MARIE STOPES AUSTRALIA

Hidden Forces

Shining a light on reproductive coercion

Draft white paper for comment

FOREWORD FROM THE CEO

When Marie Stopes Australia set out to address the issue of reproductive coercion, we looked at it from a universal perspective, and most importantly, from a universal *need*; the need for everyone to have reproductive autonomy. While this right is articulated in various forms in international human rights documents and charters such as the Sustainable Development Goals, the ability to exercise reproductive autonomy is often hampered for many individuals, particularly women.

Marie Stopes Australia cannot even begin to explore barriers to reproductive autonomy without acknowledging and identifying overt and covert forms of power and control that operate in our society. These forms of power and control exist on a spectrum from definitive such as intimate partner violence, through to the more subtle such as workplace culture and media representation. The elements of this spectrum collectively create significant barriers to a person exercising their reproductive autonomy.

Socio-economics, legal, political, religious, educational and familial structures, cultural heritage and traditions, media and social commentary all encompass forms of power and control in differing ways. This draft White Paper seeks to highlight a number of these powers and control structures and explore how they can drive reproductive coercion.

Reproductive autonomy is not only important from a rights-perspective, it is equally, if not more, important for our health and that of our family. If we are not in control of our reproductive autonomy, our sexual health and wellbeing suffers, which in turn impacts on our overall health and wellbeing and that of the future generation we may bear.

At Marie Stopes Australia, we see the impact of what happens when a person, particularly a woman, does not have full agency over their reproductive destiny. It is this insight matched with the growing urgent social focus on family violence and gender equality that has compelled us to develop this draft White Paper on reproductive coercion.

I would like to acknowledge and thank the many individuals and organisations who have submitted to this draft. There are still many areas that we need to explore and we look forward to consulting with more experts and specialists in the finalisation of this Paper.

Ultimately this is a platform to start a social dialogue about reproductive autonomy more broadly. It also provides specific knowledge and recommendations on how best to address the issue of coercion as a community.

Michelle Thompson

CEO Marie Stopes Australia

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EXECUTIVE SUMMARY

This draft White Paper is directed at researchers, policy-makers, family violence and sexual assault response agencies and healthcare advocates and providers, and any individual or organisation that has an interest in gender equality or reproductive rights.

It has been developed by Marie Stopes Australia, a national not-for-profit provider of sexual and reproductive health including abortion and contraception care with a view to addressing the issue or reproductive coercion.

It is part of an ongoing national consultation process on the issue of reproductive coercion that aims to commence a community-wide conversation including what reproductive coercion means and what it entails.

The draft White Paper aims to:

- **Identify key research gaps** to help gain an understanding of the prevalence of reproductive coercion and to use evidence to develop prevention, intervention and response measures
- **Identify how policy intersects** with reproductive coercion including where it can cause coercion, or where policy can prevent coercion
- **Identify what practices** healthcare providers can put in place to prevent, intervene and respond to reproductive coercion.

The draft Paper has been developed following a national consultation process that includes face-to-face interviews, written submissions and using a facilitated session with more than 50 stakeholders across health, academia, advocacy, media and politics.

Marie Stopes Australia has released this draft White Paper in order to seek more input from across the above sectors and beyond. The results will be collated into a final national White Paper that will be released in mid-October 2018. The final White Paper will detail final commitments that Marie Stopes Australia will undertake, as well detail final recommendations to address reproductive coercion from a research, policy and practice perspective.

This draft White Paper includes targeted questions throughout to elicit feedback on the issue from a diversity of stakeholder viewpoints. It also contains draft recommendations that will be refined as the consultation process continues. This Paper also contains key recommendations that Marie Stopes Australia will commit to now in order to prevent and respond to reproductive coercion. These commitments are:

- Reviewing internal workplace culture and practices
- Undertaking education, training and development with all staff
- Leading advocacy and reform activities and discussions
- Continuing the organisations commitment to the issue
- Coordinating consensus on a definition of reproductive coercion
- Engaging with other key stakeholders to address the issue of reproductive coercion.

Marie Stopes Australia acknowledges and thanks individuals and organisations who have contributed to the development of this draft White Paper and looks forward to continued collaboration and engagement.

1. Introduction

Up to 4.3 billion people on this planet will not have adequate sexual and reproductive health over their lifetimes [1].

This figure should be concerning for two reasons; firstly, it is almost certain that many Australians will be part of this equation; and secondly, poor sexual and reproductive health is an indicator of overall health and wellbeing[2]. Ultimately if we do not have good sexual and reproductive health, it hampers our ability to participate in economic life, it impacts on our general health, it impacts on the health and well-being of our children; and it can prove fatal[1].

Universal access to health services is a vital part of ensuring good sexual and reproductive health outcomes. Another critical driver of good sexual and reproductive health is the need for reproductive autonomy. Reproductive autonomy is important for everyone. However, evidence clearly indicates that it is ***absolutely central*** to the welfare of women; particularly given childbearing takes place in women and that women are far more likely to have primary responsibility for child-rearing[3,4]. When a woman does not have control of her reproductive choices, she is denied the right to equality and privacy. As a consequence, this will have an impact on her ability to exercise reproductive autonomy.

When a person's reproductive autonomy is compromised, they are experiencing reproductive coercion. This draft White Paper is concerned primarily with highlighting a range of issues that need to be removed for a person to exercise their reproductive autonomy because these barriers are what drive reproductive coercion.

This draft White Paper takes a macro and micro view of the issue of reproductive coercion because it is a problem that is highly complex by nature and intersects with other factors critical to good health such as mental health, socio-economic disadvantage and gender equality. Reproductive coercion is tied into a plethora of inherent power structures that exist within our society and to untie these asks all of us to recognise the inherent intersectional nature of reproductive coercion

It is important to note two things in the reading of this Paper. Firstly, this is a ***draft***. While there has been considerable stakeholder consultation in its development, the current environment around this issue and the constantly unfolding knowledge of gender equality compels considerable conversation, consultation and collaboration. It is a starting point and there are questions that beg a significant increase in the scope of research conducted and inter-sectoral reflection.

The second point is that this paper predominantly focuses on reproductive coercion as it relates women. Sexual and reproductive ill health is known to disproportionately affect women, and vulnerable populations such as women with a disability; adolescents; Aboriginal and Torres Strait Islander women; same-sex attracted, gay, lesbian, bisexual, transgender, intersex and queer people; women living in rural and remote Australia; and women from culturally diverse backgrounds including refugees[5].

While the existing evidence base of key sexual and reproductive ill health prevention and improved health outcomes is well known, there appears to be little political appetite (at any level) to adequately fund and resource woman's sexual and reproductive health, especially when the result of this can be pregnancy and abortion due to reproductive coercion. Hence the focus of this draft White Paper is on women.

This does not, however, mean that other genders do not experience coercion. Indeed this paper contains several areas where the issue of intersectionality requires further investigation. The focus on women is guided by evidence associated with reproductive coercion, much of which has come from the family violence realm, particularly evidence that indicates the intersectionality of intimate partner violence and family violence. It is a fundamental recommendation of this paper that **further investigation include the experience of reproductive coercion across genders, those who do not identify as a gender and within the context of varied relationship settings**.

1.1 A model of understanding to set the context

In developing this draft White Paper, it is clear that reproductive coercion is a complex issue. It can be influenced by internal or external factors. Exploring the complexities of reproductive coercion requires a model of understanding that acknowledges this complexity and allows for deeper investigation into how it intersects with, and is influenced by a confluence of forces.

Louise Harms' (2005) Multi-dimensional Approach provides a good contextual starting point because it emphasises the interaction of the inner-world dimensions of the biological, psychological and spiritual; and the outer-world dimensions of the relational, social, cultural and structural. The dimensions of the inner and outer worlds are both impacted by time[6].

As this White Paper is finalised, the inner and outer world dimensions articulated in Harms' model provide a useful opportunity to explore the varied drivers of reproductive coercion to ensure no stone is left unturned when addressing the issue from a whole-of-community perspective.

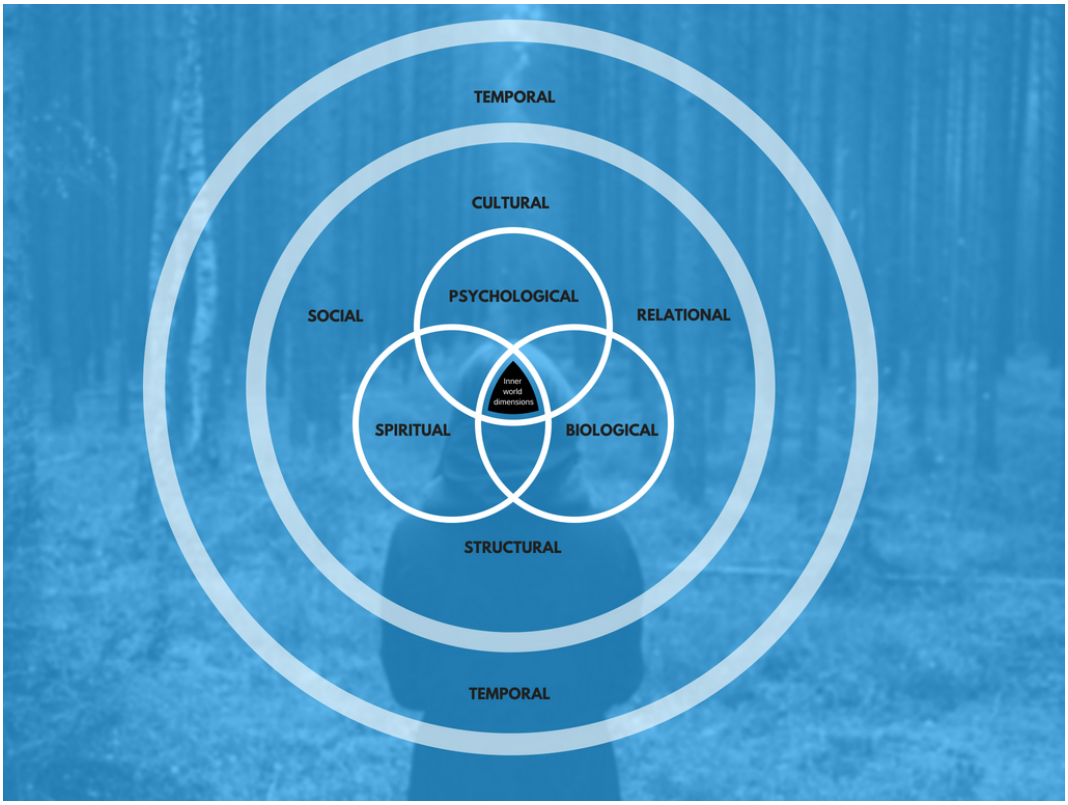


Figure 1: Multi-dimensional approach developed by Professor Louise Harms

The inner-world dimensions being:

- Biology: and can relate to a person's ability, age, co-morbidities (including existing sexual and reproductive health issues), gender; and can include common biological myths held to be true in areas such as contraceptive use, abortion and/ or pregnancy
- Psychology: and can relate to underlying mental health conditions (including treatment that employs psycho-pharmaceuticals) that can increase or exacerbate during times of pregnancy or termination of pregnancy
- Spiritual: and can relate to personal beliefs and values that can associate reproductive autonomy with some sort of negative causality, personal myths about pregnancy and or abortion/ contraception.

