ella describes how lack of income,[162] 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.[163]

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.[164]

Like the social drivers of RC, addressing cultural drivers of RC requires education linked to a whole-of-community response to RC. These are similar to responses that underpin prevention efforts for FV, IPV and SV.[165]

Religion also plays a critical role in addressing structural drivers of RC. While religious institutions are often perceived as barriers to reproductive autonomy,[166] a number of religious organisations champion reproductive justice and access to contraception and abortion.[167] Where available, engaging faith-based organisations that encourage autonomous reproductive health decision-making will also be an important part of preventing and responding to RC.[168]

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.[169]

Ella, Victoria

Economic Drivers

While there is little data about the economic drivers of RC specifically, there is a strong body of research that correlates reduction in violence against women to gender pay parity.[170] [171] 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.[172]

The tax system can also be an economic driver of IPV, FV and RC as it can be used as a means of power and control. While the tax system is mostly used as a means of interpersonal RC,[173] 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".[174] 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".[175] 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.[176] 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".[177]

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.[178] 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.[179]

The idea of gender bias in taxation is not new and has been the subject of much recent debate amongst economists globally.[180] 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,[181] 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.[182] 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.[183]

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.[184]

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.[185] 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.[186] Data from Marie Stopes Australia reveals that, on average, at least ten Tasmanian women per month have travelled interstate to access surgical services since January 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.[187] At the time of publication, a new Tasmanian service has been announced. However there are still a number of access issues and the new provider is not likely to commence until 2019.[188]

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[189] 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.[190] 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.[191]

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.[192] 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 RC, the ability to access these services in the right place at the right time is critical.[193]

Given the importance of sexual and reproductive health to overall health,[194] 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 RC. While there is no specific law that currently addresses RC in Australia,[195] there are, several laws that deal with consent that are applicable to RC.[196] For example, the following actions relevant to RC are addressed in criminal law:

- Rape: RC can be classified as rape depending on the circumstances and whether those circumstances do not constitute consent.[197]
- 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.[198]
- Assault: 'Stealthing'[199] may be classified as assault where the application of force is the sexual act and the injury is the forced pregnancy.[200]
- Procuring sexual act by fraud: stealthing in particular may constitute a false or misleading representation and so this form of RC can be viewed in the context of this criminal act.[201]
- Family Violence Act: RC fits within the Family Protection Act 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".[202]
- 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 RC.[203]

Although RC is not specifically mentioned in the above criminal laws, these criminal laws could arguably be applied to certain behaviours that are examples of RC.[204]

A final word needs to be said on the legal aspects of RC as it relates to the roll out of My Health Records. At the time of going to print, the Australian Government has announced an extension to the opt-out period to sign on to the electronic health database. 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.[205] Any health record that could detail access to STI test results, contraception and abortion procedures impacts on the issue of RC in that people experiencing RC 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 will be tabled before the House of Representatives on Monday, 26 November 2018.

RECOMMENDATIONS

This section focuses on recommendations to further investigate and address RC in Australia. The recommendations draw on the submissions and current literature considered in this White Paper consultation process and discussed in the previous sections of this report. Recommendations are presented according to the three areas of enquiry set out in the Terms of Reference, namely research, policy and practice.

Research

Exploring the Lived Experiences of RC

People experience RC 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 RC and to develop appropriate, respectful, and effective prevention and response measures, and the various lived experiences of RC 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 to be established that captures the multiple lived experiences of RC 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, Australian National University (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.

Determining the Prevalence of RC

As highlighted in a number of submissions, there is currently no data on the prevalence of RC in Australia. The ABS Personal Safety Survey provides an ideal means by which to gather this important information. Quantifying the prevalence of RC on a national level will help to shed light on RC 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 RC questions be included as part of the ABS Personal Safety Survey in order to gain a national picture of the prevalence of RC. 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 RC and IPV[206]. Currently there is no clear national data set for induced abortion procedures in Australia[207]. Given the intersection of unplanned pregnancy, abortion services and RC, gaining an understanding of the number of induced abortions across Australia will be useful in exploring the prevalence of RC.

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 World Health Organisation's International Classification of Diseases (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.

Exploration of RC as an Early Indicator of Escalation of Violence

RC may be an early indicator or marker of escalation of IPV[208] 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 RC 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 RC as part of an existing FV, IPV or SV risk assessment tool.

Policy

Embedding RC 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 RC, RC should be embedded in these policies.

Recommendation 5

That RC 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[209].
- Any reviews or policy development for FV, IPV and SV across all state and territory jurisdictions.

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[210]. 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 RC.

Recommendation 6

That a national SRHR Strategy be developed that addresses all aspects of sexual and reproductive health and rights, including addressing the drivers of RC 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 RC.
- Plan for the expanded provision of sexual and reproductive health services including contraception, sexual health screening and treatment, abortion care and access to specialised SHRH 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, adolescents, 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 RC action plan based on research findings into prevalence and qualitative analysis of lived experiences of RC.