The outer-world dimensions being:

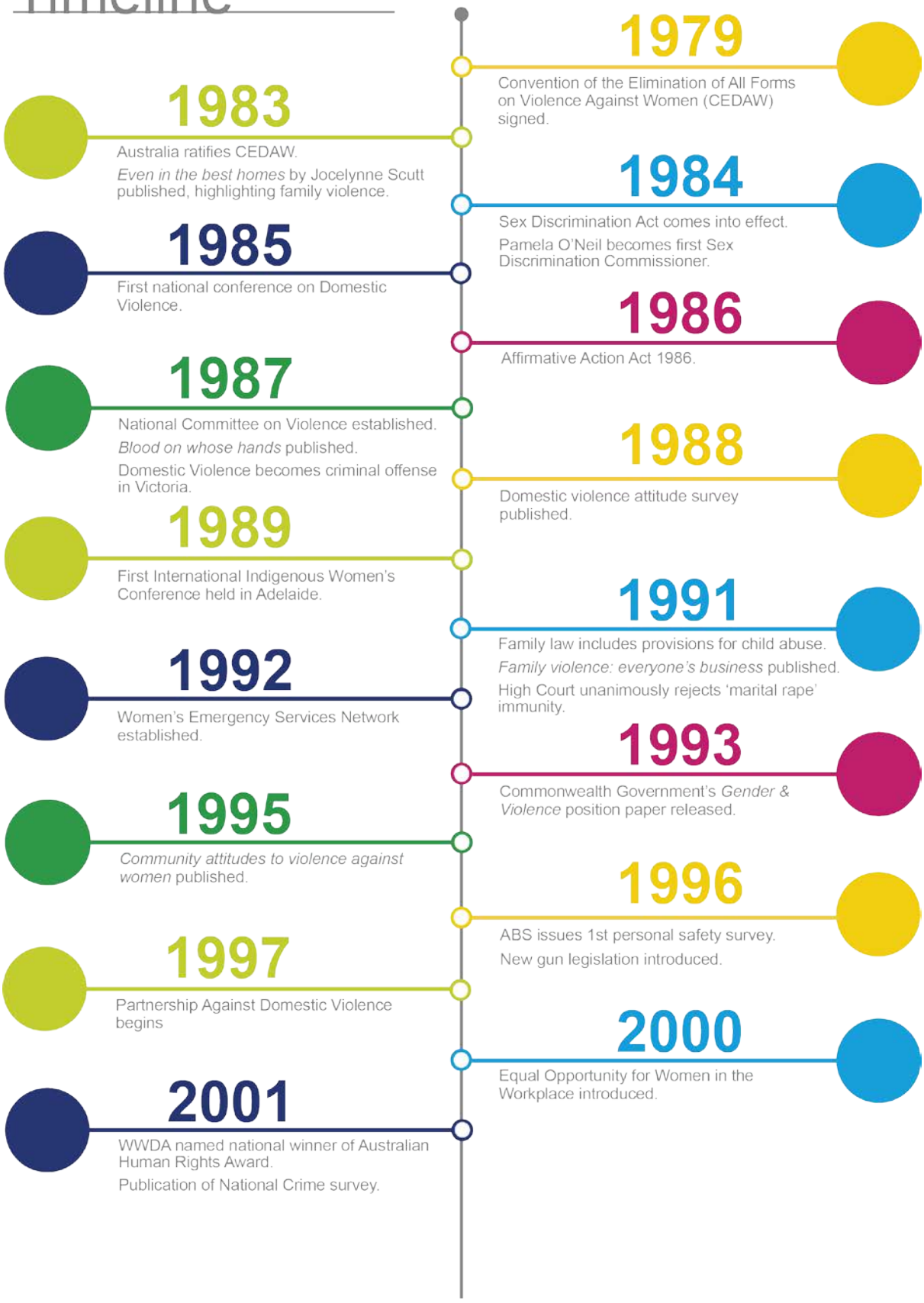
- Relational: and can encompass intimate partner and familial relationships
- Social: and can include friendship groups, parenting groups (including mothers' groups) and workplace groups
- Structural: and can include policy (for instance tax, welfare policy), practices, systems (such as the education system), legislation, contact points with medical and social services (including GPs, pregnancy crisis counselling), workplace practices (including gender pay gap, parental leave and flexible work arrangements)
- Cultural: and can include beliefs/ bias/ norms, societal influences (including media and public discourse)
- Temporal (time): and can include social evolution (including perceived versus real changes), world events, individual life experience and life spans (including career development).

The inner and outer world domains operate and interact in covert and overt ways which increases the overall complexity of establishing definitions, research approaches and therefore practices. Marie Stopes Australia has used Harms' approach to help broaden the scope of this draft paper's exploration of reproductive coercion. Different contributors to the consultation process have raised the complexity issues at several points and Harms' approach has assisted with beginning to map the various power and control structures that influence reproductive coercion. It should be noted that much of the evidence provided throughout the consultancy process has related to the relational dimension and some to the structural dimension of reproductive coercion.

1.2 Setting the context in time

This draft Paper is part of a movement of work the ties together gender equality, sexual and reproductive health, and family violence, in particular intimate partner violence. It is an extension of compelling bodies of research, policies and strategies that span global, national, state and local community settings. Marie Stopes Australia acknowledges and respects the individuals and organisations whose efforts have driven progress in these areas.

Timeline


1979
Convention of the Elimination of All Forms on Violence Against Women (CEDAW) signed.
1983
Australia ratifies CEDAW.
Even in the best homes by Jocelynne Scutt published, highlighting family violence.
1984
Sex Discrimination Act comes into effect.
Pamela O'Neil becomes first Sex Discrimination Commissioner.
1985
First national conference on Domestic Violence.
1986
Affirmative Action Act 1986.
1987
National Committee on Violence established.
Blood on whose hands published.
Domestic Violence becomes criminal offense in Victoria.
1988
Domestic violence attitude survey published.
1989
First International Indigenous Women's Conference held in Adelaide.
1991
Family law includes provisions for child abuse.
Family violence: everyone's business published.
High Court unanimously rejects 'marital rape' immunity.
1992
Women's Emergency Services Network established.
1993
Commonwealth Government's *Gender & Violence* position paper released.
1995
Community attitudes to violence against women published.
1996
ABS issues 1st personal safety survey.
New gun legislation introduced.
1997
Partnership Against Domestic Violence begins
2000
Equal Opportunity for Women in the Workplace introduced.
2001
WWDA named national winner of Australian Human Rights Award.
Publication of National Crime survey.

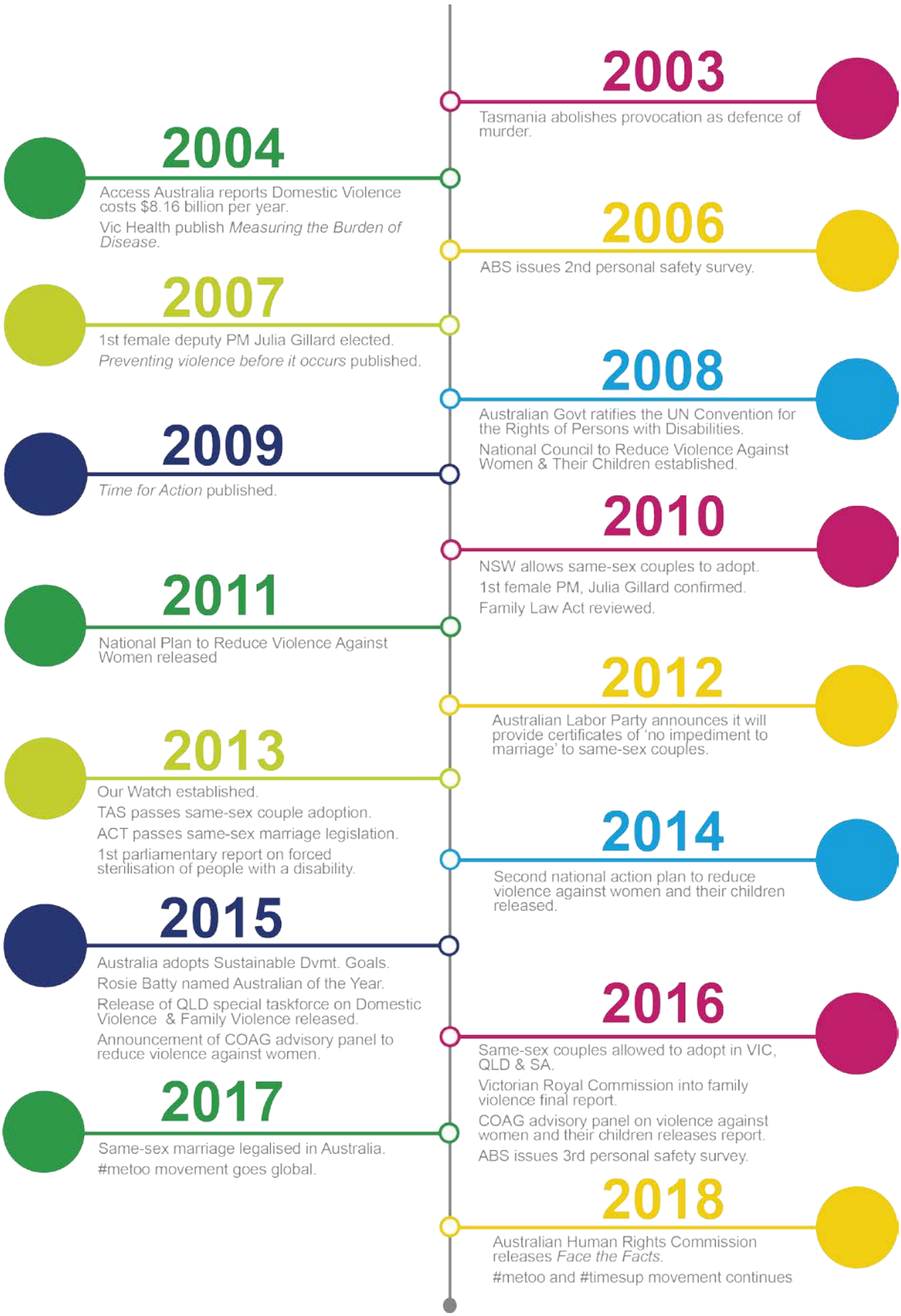


Figure 2: Timeline of key events in the development of family violence and gender equality policy in Australia

1.3 Intersection with Family Violence and Intimate Partner Violence

The World Health Organisation (WHO) estimates that between 23% and 49% of females aged 15 years and over experience intimate partner violence[7]. In Australia, more than 17% of women have experience violence from a partner since the age of 15 years and these women were eight times more likely to experience sexual violence than men[8]. Evidence shows that intimate partner violence is associated with poor reproductive outcomes for women. Further, coercion is cited as one of seven behaviours indicative of family violence as defined in section 5 of the Family Violence Protection Act 2008 Victoria. When compared to women who do not experience violence, women experiencing intimate partner violence are:

- Twice as likely to have a male partner refuse contraception;
- Twice as likely to experience an unplanned pregnancy;
- Three times as likely to give birth as an adolescent; and
- They are significantly more likely to experience five or more births than those with non-violence partners[9].

Sexual coercion, sexual abuse and sexual violence are often referred to in key policy documents as being at an intersection with family violence or referred to as re-victimisation when co-occurring with other forms of violence[10]. Reproductive coercion is a tactic of family violence, especially intimate partner violence[11]. It is, also a systemically neglected, under-researched area that has a significant impact on practice across a range of health care settings. This draft White Paper provides a further opportunity for the family violence response sector and the healthcare sector, particularly the sexual and reproductive health sector, to collaborate in identifying, screening and responding to reproductive coercion.

QUESTION:

1. What are examples of how the health, sexual and reproductive health and family violence sectors can collaborate to address reproductive coercion in Australia?

1.4 Why Marie Stopes Australia?

Marie Stopes Australia is a national not-for-profit provider of sexual and reproductive health services. These services include long-acting reversible contraception, permanent contraception measures (vasectomy and tubal ligation) and abortion care. All services include a package of STI treatment and management, trauma-informed counselling including pregnancy options counselling and pre and post procedure counselling, 24 hour nurse-led aftercare, pathology and radiology services and surgical follow up where required.

The organisation's surplus revenue along with its philanthropic activity supports access to abortion and contraception services for Australian women experiencing financial hardship. It also supports local provision of family planning services in the Asia-Pacific region.

As a major provider of sexual and reproductive health services with a national footprint the organisation comes into contact with more than 100,000 people each year. Therefore Marie Stopes Australia plays a 'first responder' role to women when they are experiencing reproductive coercion. The evidence shows that health providers, particularly those in reproductive health settings like Marie Stopes Australia, are well placed to identify and address reproductive coercion[12].

1.5 The role of healthcare provider

Australia's healthcare system plays a vital role in supporting women experiencing violence, and when it comes to reproductive coercion, health care providers in the neo-natal and sexual and reproductive health realm are in a unique position to identify, assist and respond.

We know that the ability of a woman to control her reproductive health and outcomes improves her quality of life[13]. Yet, for a significant proportion of women, autonomy over whether they become pregnant is not a lived reality. The purpose of this draft White Paper is to build a broad evidence base to change this dialogue and challenge policy makers and funders to stop accepting this as the Australian norm. It is also an opportunity to urge healthcare providers and those working in the family violence sector to consider their role in addressing reproductive coercion.

1.6 The intersection with abortion care providers

Around 50% of women in Australia will experience an unintended pregnancy in their lifetime[14]. Together with increases in family violence reporting and the relationship between violence and poor sexual and reproductive health outcomes; it is essential reproductive coercion is recognised in policy, research and by health practitioners as a critical health issue to which reproductive health care providers have unique exposure. Reducing the prevalence of unintended pregnancies in general but also unintended pregnancies as a result of reproductive coercion and therefore the need for abortion should be a public health priority, from both a patient-centred and health system perspective.

Secrecy and concealment of violence and abortion is a vicious cycle that reinforces individual and community stigma[15]. Stigma surrounding women's general sexual and reproductive health is a real and entrenched phenomenon reinforced by inconsistent and outdated laws impacting upon the human rights of women to access health care depending upon where they live [16]. While abortion is a common and essential health service provided throughout Australia, it is still considered a crime in three states to access or provide abortion services without meeting strict legal conditions, which one could argue is a structural coercive act in and of itself. The intensity of political and religious scrutiny that women face when accessing sexual and reproductive health services, most notably pregnancy termination, is unparalleled in the Australian health system.

QUESTION:

2. What are some best practice examples of how other heath sectors have engaged with abortion providers to address reproductive coercion?

1.7 Framework of the White Paper

The guiding principle of this draft White Paper is **collective impact.** Reproductive coercion, like family violence and sexual assault, is an issue that requires multiple partners to address. It is a social problem that requires a society-wide response. Together with individuals and stakeholder organisations, this draft Paper has been developed in the spirit of collective impact. This approach will continue as the draft is subject to further consultation and refinement.

The draft White Paper aims to draw together many forms of knowledge, influence and research evidence for the purpose of:

- integrating research into policy;
- identifying gaps in research regarding reproductive coercion in the Australia context for future investigation, collaboration and knowledge transfer; and
- Informing the development of evidence-based universal screening practices of screening within existing health and psycho-social services and, emergent health and psycho-social practice frameworks that address reproductive coercion systemically.

Intervention and prevention actions are most relevant, effective and sustainable when communities are involved in their development. The aim of collaborating with stakeholders and the community is to collectively shape prevailing paradigms and the way reproductive coercion and any potential solutions can be framed within Australia and Australian-based research projects.

1.8 Background to the Development of the White Paper

In May 2017, Marie Stopes Australia invited a number of consumer and stakeholder representatives to present to the organisation with a critical yet under-represented and anarchic challenge facing the sexual and reproductive health sector in Australia; a challenge that Marie Stopes could take action on from a research, policy and/or practice perspective. Reproductive coercion was identified as one of these key areas and a 'Call to Action' on this inherent public health issue was accepted by Marie Stopes Australia.

1.8.1 Reproductive Coercion Roundtable

In August 2017 Marie Stopes Australia held a roundtable event on the topic of reproductive coercion. Over 50 health practitioners, policy makers, politicians, academics, lawyers and journalists from across Australia attended the event to identify key gaps in the research, policy and practice elements of the experience of reproductive coercion in Australia.

Chaired by social commentator, writer and lecturer Jane Caro, guest speakers from White Ribbon, Children by Choice and Marie Stopes Australia led each session outlining the importance of tackling reproductive coercion with the triple focus of: understanding the impact research (or lack of); policy (or lack of); and practice (or lack of best practice examples) has on women.

The outcome of the event was unanimous support for and a public commitment by Marie Stopes Australia to lead and continue this important work. The summary of the mapping undertaken by the participants informed the development of the Terms of Reference for this draft White Paper and guides the formulation of this report.

1.8.2 White Paper consultation process

To develop the draft Marie Stopes Australia sought submissions from stakeholders with appropriate knowledge of and/or a demonstrated strong interest in supporting women experiencing reproductive coercion, especially those involved in:

- Health, particularly women's health, abortion care and broader sexual and reproductive health service;
- Family violence 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, family violence and law reform.

The submission process was open for 3 months and closed on 10 March 2018. The Terms of Reference were sent to a wide range of organisations throughout Australia with a request to forward to relevant networks or experts that may consider providing a submission to the draft White Paper.

For those organisations that had limited resources or where individual consumers wished to provide a submission, Marie Stopes Australia collated verbal submissions both by phone and in local meetings.

1.8.3 Terms of reference

Marie Stopes Australia sought submissions that focussed on the following key areas:

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

2. **Key recommendations and actions to address the gaps in:**
   - Research including compilation of data to assess the scope, scale and concentration of 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 with abortion providers so that women requiring assistance have clear, supportive and consistently quality referral pathways.

3. **Future opportunities including:**
   - Cross-sectoral collaboration
   - Application of innovative models, approaches from other fields

1.9 Submissions

A total of 19 submissions were received (16 formal submissions, 3 verbal submissions). These submissions represented 40 identified organisations covering all States and Territories in Australia except the Northern Territory. A number of National and State-based peak health, women's health and family planning organisations provided submissions on behalf of their members. Submissions were received from organisations and individuals that have extensive experience in a range of health and socio-ecological areas including family planning, disability, women's health, sexual health, rural health, domestic/family violence, public health, unplanned pregnancy, medicine, LGBTI issues, sexual abuse/assault and adolescent health.

Numerous submissions identified case studies relating to women who have experienced reproductive coercion to assist in ensuring the women's voice were included in this draft Paper.

Marie Stopes Australia acknowledges and thanks the individuals and organisations who have contributed to the development of this draft White Paper.

Australian Women Against Violence Alliance
Australian Women's Health Network
Children by Choice
Dani Fried
Domestic Violence Australia
Domestic Violence Victoria
Eastern Metropolitan Region Sexual & Reproductive Health Strategic Reference Group
Economic S4W
Equality Rights Alliance
Gippsland Women's Health
Harmony Alliance
Multicultural Centre for Women's Health
National Aboriginal and Torres Strait Islander Women's Alliance
National Foundation for Australian Women
The National LGBTI Health Alliance
National Rural Women's Coalition
Dr Catriona Melville
Penrith Women's Health Centre
Public Health Association of Australia
Sexual Health Quarters WA
SHE (TAS)
The Royal Women's Hospital Victoria
The University Of Melbourne, Melbourne Research Alliance to End Violence Against Women and their Children (MAEVe) and Centre for Family Violence Prevention,
Victorian Rural Women's Health Organisations
Women's Health and Wellbeing Barwon South West
Women's Health Goulburn North East
Women's Health Grampians
Women's Health in the North
Women's Health in the South East
Women's Health Loddon Mallee
Women's Health West
Women's Health Victoria
Women With Disabilities ACT (WWDACT)
Women with Disabilities Victoria

We look forward to receiving further submissions and feedback over the following months to refine this White Paper to its final version.

2. Establishing the evidence

A significant part of the consultation stage highlighted the need for more research in the area of reproductive coercion in order to establish evidence-based policy and practice. Many of the submissions, however, did draw on research from across the power and control spectrum ranging from intimate partner and family violence through to more structural and cultural factors such as government policy and legislation.

2.1 Defining reproductive coercion

Maries Stopes Australia has taken a broad view of reproductive coercion for the purposes of this draft, however it is important to acknowledge that there needs to be an agreed definition so as to assist with screening, identification and response. The subject of a definition was a strong theme in the consultation to date. Without a specific and mutually agreed definition of reproductive coercion, having an open conversation on this important public health issue can be difficult. A clearly articulated definition of reproductive coercion also has multiple implications for research including allowing for comparative research and its replication. Further, it informs defining and developing best practice and consistent application in the community.

All submissions identified the need for a mutually agreed, consistent and clear definition of reproductive coercion for the Australian context. The review of Australian and international literature found a number of different definitions of reproductive coercion. Similar inconsistencies were identified through the submission process, with stakeholders expressing preferences for definitions based on key research publications (see below).

Table 1: Definitions of Reproductive Coercion in the literature

AUTHOR	DATE	REPRODUCTIVE COERCION DEFINITION
Heise, Moore and Toubia[16]	1995	Originally defined as "sexual coercion", reproductive coercion referred to a wide range of sexualised behaviours including verbal harassment, intimidation, physical force, social pressure and intimidation of all kinds
Moore, Frohwirth and Miller[17]	2010	Male reproductive control which encompasses pregnancy-promoting behaviours as well as control and abuse during pregnancy in an attempt to influence the pregnancy outcome
Miller and Silverman[18]	2010	Male partners' attempts to promote pregnancy in their female partners through verbal pressure and threats to become pregnant (pregnancy coercion), direct interference with contraception (birth-control sabotage), and threats and coercion related to pregnancy continuation or termination (control of pregnancy outcomes)
Chamberlain and Levenson[19]	2012	Form of intimate partner violence where behaviours to maintain power and control in a relationship related to reproductive health by someone who is, was, or wishes to be involved in an intimate or dating relationship
American College of Obstetricians and Gynaecologists[20]	2013	Reproductive and sexual coercion involves behaviour intended to maintain power and control in a relationship related to reproductive health by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent
Children by Choice[21]	2015	Interference with reproductive autonomy that denies a woman's decision-making and access to options. This behaviour may be deliberate or indirect and can manifest in a number of different ways
White Ribbon Australia[22]	2017	Any behaviour, physical and emotional, aimed at establishing and maintaining power and control by restricting a woman's reproductive autonomy, denying her control over decisions related to her reproductive health and limiting her access to reproductive health options.
Children by Choice[23]	2018	Any perpetrator behaviour aimed at establishing and maintaining power and control over a woman who they are, were, or seek to be in a relationship with, by interfering with her reproductive autonomy, denying her control, decision-making and access to options regarding reproductive health choices. These behaviours may include pregnancy pressure, contraceptive sabotage, and pregnancy outcome control.

Guttmacher Institute[1]	2018	behaviours, such as those routinely adopted by individuals, faith- based groups, atypical medical professionals and politicians, that aim to: withhold information or provide deliberately misleading information; actively obstruct women's access to health services or providers; attempt to ban services outright women's access to contraception and abortion; and empowering third parties to impose their views on others

A particular contention raised through the submission process was the use of definitions of reproductive coercion that make broad or descriptive statements about behaviour towards women whilst neglecting the intention of the behaviour. The submissions consistently agreed that it is the intentionality of the behaviour that is the critical element of any definition of reproductive coercion.

The recognition that reproductive coercion is a form of violence was a central tenant to all preferred definitions and outlined in all submissions as a critical element of defining reproductive coercion. Submissions and the broader consultation process highlighted the importance of:

- Referencing the gendered drivers of violence
- The establishment and maintenance of power and control by the perpetrator towards the woman
- That reproductive coercion can occur before, during and after a relationship.

It was recognised that reproductive coercion can occur in the absence of other forms of violence and control or it can be part of a much larger, ongoing pattern of violence against women including sexual, physical, emotional and financial abuse.

Much of the research on reproductive coercion and the identification of the behaviour of reproductive coercion as phenomena has been within the context of intimate partner violence. While some identify reproductive coercion as a separate and discrete form of violence; others consider reproductive coercion as just one of many tactics used by perpetrators of violence against women. Others view reproductive coercion as intersecting with other forms of violence against women.

Reproductive coercion also refers to the prevailing and socially accepted attitudes and behaviours of individuals as well as structural drivers such as state policy and legislation aimed at establishing and maintaining power and control of a woman's sexual and reproductive autonomy. A woman's individual circumstances and structural issues related to gender, (dis)ability, ethnicity and social class suggests that reproductive coercion "exists on a continuum", perpetrated at one end by individuals including intimate partners, family, peers and health professionals and continuing through to faith-based groups and governments[24].