Practice

Equipping Healthcare Professionals

RC 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, RC can take place in the absence of physical violence. Healthcare professionals, particularly GPs, can play a key role in identifying and responding to RC. However in order to do so effectively, healthcare professionals require training in RC identification, risk assessment and response.

Recommendation 7

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

- Includes an approach to RC risk assessment.

- Is developed for healthcare settings and professions that are likely to come into contact with people experiencing RC. These include obstetrics and gynaecology settings, GPs, abortion and contraception care providers, maternal and child health settings.
- Teaches a trauma-informed approach to RC 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.

NEXT STEPS

A national response to RC, 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 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 RC 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 action to address RC.

The following represents the next steps in Marie Stopes Australia's efforts to address RC on an organisational level.

Commitment 1

That Marie Stopes Australia implements internal processes and practices to better support people accessing the organisation's services who may be experiencing RC. 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 RC.
- 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 RC.
- Continuing to raise funds and support clients at risk of RC through the organisations Choice Philanthropic Fund.[211]

Since its establishment in October 2017 the Marie Stopes Australia Choice Fund has assisted 169 women across Australia to access termination and contraception services. Of these clients, 34% reported experiencing domestic violence and 13% reported experiencing RC to continue a pregnancy.

Data from The Marie Stopes Australia Choice Fund October 2017- September 2018

Commitment 2

That Marie Stopes Australia engages in further research as part of a collaborative effort to progress understanding of the prevalence, lived experiences of, and most appropriate response to RC, including through:

- Including RC as part of the current Australian National University and Marie Stopes Australia research collaboration on What Women Want in Abortion Care.[212]
- 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 RC in healthcare settings.

Commitment 3

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 RC, 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.

Commitment 4

That Marie Stopes Australia will lead a submission to the World Health Organisation (WHO) to amend the ICD coding that will enable better data capture of abortion procedures across health systems globally:

- The submission will 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 RC so as to better target intervention and response efforts.

Commitment 5

That Marie Stopes Australia continues to foster an internal workplace culture responsive to FV, IPV, SV and RC by supporting staff who may be experiencing any of these issues by:

- Providing staff with up to 10 days paid FV leave each year.

Share your feedback

With the publication of this White Paper, Marie Stopes Australia recognises that our journey to address RC is one of continuous improvement. We welcome the opportunity to share knowledge on our journey regarding this important issue.

For more information contact research@mariestopes.org.au

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ANNEX 1. CURRENT RC, IPV, FV, SV RESOURCES FOR AUSTRALIAN HEALTHCARE PRACTITIONERS

Tool / Program	Details	Purpose	Reference to RC	State	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 RC being asked at the initial antenatal visit developed by NSW Health	Routine screening for domestic and RC 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 DHHS, Victoria	To assist professionals and practitioners to identify risks associated with RC 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 QLD 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 RC is in place in NT	To screen for domestic and RC 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 RC 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 RC	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 RC experienced by patients. Includes mandatory reporting requirements across Australia	Provides information to assist with identifying RC and suggested referral services	No	Nationa l	https://ama.com.au/article/ama-family-violence-resource

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[172] Aizer shows that pay parity reduces violence in the household and specifically has better health outcomes for the woman. Aizer also posits that given there is a better health outcome for women, there is likely to be a better health outcome for children.

[173] The National Social Security Rights Network published How well does Australia's social security system support victims of family and domestic violence? in 2010. The study found that controlling partners can use the tax system including delaying tax returns as a means of delaying child support. The study also found that assessment of couples under the Family Tax Benefit schemes can often unfairly penalise the partner experiencing violence.

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[190] ABC Background Briefing recently aired a story about the issue of inconsistency in abortion laws, regulations and services across Australia that penalise women accessing termination of pregnancy services based on where they live: https://www.abc.net.au/radionational/programs/backgroundbriefing/the-clinic-of-last-resort/10205912

[191] 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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[195] A contribution to this White Paper from HWL Lawyers highlighted a number of laws that can address RC. HWL's contribution was based on Victorian laws. However the laws relevant to RC are similar in other states.

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

[197] 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.

[198] 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

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

[200] 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.

[201] 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.

[202] 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.

[203] 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 RC (or IPV and FV) it can bond an abusive partner to the mother.

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

[205] Norman J. My Health Record: Greg Hunt to strengthen penalties for misusing patient data, addressing Senate's concerns. ABC News 8 November 2018

[206] Miller E, McCauley HL, Tancredi DJ, Decker MR, Anderson H, Silverman JG. Recent reproductive coercion and unintended pregnancy among female family planning clients. Contraception. 2014;89:122–8.

[207] The Australian Institute of Health and Welfare. Use of routinely collected national data sets for reporting on induced abortion in Australia. 2005.

[208] 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 RC can be used as an early indicator of escalating violence.

[209] 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. RC should be considered within these two sections of the plan.

[210] 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.

[211] The Marie Stopes Australia Choice Fund is a philanthropic fund set up by the organisation in October 2017 to support women accessing abortion and contraception care who are experiencing severe financial and other hardship. Since the launch of the fund, the organisation has provided support for 169 women, 34% of whom have experienced FV and 13% of whom have experienced reproductive coercion.

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

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