The submissions identified that a definition of reproductive coercion is most likely to be relevant to the Australian context if it is ***multifaceted***. The identified connection reproductive coercion has with the spectrum of behaviours associated with family violence and the difficulties involved in preventing, identifying and addressing those behaviours also supports this approach. A definition that recognises that access to services for sexual and reproductive health must be available, affordable, and culturally informed is another element to consider.

QUESTIONS:

3. What are the critical elements that need to be included in the definition of reproductive coercion?
4. What are the means by which to bring together multiple sectors to develop and reach consensus on a definition?
5. What are the means by which the voices of those experiencing or at risk of experiencing reproductive coercion are captured in the process of defining reproductive coercion?

2.2 Prevalence of reproductive coercion

Without having a clear understanding of how reproductive coercion is defined and therefore measured it is problematic to determine prevalence. Similarly, most of the data regarding the prevalence of reproductive coercion has been collected in specialised health settings located overseas including in family violence, counselling and family planning clinics, and may be challenging to generalise to the broader community. The limited Australian data also makes determining prevalence difficult.

What we do know is:

- Pregnancy is a particular risk factor for violence: almost one in four women (22%) experiencing partner violence have experienced it during pregnancy, and 13% of those women were pregnant when the violence started[25].
- Young women aged 18-24 experience significantly higher rates of physical and sexual violence than women in older age groups. Young women experience the highest rates of violence of any age group[26].
- Women with a disability experience higher rates of violence than both men with a disability and women without a disability[10].
- Immigrant and refugee women experience a broad range of different forms of family violence, including violence that is associated with, and exacerbated by, some of the social and structural consequences of migration and settlement, for example, precarious visa status[27].
- Violence against immigrant and refugee women tends to be long-term, and in some cases includes multi-perpetrator violence from members of the extended family or close community. In multi-perpetrator violence family members encourage or support the male partner's control and abuse of female partners[28].
- Aboriginal and Torres Strait Islander women experience higher rates and more severe forms of violence[29] and are at a greater risk of experiencing domestic and family violence during pregnancy[30]
- A 2010 study found that 35% of women attending a family planning clinic in the USA had experienced reproductive coercion, which included contraception sabotage and pregnancy coercion[11].
- 2015 research in Queensland has found that 'almost 40% of clients reporting sexual violence also report domestic violence, highlighting the prevalence of forced sex within ongoing relationships that are also abusive in other ways'[21].
- Data from Tasmania shows that at any given time 1 in 10 women (on average) are experiencing reproductive coercion in one or more ways[31].

Much more research and national data collection reform is needed before accurately judging the prevalence of reproductive coercion in Australia. In tandem, there is also a clear need for research into women's lived experiences of reproductive coercion through the generation of both qualitative and quantitative data.

However, there is a clear picture of the prevalence of violence against women, of which reproductive coercion can be a tactic. We know that pregnancy is a time of heightened risk for intimate partner and family violence, and that violence often begins during pregnancy[30]. We also know that forced contraception can mask abuse in families, institutional settings or within the wider community, resulting in under-reporting and a failure to recognise and respond to such abuse. Similarly, while not using the same measurements, a number of studies have determined prevalence of reproductive coercion within their patient samples:

Table 2: Studies that report directly and indirectly on Reproductive Coercion prevalence

YEAR	Country	Author	Study Setting /survey type	Prevalence or reproductive coercion
2006	AUS	Vos et.al. [32]	Burden of disease study	• Intimate partner violence was associated with 7.9% of the overall disease burden • Intimate partner violence presented a larger risk to health than risk factors such as raised blood pressure, tobacco use and increased body weight. • Poor mental health contributed to 73% and substance use 22% of the disease burden attributed to intimate partner violence.
2009	USA	Gee[33]	Family planning clinic	• 4.6% women reported that their partner makes it difficult to use birth control (past 4 months) – no intimate partner violence • 13.5% women reported intimate partner violence in the past year • 6.1% reported that partner did not use birth control because partner did not want to/wanted woman to get pregnant.
2010	USA	Miller et.al. [11]	Family planning clinics	• 19.1% reported pregnancy coercion • 15% reported contraception sabotage • African American women higher rates of reproductive coercion o 25.9% experience pregnancy coercion o 27% experience contraception sabotage.
2010	USA	Silverman[34]	Survey of sexually active males	• 4.1% had engaged in abortion coercion in the past.
2011	USA	Silverman[35]	Cross-sectional Survey	• 20% women had been coerced into sex without a condom.
2012	USA	Foster et. al[36]	Abortion clinic setting	• 2% reported being pushed into an abortion against their wishes.
2014	USA	Clark et. al[37]	Cross-sectional survey	• 16% women had experienced reproductive coercion.
2014	USA	Kazmerski[38]	Family planning clinics	• 13% women had experienced reproductive coercion.
2014	USA	McCauley[39]	14-19yo girls at school based health clinics	• 12.4% girls had experienced reproductive coercion.
2015	AUS	Rowe et.al.[40]	National Survey	• 27% women experienced being forced or frightened by someone into doing something sexually that they did not want to do • 2.8% rape resulting in pregnancy.
2015	USA	Sutherland[41]	18-25yo University students	• 8% had experienced reproductive coercion • 6.8% had experience pregnancy coercion • 3.9% had experienced contraception sabotage.
2015-2016	AUS	Children by Choice[21]	Counselling service client data	• Approximately one in eight contacts experiencing reproductive coercion • 60% of these women aged in their 20s • Women from Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse (CALD) backgrounds were over represented

				• Women reporting reproductive coercion were: o three times more likely to experience suicidality o almost twice as likely to experience mental health problems. o
2016	USA	Chalk et.al[42]	Routine obstetrics and gynaecology care (urban clinic)	• 16% women experienced reproductive coercion currently or in the past • Among women who experienced reproductive coercion, 32% reported that intimate partner violence was occurring in the same relationship.
2016	AUS	Australian Bureau of Statistics[8]	Personal Safety Survey	• two in five people aged 18 years and over had experienced violence since the age of 15 • One in five women and one in 20 men had experienced sexual violence • 17% of women reported experience of intimate partner violence • women were three times more likely to have experienced partner violence than men • 23% of women experienced partner emotional abuse.
2017	USA	Northridge et.al[43]	High school-aged (14-17yo) girls living in high-poverty areas while awaiting medical care in clinic/school	• 19% of girls reported reproductive coercion • 79% reported a romantic or sexual partner had "told them not to use any birth control" • 43% reported a romantic or sexual partner had taken a condom off during sex • 21% reported a male partner had told them he would leave them if they didn't get pregnant • Girls reporting reproductive coercion were (compared to girls not experiencing coercion): o nearly 3 times more likely than those not coerced to have had chlamydia o nearly 5 times more likely to report intimate partner violence o less likely to have high recognition of abusive behaviours • Less likely to have high comfort communicating with their sexual partners.
2017	USA	Van Parys[44]	Prevalence of intimate partner violence	• rates for intimate partner violence during pregnancy is estimated to range between 3% and 30% within different populations internationally • Intimate partner violence more prevalent than commonly discussed maternal health conditions, such as pre-eclampsia, that have comparable negative health outcomes.
2017	AUS	Gafforini[45]	Abortion clinic health professionals	• Pregnancy coercion was disclosed to clinicians on a weekly basis by women • Partners threatening to leave a relationship if a pregnancy was not terminated occurs at least weekly, often daily • Concealing a pregnancy and the subsequent pregnancy termination from a male partner due to fear of their partner was the most frequent type of reproductive coercion disclosed to health practitioners by women seeking abortion • women rarely or never reported contraception coercion when seeking pregnancy termination services • Nurses were more likely to report having had reproductive coercion disclosed to them than medical practitioners.

United Nations data estimates that in 2015 10% to 20% of women in Australia had an unmet need for family planning among those aged 15 to 49 years who are married or in a relationship[46]. Meaning when compared to other OECD countries, Australia is behind Canada, the USA, and countries in Western Europe in terms of providing family planning, including contraception to

women of reproductive age. In addition, a report from the Committee on the Elimination of Discrimination against Women highlighted that Aboriginal and Torres Strait Islander peoples and women with a disability in Australia have less access to family planning information, counselling and education than the general population[47].

QUESTIONS:

6. How can we begin to understand the multiple experiences of reproductive coercion along different population groups?

7. What research methods should be employed to capture these experiences?

8. What are the key research partnerships that need to be established?

2.3 Health impacts of reproductive coercion

Reproductive coercion, like other forms of violence against women, has a significant impact upon the health of women and their children. The literature highlights that the negative health impacts of reproductive coercion can include:

- Poor mental health including depression, anxiety, self-harm, post-traumatic Stress Disorder (PTSD) and other complex mental health presentations[39].
- Physical health impacts such as injuries or disability related to other co-occurring forms of violence[48].
- Sexually transmitted infections including HIV/AIDS[44].
- Unintended pregnancy and higher rates of unintended pregnancy than women who have not experienced reproductive coercion[11].
- High rates of pregnancy complications[17].
- Higher rates of abortion, miscarriage, unsafe abortion, repeat abortions and later gestation abortions[17].
- Alcohol and other drug co-morbidities[49].
- Gynaecological disorders[50].
- Limited ability to negotiate reproductive choices[50].
- Long term sexual and reproductive ill health[50].

The denial of sexual and reproductive health information and service, particularly abortion and contraception services intensely impacts women's lives and health, and inhibits the fulfilment of a range of civil, political, economic and social rights including exercising their preference on the number and spacing of their children[51].

2.4 Mental Health

Mental health issues can often occur in concert with poor sexual and reproductive health and can be a product of violent relationships. While the mental health effects of domestic violence are well established in the literature, such as the occurrence of PTSD[52], given the emergent nature of the identification of reproductive coercion, very few studies have explored the impact of reproductive coercion on a woman's mental health and overall wellbeing.

In Australia, anecdotal data suggests that women experiencing reproductive coercion are more likely to experience complex mental health concerns and suicidal ideation than women who are not experiencing reproductive coercion. A 2017 study conducted in Korea confirmed that interpersonal violence is associated with increased prevalence of depressive symptoms and suicidal ideation. It also found that this association increases among women experiencing violence if they also adhere to historically traditional gender roles within their relationships and families[53].

Research also supports the connection between women's experiences of violence and substance abuse. This association is important in the context of reproductive coercion as substance use is also related to increased risk of unintended pregnancy, increase in complex mental health concerns and sexually transmitted infections[49].

The combination of social inequality and female victimisation are known risk factors for the development of mental health concerns among women experiencing violence[47]. These are modifiable factors that can be addressed through changes to policy and the delivery of timely and appropriate mental health supports to people experiencing or at risk of experiencing poor sexual and reproductive health outcomes.

2.5 Sexual health literacy

The WHO defines sexual health "*as a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled*." [54]

Other United Nations instruments support the need to improve sexual health literacy and recommend that nations like Australia adopt comprehensive sexual education systems which would provide "opportunities to explore one's own values and attitudes and to build decision-making, communication and risk reduction skills about many aspects of sexuality, sexual and reproductive health[49]." This highlights the critical need to address complex issue's concerning reproductive coercion within the space of community awareness and sexual health literacy. This will only be achieved through the implementation of national legal mechanisms that enforce women's rights to access high quality sexual health education.

The Public Health Association of Australia advocates that women and girls must have access to balanced sexual and reproductive health information and education including accurate information about modern contraceptive methods, emergency contraception and safe abortion. This is supported by research from the United Nations which confirms that access to accurate and timely information, including sexuality education, is essential to making informed choices and decisions about sexual and reproductive health and rights with particular attention given to ensuing women and girls from vulnerable populations have access to appropriate information and services. This includes communities such as adolescents, rural and remote communities, women and girls with disabilities, refugees and migrant women, and in Australia, Aboriginal and Torres Strait Islander women and girls[55].

In many states in Australia, sexual health education is rightfully embedded within a respectful relationships framework. However without a monitoring body to ensure consistency in messaging, there is no way to ensure consistency in the delivery of education or that all school-aged children are able to access appropriate information and support.

QUESTIONS:

9. What role do health literacy programs play in addressing the issue of reproductive coercion?

10. How can reproductive coercion be included in existing health literacy programs?

2.6 Cultural and social norms

Cultural and societal norms play a significant role in access to quality health care and the health outcomes of women. These variables include socio-economic status, race, ethnicity, gender and gendered roles, health and mental health, sexual identity, immigration status and acculturation, educational attainment, poverty and deprivation, familial and relational status, social networks and support, and environmental factors. Characteristics of the social environments also impact upon health including as the distribution of income, social cohesion and social capital.

Cultural norms are a key determinant of sexual and reproductive health and can promote or hinder sexual and reproductive health. These norms are influenced by an individual's and community's belief systems. For some cultural groups, cultural norms and health practices are an explicit form of reproductive coercion.

QUESTION:

11. What else should be covered when considering the research gaps and requirements to address reproductive coercion?

3. The Importance of Policy Reform

The policy element of the submissions and broader consultation process has been particularly challenging given there is a clear need for evidence in order to develop the most appropriate policy interventions and/ or reforms. For this reason, this section, while drawing on feedback within the submissions, also relies heavily on the current literature. It is supplemented with the experience of Marie Stopes Australia, as an organisation that often sees first-hand the impact that either limiting or permissive policy can have on reproductive autonomy.

3.1 Impact of policy on health

Policy can have positive and negative effects on the health of the community, and this is especially true when it comes to women's health. Getting the policy context right is essential for the universal provision of actions to prevent reproductive coercion. The positive impact of policy can include:

- Creating opportunities for open dialogue about reproductive coercion and the development of prevention strategies
- Mandatory reporting of perpetrators with the adequate provision of support to victims of violence and remediation supports for offenders
- Resources and guidelines for health professionals to screen and support victims of reproductive coercion
- Resourcing of the education of men (and boys) about contraception and reproductive coercion
- Positively impacting the early identification of reproductive coercion and early access to interventions.

Throughout Australia policies that focus on sexual and reproductive health, and women's experiences of violence including reproductive coercion are patchy, disjointed and rarely receive adequate funding. There is a gap in state and federal policy that addresses sexual and reproductive health within a comprehensive and evidence-based framework that also attends to the inter-connections with other relevant areas, such as mental health, education or drug and alcohol strategies. Given this, it can be argued that many current sexual and reproductive health policies, and others affecting sexual and reproductive health are not consistent with best practice.

Despite this, reproductive coercion has not informed policy development and law reform. This is likely due to the fact that reproductive coercion is either not recognised or is viewed as siloed from family violence, sexual health and sexual assault. Each of these sectors have their own distinct and separate history of policy development, law reform, and practice or service reform and each field has an important role in identifying and supporting women experiencing reproductive coercion.

3.2 Tiers of policy

Local, state and national policies greatly impact the ability of communities to respond to public health issues. While these impacts can be both positive and negative, the existence of policy can provide a whole-of-community view within which to frame a problem, particularly one as inherently difficult to establish as reproductive coercion. In the context of reproductive coercion, family violence, sexual assault and sexual and reproductive health, policies exist, to varying degrees, within the international, federal and state realms.

3.2.1 International policy context

Overarching international strategies, frameworks and policies provide a unique opportunity to place Australia within a global context, drawing on international research to guide the research agenda locally and to develop localised responses.

The Sustainable Development Goals (SDG) [56], which Australia endorsed in 2015, provide a global context to consider universal access to sexual and reproductive health, and more specifically the rights of women to control their reproductive autonomy. While these goals have a strong focus on Australia's foreign policy and development commitments, the SDGs are also designed to guide policy and actions domestically and within a human rights framework.

The role of the SDGs in addressing reproductive coercion has been referenced a number of times throughout the draft White Paper consultation process. Specifically parts of SDG 3, 4 and 5, although a case can be made that all of SDGs provide a relevant policy context to this issue.

3.7	By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes	3.7.1	Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods
		3.7.2	Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group
4.7	By 2030, ensure that all learners acquire the knowledge and skills needed to promote sustainable development, including, among others, through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship and appreciation of cultural diversity and of culture's contribution to sustainable development	4.7.1	Extent to which (i) global citizenship education and (ii) education for sustainable development, including gender equality and human rights, are mainstreamed at all levels in: (a) national education policies, (b) curricula, (c) teacher education and (d) student assessment
5.2	Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation	5.2.1	Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age
		5.2.2	Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence
5.3	Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation	5.3.1	Proportion of women aged 20-24 years who were married or in a union before age 15 and before age 18
		5.3.2	Proportion of girls and women aged 15-49 years who have undergone female genital mutilation/cutting, by age
5.4	Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate	5.4.1	Proportion of time spent on unpaid domestic and care work, by sex, age and location
5.6	Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences	5.6.1	Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care
		5.6.2	Number of countries with laws and regulations that guarantee women aged 15-49 years access to sexual and reproductive health care, information and education

Figure 3: Sustainable Development Goals 3, 4 and 5

The SDGs provide a positive policy and human rights context within which to address sexual and reproductive health, sexual assault and reproductive health. However there are other forms of international policy that have impacted negatively on these issues. The Mexico City Policy[57], more

commonly known as the Global 'Gag Rule' is a U.S Executive Order that prohibits any international organisation from receiving U.S Government funding if they provide or make referrals to abortion services – regardless of how those services are funded. The policy has resulted in vulnerable and isolated populations no longer receiving access to a range of sexual, reproductive, maternal and child health care; HIV and sexually transmissible infections testing and counselling[58]. Cervical cancer screening and access to contraceptives has also been severely limited. Each time this sanctioned reproductive coercion policy is resurrected by U.S Presidents, the health impacts faced by women are immediately evident including increases in the rate of unsafe abortions, unwanted pregnancies, STI infections and dramatic rise in the maternal death rate[58].

3.2.2 Federal policy context

There is a vacuum in national policy direction when it comes to sexual and reproductive health in Australia. Currently there is no overarching strategy to best direct policy, planning, interventions and funding. Given that universal access to sexual and reproductive health services plays such a significant role in reproductive autonomy and overall health and wellbeing, a national sexual and reproductive health strategy will help deliver on Australia's SDG commitments and should deliver equitable funding and service delivery across the nation.

The lack of sexual and reproductive health policy and support at a national level is best illustrated by the current patchwork of abortion laws, regulations and access across Australia. Abortion must be a critical, funded part of any federal reform in the sexual and reproductive health space. Currently there are significant gaps in abortion care deliver in Australia with Tasmania and North and West Queensland without adequate surgical abortion services owing to lack of funding and policy provision from the respective State Governments. Access to sexual and reproductive health services, of which abortion is a part, should not be determined by where a person lives. If Australia is to fulfil its obligations under the SDGs and to improve the health outcomes of the nation, this issue is dire need of resolution.

In the area of family violence, there has been more progress at a federal level with the development of the Family and Domestic Violence strategy[59]. There has also been significant advocacy and lobbying at the federal level from organisations such as Our Watch and individuals such as Rosie Batty AO. It is important that this national focus is not lost and far reaching reforms remain a policy and funding priority.

An area that does require urgent attention however is the issue of universal screening. Currently there is no mandated universal screening of family violence and intimate partner violence. While states and territories have implemented several screening tools, there is a unique opportunity to have a holistic, evidence-based overview of family violence, particularly intimate partner violence. However, it is important to note that screening ***on its own*** will not address issues such as family violence or reproductive coercion adequately. Screening must also be accompanied by education and workforce development initiatives and strong referral pathways to ensure there are adequate supports available to those experiencing violence and/ or coercion. This issue is discussed in further detail in the practice section of this draft White Paper.

Given that reproductive coercion can take place in the absence of sexual, physical, emotional, psychological and financial violence[23], there is a case to be made for universal screening that is a stand-alone tool designed to identify reproductive coercion. The need for a discrete tool has been raised several times throughout the consultation and submission stage of this draft White Paper.

QUESTIONS:

12. What are the mechanisms by which a national sexual and reproductive health strategy can be developed and funded?

13. How do we ensure such a strategy is funded and provides for uniform, non-discriminatory service provision of sexual and reproductive health services (including abortion provision) across the country?

3.2.3 State policy context

Across Australia, State and Territory Governments have addressed the issue of sexual and reproductive health, sexual assault and family violence in varied ways. Western Australia currently provides access to contraception and abortion care, counselling and associated support services through the provision of public sexual and reproductive health services in private health settings. This has had the dual benefit of decreasing costs to the State while increasing access to essential health services to western Australian women.

In Victoria from 2016 all key findings and recommendations from the Royal Commission into Family Violence[60] were comprehensively agreed upon with the Daniel Andrew's Government committing to fully fund the recommendations. State-wide government strategies were initiated for the prevention of violence against women and gender equity. However women carrying pregnancy to birth has only been marginally noted in the Royal Commission, while abortion and reproductive coercion were not mentioned.

While each of these strategies represents a considerable step forward, none specifically address or identify reproductive coercion as a public health issue despite the fact that international research affirms that woman at the early stages of pregnancy are highly vulnerable to the onset of intimate partner violence[53]. This oversight in informed policy means that no action is being taken to recognise the prevalence of the issue, address the issue and thus support women experiencing it. It remains a covert operant of family violence and so it is important that a light is shown on the issue and all of its intersecting factors and forces.

The Royal Commission into Family Violence recommendations identified coercion discreetly but not in relation to reproduction. This omission leads to systemic misconception and thus misdiagnosis in the sector of the sexual and reproductive aspects of family violence, its inherent relationship to intimate partner violence and prevalence. Due to uninformed policy and practice the real impact of reproductive coercion on family, lack of reproductive autonomy and the consequential psychological impacts of prolonged reproductive coercion are misdiagnosed and undertreated. This means women's real experiences of reproductive coercion continue to remain hidden regardless of recent policy and practice reforms in the family violence sector.

3.4 Women with a disability

Current Australian sexual and reproductive health policies for women with a disability focus on pregnancy or children only. These policies do not recognise that people with a disability have sexual and reproductive health needs. Current policies do not extend to ensuring women with a disability have access to key health services such as abortion and contraception. This can undermine the reproductive autonomy of women with disabilities. Currently no State of Federal policy addresses the forced sterilisation of women with a disability and few consider the woman's voice in decision-making or provision of choice in available reproduction or contraception options.

3.5 A multi-sectoral approach

Policy to address reproductive coercion must be underpinned by a comprehensive, multi-sector rights-based approach to sexual and reproductive health[54]. A critical element that has come out of the submissions is the need for this approach to encompass the three levels of prevention, as well as response. These policies must consider universal (population level), selective communities or psycho-social service contact points (targeted at specific communities or settings of need) and indicated approaches (targeted to individuals and families) and the needs of priority populations including young women, Aboriginal and Torres Strait Islander women, LGBTI+ people, refugee and migrant women, and those women living in rural or remote areas.

Research and data collection will help form the basis for policy makers and service planners to develop a national strategy on reproductive coercion. Greater breadth and depth of information encourages open dialogue, both in prevention-orientated consumer education and policy making settings. Policy that underscores education and training of the workforce is vital to ensuring appropriate support for women experiencing reproductive coercion, in addition to early identification strategies and clear referral pathways.

3.6 Politically motivated reproductive coercion

Politically motivated reproductive coercion can take many forms including withholding sexual and reproductive health and rights information and funding (for example, abortion access in Tasmania and North and West Queensland), obstructing access to health services or providers through legislation, attempting to ban services outright and empowering third parties to impose their views on others[25].

Both historically and today, women have been the target of reproductive coercion from the state. Such experiences include the forced removal of children from Aboriginal women and communities resulting in the Stolen Generations, permitting forced marriage and child marriage and forced sterilisation of women with disabilities. More broadly, limited access to affordable contraception and abortion continues to force many women to continue pregnancies against their wishes. This is particularly true for women in remote areas and women with low income. Political leadership in preventing reproductive coercion is critical to achieving meaningful changes for women.

Accessing contraception is a right protected by international law and applied to all women without discrimination[61]. However, some women face barriers to exercising their reproductive rights including women with disabilities and women from CALD backgrounds[62]. These barriers are mostly societal and are translated into paternalistic regulations that remove autonomy and choice, actively transferring decision-making to third parties without the opportunity to determine the woman's needs or preferences.

The current Australian criminal codes that criminalise abortion were written at the end of the 19th century. Today, these archaic laws act as a structural form of reproductive coercion; limiting choice, autonomy and in some cases forcing women to continue a pregnancy if they do not want. Further, they inform cultural and other systemic bias such as attitudes in the medical profession that can stigmatise a woman seeking an abortion.

Waitlists to access contraception in public health settings also highlight the reluctance of governments to address reproductive coercion. The lack of funded public provision of abortion and contraception services on a national level is a clear example of gender inequality and perpetuating reproductive coercion against the most vulnerable women who cannot afford to access these services in community-based or private health care settings.

QUESTION:

14. What are some of the other political drivers of reproductive coercion?

3.7 Drivers of gender inequality

The 2018 Breaking Ground report[63] produced by the U.S-based Centre for Reproductive Rights highlights that countries such as Australia often uphold patriarchal systems of control through reinforcing outdated and religiously-driven models of health. When it comes to sexual and reproductive health, this leads to gender bias and inequity and consequent loss of reproductive autonomy.

In order to prevent all forms of violence against women including reproductive coercion, the underlying drivers of gender inequality need to be addressed. This means:

1. Challenging the condoning of violence against women

2. Promoting women's independence and decision making

3. Challenging gender stereotypes and roles

4. Strengthening positive, equal and respectful relationships[63].

Gender discrimination and inequality continues to inhibit the ability of many people, particularly women and girls, to exercise autonomy and self-determination, as well as make important life decisions relating to their sexual and reproductive health and rights, without undue influence or coercion. Women and girls are unable to exercise reproductive autonomy where laws, policies and practices restrict this autonomy, imposing arbitrary or unlawful restrictions on their right to access sexual and reproductive health services and information. United Nations Treaty monitoring bodies recognise that women and girls are denied reproductive autonomy when they are subjected to violence and/or coercion[64].

3.8 Religiously motivated reproductive coercion

In Australia religion can be a particularly coercive force when it comes to reproduction. This is particularly apparent where faith-based organisations are contracted to run public hospitals. Under these contractual arrangements, contraception and abortion services are not available due to the religious-bias of the contracted agency.

The presence of religious picketers outside clinics that provide abortions is another form of coercion that exists in Australia. Safe access zones have helped buffer the coercive acts of picketers where such zones are mandated. They provide a bubble of safety for women seeking

sexual and reproductive health services such as abortions and contraception. The zones stop harassment, intimidation and filming and photographing of women as they are trying to access their chosen medical service. Safe access zones are currently in place in Tasmania, Northern Territory, the ACT and Victoria.

The ability for public health services and medical practitioners employed within public health settings to conscientiously object to the provision of abortion is another form of religiously (and politically) motivated reproductive coercion. Anecdotal evidence, particularly from Victoria and Queensland, shows that where a medical practitioner objects to the provision of abortion on religious grounds, they can deliberately obstruct or delay referring a woman to a service willing to assist her. This can result in the women either continuing the pregnancy against her wishes or having to seek an abortion service at a higher gestation increasing cost and potential risk.

QUESTION:

15. What are some of the other religious drivers of reproductive coercion?

3.9 Pregnancy Counselling

The Federal Government's 2006 pregnancy support counselling scheme[65] is also an example of reproductive coercion. The scheme excluded counsellors employed by abortion providers from being eligible to access Medicare funding for the provision of counselling under the Medicare pregnancy choices scheme. This ruling assumes, without evidence, that counsellors employed by abortion providers though bound by the same code of ethics as their peers, are prone to bias where other counsellors are not. This faulty condition has not been reviewed since its inception ten years ago.

As noted in the submission by Children by Choice[23], most pregnancy counselling services that support a woman's right to determine her reproductive outcomes fundamentally offer empathic and supportive, professional therapeutic relationships. These relationships are quickly built by the counsellor's capacity to engender trust and safety within the given therapeutic relationship while remaining mindful of gestational limitations that may inform the pregnancy decision-making process.

Pregnancy crisis counselling services that are sanctioned by faith-based groups and staffed by unqualified volunteers can also impact on a woman's reproductive autonomy. These free counselling services are often advertised as non-judgemental, options-based counselling support, however many are opposed to abortion and therefore actively persuade clients wishing to choose abortion, to continue their pregnancy. The psychological damage these services can have on vulnerable women due to insufficient knowledge of risk associated with family violence, the provision of misinformation, coercion towards pregnancy and lack of formal mental health training is an issue that requires Federal Government attention. In no other sector can such unregulated practices occur without legal ramifications. Unlike professionals working in the pregnancy counselling field, these masked organisation are not bound by ethical governance structures that preclude them from pushing personal bias guised as counselling.

4. Putting it into Practice

Addressing reproductive coercion in practice requires working on the prevention and the response sides of the issue. This next section explores both of these areas drawing on the knowledge provided in the submissions, the broader consultation process, the practical experience of Marie Stopes Australia and existing evidence and literature.

Marie Stopes Australia acknowledges the role it needs to play in developing and implementing practical measures to prevent and respond to reproductive coercion internally (these are highlighted in the recommendations section). However, as with much of the discussion in this draft White Paper, prevention and response efforts are multi-sectoral and require engagement from right across the health and family violence realms. No one organisation or entity can do it alone and so multi-agency alliances spanning public, private and not-for-profit sectors are especially important in addressing reproductive coercion.

4.1 Prevention

Marie Stopes Australia often works on the response side of the issue given the nature of the services provided by the organisation. However, prevention is just as important as responding to reproductive coercion, a message that has been delivered strongly through the submissions. The following prevention measures have been developed as part of the consultation process and will require further exploration and refinement.

4.1.1 Person-Centred

Not all experiences of reproductive coercion are the same, although they may follow similar patterns or have similar indicators. As such any prevention measures, or indeed response measures, need to be developed in consultation with those who have experienced or are at risk of experiencing reproductive coercion. This includes paying attention to those voices that are often silenced, overlooked or in some ways sidelined. These voices include women with disabilities, culturally and linguistically diverse communities, young women, Aboriginal and Torres Strait Islander communities and the LGBTIQ community. Just as family violence prevention initiatives need to be culturally appropriate, so too do responses to reproductive coercion.

Consumer advocates and Community Boards that exist within a number of hospitals and healthcare service providers provide an excellent opportunity to gain greater insights into how healthcare providers can better address underlying drivers of reproductive coercion. Such insights can help shape internal training and capacity building programs, screening tools and policies and procedures that can provide for greater reproductive autonomy.

4.1.2 Internal Culture

Great strides have been made in the way that organisations, particularly healthcare providers address the drivers of family violence. Initiatives such as the White Ribbon Workplace accreditation program have helped foster cultures that prevent discrimination and violence towards women internally and externally. Additionally, cultural safety and sensitivity programs have assisted healthcare providers to better support and provide patient-centred services to diverse communities.

In order for healthcare providers such as Marie Stopes Australia to play a role in preventing reproductive coercion, a light needs to be shone on the internal processes, practices and ensuing culture in a safe and productive way. This introspection will help to identify and remove conscious

and unconscious bias that may inadvertently impact on the reproductive autonomy of patients and staff.

4.1.3 Advocacy for Sexual and Reproductive Health Services

It is well established in the literature that universal access to sexual and reproductive health is imperative for overall health and wellbeing. It is also a necessary factor in ensuring people can exercise their reproductive decision-making and autonomy[61]. Healthcare providers can and should be involved in advocating for this universal access from an overall health perspective. Equally lobbying for universal access to these services is likely to play an important role in the prevention of reproductive coercion as it is an opportunity to provide information and services (such as long acting reversible contraception and screening) that will help people, particularly women, have greater control over their reproductive choices, thus helping to prevent coercion. From a practical standpoint, healthcare providers across the spectrum can lend their voices to government lobbying efforts to secure universal access to sexual and reproductive health services.

QUESTIONS:

16. What are the most relevant cultural training programs that exist to help equip sexual and reproductive health providers respond to reproductive coercion in culturally-appropriate ways?

17. What are some of the existing tools, training and practices that can be used to help shape healthcare provider responses to reproductive coercion?

4.2 Response and intervention

Response and intervention measures are critical to addressing the issue of reproductive coercion. Given the significant body of work that has taken place in the realm of family violence and sexual assault, there are a range of tools, techniques and practices that can either be employed, or used to shape the healthcare provider responses to reproductive coercion.

4.2.1 Universal Screening

It is important to note that universal screening on its own is unlikely to decrease prevalence of violence and/ or coercion. [11] However, when coupled with workforce training and development, provision of appropriate information and supportive referral pathways, screening can provide an opportunity to respond to specific instances of reproductive coercion. [21]

In Australia, most women who carry a pregnancy to term are routinely screened for violence during pregnancy through the Australian Maternal Health Program (note the ACT does not have a specific screening tool for violence during pregnancy). [66] Further, the Australian Government's Clinical Practice Guidelines[67] for healthcare professionals recommends that all women are asked about family violence at ante-natal visits. However screening of this nature is not widely employed in abortion care setting hence there is a bias of care towards women continuing their pregnancies compared to women who choose to discontinue their pregnancies.

A number of screening tools also exist across the community and law and order sectors to identify family violence including intimate partner violence. As research into reproductive coercion grows, the evidence will help inform the development of screening questions and standalone screening tools that can be applied across a range of healthcare and family violence support services. As a commitment to the growth of this research field, Marie Stopes Australia has committed to a

national screening trial for reproduction across its network of clinics. The results will guide and refine future screening and response mechanisms that can be applied across the sexual and reproductive health field.

Table 3: Current Family Violence Screening Tools

State	Tool
NSW	Domestic Violence Routine Screening[68] Domestic Violence Safety Assessment Tool (DVSAT)[69]
VIC	Common Risk Assessment Framework (CRAF)[70] SCTT single page screener on family violence (community health)[71]
ACT	None
QLD	Domestic Violence Risk Assessment Questionnaire[72] Children By Choice's Screening to Safety Tool[73]
WA	Common Screening Tool [74]
SA	AnteNatal Risk Questionnaire (ANRQ)[75]
TAS	ObstetrixTas[76]
NT	Domestic and Family Violence Survey[77]

Screening measures can be formal, such as the above tools, or they can be informal. It is imperative that informal measures are implemented in conjunction with formal screening tools. Questions designed to elicit disclosure will only go part of the way to identify coercive elements. Being able to identify help-seeking behaviour that is non-verbal or non-specific is a critical tool in identifying and hence responding to reproductive coercion.

4.2.2 Workforce development

In order to screen, formally and informally, for reproductive coercion there must be proper training and development initiatives in place to ensure healthcare providers and family violence support services can identify behaviours that can signal coercion, as well as to respond properly to disclosures. It is also imperative that training is ongoing, refreshed and formalised as part of workforce roles.

Training and development programs can be provided by employers to staff and as part of professional development programs through medical colleges such as the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), the Royal Australian College of General Practitioners (RANCGP) and the Australian College of Nursing (ACN). Ideally short refresher courses should attract Continuing Professional Development (CPD) points.

4.2.3 Referrals

Responding to instances of reproductive coercion means that healthcare providers such as Marie Stopes Australia are likely to come into contact with both victims of coercion and perpetrators of coercion. Building referral pathways with aligned organisations to support victims is paramount. These pathways need to be clear, the language used to refer victims needs to be accessible and shared across sectors, and the support structures need to promote a continuity of care for the victim.

Potential referral networks would be very similar to those in place for victims of family violence and can include (but are not limited to):

- Healthcare services and support (including maternal health, abortion and contraception care and trauma-informed counselling)
- Accommodation services
- Legal services including police liaison where appropriate and access to legal advice
- Financial assistance and support.

From a perpetrator perspective referral networks exist through the Men's Referral Network, Men's Line and No to Violence.

QUESTIONS:

18. How can reproductive screening and response training be incorporated into existing clinician training programs?

19. How can healthcare providers tap into existing family violence and intimate partner violence programs for victims and perpetrators of reproductive coercion?

20. How can family violence and sexual and reproductive health providers better work together in responding to reproductive coercion?

4.3 Partnership Approach

Addressing reproductive coercion requires a holistic, multidimensional approach that works at the prevention and the response ends of the issue. It is in the area of practice where all of the elements that incorporate prevention and response come together. As such the need for a multi-sectoral approach is imperative. Like family violence, a whole-of-community response will ensure that prevention and intervention initiatives have the very best chance of success. The need for a multi-sectoral approach has featured throughout the consultation process and within the submissions.

4.3.1 Partnerships in Practice

As has been outlined throughout this draft White Paper, reproductive coercion is, like family violence, intersectional in nature. Someone experiencing family violence may not necessarily disclose their experiences to a family or domestic violence support service. However, the evidence shows that there is a high number of disclosures made to healthcare professionals, particularly by women who are more likely to access healthcare than men[78]. It is important that when a woman discloses violence or coercion, healthcare providers '*meet her where she is'*. In other words, acknowledge her trust, respect where she is at in terms of her support requirements, and provide her with clear, accessible and high quality referral pathways should she ask for support. By the same token, someone disclosing reproductive coercion to a family violence support service deserves support to assist with appropriate sexual and reproductive health requirements.

4.3.2 Linking the Family Violence and Sexual and Reproductive Health Providers

Given the intersectional nature of reproductive coercion, there is a need to develop strong links between family violence support services and relevant sexual and reproductive health providers, be they STI screening and treatment facilities, contraception and/or abortion care providers. These links need to be supported by training and workforce development initiatives in both sectors

especially given that reproductive coercion can be deceptive in nature and awareness of what it is and what it constitutes is generally low among health practitioners[79]. It would also be reasonable to assume that awareness among family violence support service workers would likely be low.

The formation of these links is in line with the findings of the Victorian Royal Commission into Family Violence[60]. The Royal Commission found that the inter-relationships between family violence services, sexual assault services and universal health services are critical to identifying and addressing the issue. The Commission's Report also identified that some women who experience violence will not consider engaging with a family violence service but prefer to interact with health professionals at times of heightened risk, for example, during pregnancy. As previously highlighted in this report, failing to identify signs of family violence or minimising disclosures by patients can have a profound impact on victims and deter them from seeking help in the future[60]. The Commission made several recommendations for the general health sector going forward, including whole of workforce family violence risk assessment training and fostering coordinated, cross sector interventions.

Marie Stopes Australia acknowledges that many of the initiatives in this section require further investigation, research and partnership building. These areas will form part of the next phase of consultation in the finalising of this White Paper.

5. Priority Populations

While much of this draft White Paper has focused on the experience of reproductive coercion as it relates to women, addressing the issue of coercion requires an intersectional approach that is both tailored and developed with the each population group.

This section highlights priority populations based on the consultation process and through exploration of the current research on sexual and reproductive health outcomes and family violence prevalence.

5.1 Aboriginal and Torres Strait Islander women

On average, Aboriginal and Torres Strait Islander people experience poorer sexual and reproductive health outcomes than other Australians, including substantially higher rates of STIs, teenage pregnancy and birth rates; pregnancy complication rates low birth weights and rates of infant mortality[80]; Cervical cancer mortality[81]; and hospitalisation rates for violence related assaults.

Improving the sexual and reproductive health of Aboriginal and Torres Strait Islander people should be prioritised in national sexual and reproductive health strategies, and supported by sustained action at both federal and state levels that is developed and led by Aboriginal communities. Addressing reproductive coercion experienced by Aboriginal and Torres Strait Islander women is an important step to ensuring all Australian women are able to control their reproductive autonomy and in closing the gap in health outcomes between Indigenous and non-Indigenous Australians more generally.

Elders in Aboriginal communities are fundamental to sexual and reproductive health interventions, as is 'whole of community' engagement and capacity building among Aboriginal health workers. Community-led strategies with holistic, integrated approaches working with the whole family and community from a strengths based perspective are required to address the complexities involved with bridging the health gap.

The Royal Australian College of General Practitioners' Practice Guidelines[82] for working with patients experiencing violence and abuse includes a chapter dedicated to Aboriginal and Torres Strait Islander communities. This chapter notes the importance of addressing the issue of violence and abuse with Aboriginal and Torres Strait Islander patients presenting with indications of being a victim; as well as showing community leadership through local organisations to advocate for the provision of appropriate services.55

QUESTION:

21. What are some best practice examples of how community-led initiatives have improved the ability of Indigenous women to take control over their reproductive autonomy?

5.2 LGBTIQ people

Australian policies and laws have a long history of facilitating reproductive coercion of LGBTIQ people[83,84,85]. While marriage equality was the ultimate example of this, another is the requirement for a person to demonstrate that they have received surgery (sterilisation), in order to change the gender on their birth certificate. Unfortunately the involuntary or coerced sterilisation of LGBTIQ people, especially young people, in Australia is not new. So called "conversion therapy" and camps are still practiced in Australia and though largely illegal, continue to be offered by religious groups.

Trans and intersex people face additional challenges including structural barriers to accessing sexual and reproductive health care, medication and health screening, or to health services that presuppose binary gender categories that are assigned at birth. Within healthcare settings, gender-normative language and assumptions can play a powerful role in inhibiting access to health services and can act to encourage reproductive coercion[86, 87].

Research highlights that intersex people have reported being coerced into "normalising" procedures to remove gonads and other tissue[88]. Trans and intersex people remain at risk of cancers of the reproductive tract, including ovarian, cervical, uterine and prostate cancers [89]; however, they often underutilise screening services, and may avoid or delay seeking medical care due to fears of discrimination, judgment or stigmatisation.

Strategies to reduce reproductive coercion and improve sexual and reproductive health of LGBTIQ people must strive to balance focused interventions with equal emphasis on broader population initiatives that address social determinants of health regardless of gender.

QUESTION:

22. What are some best practice examples of initiatives that have improved the ability of LGBTIQ+ people to take control over their reproductive autonomy?

5.3 Women with a disability

Women with disabilities are more likely to experience violence, rape [90] and reproductive coercion than other women. However, very little data or research in Australia is available concerning the reproductive health and access to contraception for women with disabilities. Australia's first large-scale study investigating experiences of women with disabilities in obtaining gynaecologic care was only published in 2017 [91]. Even overseas, the most comprehensive study on the sexual and reproductive health of women with disabilities published in 2015 by Open University in the United Kingdom (UK) only sampled 19 women with learning disabilities [92].

The lack of research is hypothesised to be due to the need for studies involving women with disabilities to also look at intersectional discrimination and social taboo experienced by women with disabilities when accessing health care [93]. The call for more action in this research space is a regular one, most recently in 2016 from the Australian Healthcare and Hospitals Association calling for the creation of appropriate guidelines to support medical practitioners to assist women with disabilities in their contraceptive choice. Knowledge creation and the translation of this evidence into practice is critical in developing a more holistic understanding of how to address reproductive coercion of women with disabilities.

Australian policies and practices that support and regulate sexual and reproductive health services should ensure that healthcare is provided to people of all abilities [94]. Yet legislation regarding decision-making does not often follow a person-centred care or inclusive process, especially given that the wishes of the person with a disability are not always legally protected 117.

People living with disabilities experience reproductive coercion from family members and others. The 2013 Senate inquiry into the sterilisation of Australian girls and women with disabilities[95] documented numerous stories of coercion and force in relation to contraception and sterilisation, frequently without informed consent and including instances where decisions about a girl's or woman's reproductive health was made by a third party, such as a family member or foster carer.[96]

Similarly, Australian state and territory statutes dealing with guardianship, medical consent and health care are evasive when it comes to contraception, creating numerous access hurdles. The absence of a requirement to achieve informed consent infringes reproductive rights as does physical and attitudinal barriers in accessing contraception. A 2017 International Planned Parenthood Federation (IFFP) report acknowledges that women with disabilities are not recognised as sexual beings and that they lack information regarding family planning and contraception[62]. However, international surveys reveal an over representation of these contraceptive methods among women with disabilities.[97]

QUESTION:

23. What information is given to women with a disability on contraceptive options and their role in the decision making process?

While there is more accurate sexuality and relationships education available for young people with disabilities in mainstream and special development schools, access to appropriate information for adults with disabilities can be limited and controlled by individuals in positions of power.

All people with physical, cognitive, or psychiatric disabilities have a right to education when it comes to sexuality, sexual health care, and opportunities for sexual expression and affirmation of their gender. These information, education and resources are essential to support people with a disability to make informed choices about their sexuality and sexual and reproductive health needs. Medical practitioners, healthcare workers and other caregivers should also have access to comprehensive sexuality education, as well as training in understanding and supporting sexual development, behaviour, and related healthcare for individuals with disabilities.

QUESTION:

24. What is the best way to inform women with a disability about reproductive coercion and how to prevent it?

5.4 Refugee and migrant women

Many women from CALD backgrounds experience poor sexual and reproductive health outcomes due to the underutilisation of sexual health services, lack of knowledge, and social stigma associated with discussions of and expressions of sexuality. [98, 99, 100] Research shows that migrant and refugee women are at a greater risk of; poorer maternal and child health outcomes; lower use of modern contraceptive methods; and a greater risk of contracting STIs[101,102]. Young women from refugee backgrounds also experience elevated rates of teenage pregnancy relative to other young women. [103,104]

In a number of cultures, consent to participate in sex assumes consent to pregnancy. Maintaining privacy of sexual relationships is viewed as more important than whether a women consents to contraceptive use. In fact the only time reproductive coercion is prohibited is when a woman is coerced into an abortion[105]. In many cultures, family violence is considered a private matter and seldom discussed in public settings. It is likely that all forms of violence including reproductive coercion are unreported in a number of CALD groups.

Changing gender norms post-resettlement, and exposure to war and conflict in home countries may increase the vulnerability of women and adolescent girls to violence once in Australia. [106] Practices such as female genital mutilation (FGM) and early marriage are deeply engrained in societal values pertaining to women's sexuality. Patriarchal concepts of women's roles within the

family mean that women are often valued based on their ability to reproduce. Early marriage and pregnancy, or repeated pregnancies spaced too closely together, often as the result of efforts to produce male offspring, can have a devastating impact on women's health. [107]

The provision of reproductive and sexual health services to CALD communities requires culturally appropriate services, translation of information, and access to female health professionals. Some existing international resources include the WHO Inter-agency Working Group on Reproductive Health in Crises' Inter-agency field manual on reproductive health in humanitarian settings 2010; and the Women's Refugee Commission Facilitator's Kit: Community Preparedness for Reproductive Health and Gender. [108]

QUESTION:

25. What is the best way to include sexual and reproductive health promotion in resettlement processes?

5.5 Women in rural Australia

Women living in rural and regional Australian communities can experience reproductive coercion as a continuum through lack of availability of comprehensive sexual and reproductive health services; lack of privacy and confidentiality; conscious objection from health professionals; and fear of judgement and shame from peers, professionals and community members. "*Embarrassment, fear of or shame from family, community and refusal of doctor of pharmacist to supply contraceptio*n" was rated as the top issue affecting young people's sexual health by 72% of young women and men surveyed in regional Victoria[109].

Women living in rural and regional Victoria do not have timely access to sexual and reproductive health care, especially termination of pregnancy services. Even in areas where abortion reform and safe access legislation facilitate access to health care services, many women choose to travel to access health care in order to maintain their privacy. Telehealth also provides greater access, however in general women in rural and regional Australia struggle to control their reproductive autonomy through limited choices[110, 111,112].

QUESTION:

26. What are some best practice examples of how women living in rural and regional Australia can improve their ability to control their reproductive autonomy?

5.6 Young women

Adolescence is a critical time for the development of sexual identity and interpersonal relationships and the onset of reproductive coercion behaviours[113]. A range of population health surveys have identified an alarming trend of violence and reproductive coercion perpetrated against girls and young women. These findings regarding women aged 18-24yo include:

- experiences of sexual harassment in public occurs regularly
- significantly higher rates of physical and sexual violence than women in older age groups;
- and were more likely to continue a pregnancy that was a result of violence[114].

The early onset of sexual activity during adolescence is associated with a greater risk of unplanned pregnancy and STIs[115]. Acquiring STIs at an early age can impact future sexual and reproductive health, and result in infertility. Similarly teenage pregnancy is associated with a wide range of

indicators of poor health including economic disadvantage, compromised educational outcomes, and higher levels of psychological distress. [116]

Youth is also associated with risk-taking, including risk-taking in sexual activities[117,118]. The lack of relevant and accessible resources that address same-sex sexual health information, sexuality, and gender identity can be a barrier to preventing and responding to reproductive coercion. Barriers to accessing affordable, confidential, and comprehensive clinical services should be identified and minimised, particularly in relation to young people who are at risk.

Comprehensive data on the sexual health of young Australians that is cross-referenced with wider social indicators of health and wellbeing would provide a foundation for informed policy development and planning.

QUESTION:

27. What is the best way to collect and disseminate data on the sexual health of young Australians & best practice interventions?

6. Extending the exploration of reproductive coercion

Marie Stopes Australia sees thousands of patients each year. Each one of these patients has their own story and will approach their sexual and reproductive health decisions in their own context, something that is beautifully illustrated using Harms' multi-dimensional approach. Their decisions are influenced by a multitude of factors, some obvious and some unconscious. It is these unconscious or less obvious forces that make up 'grey areas'. In other words, their decisions are not made in the context of 'black or white', 'right or wrong'. As a species, humans are often very uncomfortable with the 'grey area', preferring instead to organise life in absolutes. When it comes to reproductive autonomy, the only absolute is that each person has a right to exercise their autonomy.

Much of the focus of the draft White Paper and the associated consultation and submissions have provided insights into how health-related and family-violence related evidence, policy and practice impacts on reproductive autonomy. However, as highlighted in the introduction and throughout the draft White Paper, power and control over reproductive autonomy exists along a spectrum. As such there are areas that are beyond the scope of expertise of Marie Stopes Australia and indeed beyond the scope of many of the stakeholders who have provided input so far. This section seeks to identify the forces that exist on the spectrum that can be characterised as 'grey'. There may be anecdotal evidence or assumptions that these forces do drive coercion. However, more exploration is needed in order to confirm this. These 'grey areas' highlighted below provide an opportunity for more diverse stakeholder input into the final White Paper and will guide the next stage of consultation. Each one has been accompanied by key questions to help guide consultation and feedback.

6.1 Social Norms

Social norms play a critical role in human development[68]. They shape how we think, behave and the context within which we make decisions. They shape traditional views of gender and consequent gender roles. They shape traditional views of motherhood (and fatherhood) and set expectations of these roles. They also shape how we view people who choose not to have children. Social norms can also influence expectations of parenthood; expectations that may often not meet reality or may generate a feeling of failure by a parent if they do not match expectations.

The degree to which social norms influence reproductive autonomy and their potential to drive reproductive coercion is an area worthy of further exploration.

QUESTIONS:

28. What are the key social norms that can impact on a person's reproductive autonomy?

29. What research and evidence exists that links social norms to the issue of coercion?

30. Are there examples of research, policy and/ or practice that show how communities have identified and addressed social norms as barriers to reproductive autonomy?

6.2 Media

Media can reinforce existing social norms, particularly when it comes to gender roles, traditional views of marriage and expectations of child-bearing and child-rearing. If you watch television during a week day, you are likely to see advertisements for cleaning and other household products that are targeted squarely at women, reinforcing the traditional view of women as being responsible for the primary child-rearing and domestic duties. Media coverage following the wedding of the Duke and Duchess of Sussex focused predominantly on when (not if) the couple would have children; reinforcing the traditional view of marriage as one built on child-bearing and child-rearing.

Media can also play a role in challenging existing social norms. The recent #metoo and #timesup movement is a prime example of how media has led the systematic questioning of social norms towards women in the media, as well as women in the workplace more broadly. Both social and traditional media platforms have amplified stories of discrimination, sexual assault, harassment and violence towards women and men in the media industry. The media has questioned the prevailing social norms of its very own industry. In doing so, it is driving awareness and social and structural change particularly when it comes to gendered drivers of discrimination in the workplace.

QUESTIONS:

31. To what extent does media influence reproductive autonomy?

32. What role can media play in addressing the issue reproductive coercion at a societal level?

6.3 Workplace Culture and Practice

A significant body of work has been done to improve workplace culture when it comes to addressing violence against women and creating workplaces that are respectful and supportive of the LGBTI community. However, there is still significant work that needs to be done to address the yawning gender pay gap, address underlying conscious and unconscious gender bias in the workplace and develop workplaces that do not penalise women (or men) for pausing their paid career to have children. Evidence also shows that the gender pay gap can widen for women once they do have children[119].

When you add to this the fact that the superannuation balance of a woman is just over half that of a man's[120], it is clear that workplace cultures and practices can play a significant role in influencing gendered discrimination, which in turn can lead to undue influence on a person's reproductive autonomy.

QUESTIONS

33. To what extent do workplaces cultures and practice influence reproductive autonomy and cause coercion?

34. Are there inherent biases in workplace legislation including the payroll tax system that could drive a decision not to have children or to delay having children?

35. What, if any, evidence, policy and practice examples exists that shows how workplace cultures and practices can hamper reproductive autonomy?

6.4 The Law

There is a dearth of knowledge when it comes to reproductive coercion and the law. While most states and territories have, to varying degrees, laws that govern consent, these laws may not have kept pace with social evolution.

The recent ABC Four Corners coverage of 18 year old Saxon Mullins and the 2013 rape trial of accused Luke Lazarus has brought into the light the issue of what constitutes consent. When coupled with recent phenomena such as 'stealthing' (the deliberate removal of a condom during sex), there is an opportunity to explore the legal dimensions of reproductive coercion, particularly in the context of consent.

QUESTIONS

36. What, if any, are the current laws that relate to reproductive coercion?

37. What impact will a definition of reproductive coercion have from a legal perspective?

38. What are intersecting legal dimensions of reproductive coercion with consent laws?

6.5 Continued Pregnancy

As an abortion care provider, Marie Stopes Australia predominantly engages with women seeking to discontinue their pregnancies. Therefore, much of the work of this draft White Paper has focused on reproductive coercion in relation to women seeking abortion care. While this subject has been addressed to a degree in the preceding sections, there is still a significant body of work that needs to be done to investigate reproductive coercion in the context of a continuing pregnancy. This is where maternal and child hospitals, General Practitioners, Obstetricians and Gynaecologists, Nurses and Midwives and pre and post-natal support services as well as associated colleges and professional organisations can play a critical role in addressing knowledge gaps in this area.

QUESTIONS

39. What evidence is available to help determine the prevalence of reproductive coercion in instances where women continue their pregnancies?

40. What role does (or should) the neo-natal and post-natal medical professional play in identifying and addressing reproductive coercion?

41. What are the structural barriers to neo-natal and post-natal medical professionals in addressing reproductive coercion?

Marie Stopes Australia recognises that there may be other areas that require investigation and welcomes contact from organisations and individuals who can provide greater context to reproductive coercion beyond the topics outlined above.

7. Recommendations

Marie Stopes Australia acknowledges that the draft White Paper process has already yielded some clear outcomes that need to happen in order to address the issue of reproductive coercion.

This section outlines recommendations from both an internal (Marie Stopes Australia) and an external (stakeholder, partner and macro level) perspective.

7.1 Internal recommendations

In the development of this draft White Paper, Marie Stopes Australia has made public and enduring commitments to address the issue of reproductive coercion. As an organisation that sees more than 100,000 patients each year for sexual and reproductive health services, it is important that the organisation can 'practice what it preaches' when it comes to addressing the issue of reproductive coercion

7.1.1 Workplace Culture and Practice:

- Embark on the White Ribbon Workplace accreditation program commencing in 2018/19;
- Audit patient touch-points to assess if and where there are practices that may inadvertently facilitate partner coercion, and commit to addressing any such practices; and
- Put in place a program of formal and informal screening techniques including piloting a national screening trial and committing to reviewing, assessing and publishing the results.

7.1.2 Education, Training and Development:

- Through the not-for-profit pharmaceutical arm of Marie Stopes Australia, MS Health, developed reproductive coercion training modules for registered prescribers of medical abortion;
- Commit to the training requirements that are part of the White Ribbon Workplace accreditation program; and
- Embed trauma- informed and empathy technique training across the organisation to better understand and respond to reproductive coercion.

7.1.3 Advocacy for Reform:

- Lead national advocacy effort to reform sexual and reproductive health policy , planning and funding of services such as abortion care so that no Australian is penalised when it comes to accessing these services based on where they live; and
- Continue commitment to actively lobby for abortion reform in each state and territory including increased publicly funded access, decriminalisation and the implementation of safe access zones.

7.1.4 Continued Commitment to Addressing the Issue of Reproductive Coercion:

- Finalise the White Paper and engage across multiple sectors and across governments to ensure the issue is afforded adequate attention and resources; and
- Commit to partnerships to address the issue of reproductive coercion on a national level.

Marie Stopes Australia commits to the above recommendations.

7.2 External recommendation

It has been highlighted many times in this draft White Paper that a multi-sectoral and multifaceted approach to addressing reproductive coercion is required. Hence the following recommendations have an external focus and concentrate on where stakeholder partnerships are required. Each recommendation includes a commitment from Marie Stopes Australia as to how the organisation can assist in these fields.

7.2.1 Agreement on Definition

As explored in the evidence section of this draft Paper, there is currently no formal consensus on the definition of reproductive coercion. It is therefore recommended that consensus is reached amongst those agencies, services and existing research bodies that directly and indirectly engage with reproductive coercion. This definition includes the intentionality, the engendered nature and the associated power and control drivers inherent in reproductive coercion. Further reproductive coercion can often act on a temporal continuum, meaning reproductive coercion may occur prior, during or after a formal or informal relationship exists.

Marie Stopes Australia commits to coordinate a process to try to reach consensus on the definition of reproductive coercion.

7.2.2 Legislative Reform

This draft White Paper strongly supports national reform that ensures equal access to abortion and other sexual and reproductive health services across all states and territories by the removal of existing coercive state and territory legislative barriers. The most important mechanism to do this is to reform the way sexual and reproductive health is funded. If funding is transferred from state and territory to the federal health realm, as is the case with primary health care, such a move would drive a nationally consistent approach to legislation and regulation.

Marie Stopes Australia commits to advocating for this national sexual and reproductive health reform to ensure no Australian is discriminated based on where they live.

Reform also needs to be focused on the Medicare Benefits Scheme (MBS) for three key reasons:

- Better data collection of sexual and reproductive health services;
- Reform of the provision that blocks pregnancy options counsellors who are co-located with abortion care providers from accessing the relevant MBS item number for pregnancy counselling; and
- Review, addition or amendment of MBS item numbers for sexual and reproductive health services including abortion and contraception so that they provide more support for Australians accessing these services.

Marie Stopes Australia commits to leading this reform discussion with government and other stakeholders.

Legislative provisions are explored to mandate disclosure of faith-based crisis pregnancy counselling so they must communicate biases that can impact on clients' mental health and

reproductive autonomy. Such legislation has been drafted and sponsored previously in the Australian Senate[121].

Marie Stopes Australia commits to furthering this conversation at a federal government level.

7.2.3 Data Collection Gaps

To collect and effectively work with comprehensive data sets regarding abortion prevalence and intersectionality with family violence, abortion in clinical and non-clinical settings needs to be nationally coded using the ICD methodology of medical coding. Because a surgical abortion procedure is indiscriminate within this coding capture, all public, private and community providers of dilation and curette procedures are not required to specifically report abortions thus distorting key data sets that are foundational to the establishment of research in this field.

There is also currently no requirement for medical abortion procedures to be reported on retrospectively i.e. whether the patient has completed the procedure or not, further distorting a national data set of prevalence.

Marie Stopes Australia commits to lobby to reform ICD medical coding to appropriately reflect procedures and their prevalence.

7.2.4 Research and Knowledge Sharing

In order to address the issue of reproductive coercion, it is important that the issue is adequately represented in cross sector forums. This will assist with knowledge sharing and establishing links across the healthcare and family violence sectors and beyond. This includes regular submissions to present at conferences, publishing of research papers and establishment of research collaboration groups.

Marie Stopes Australia commits to publishing relevant research and submitting abstracts to present at relevant cross sector conferences on the issue of reproductive coercion.

7.2.5 Workforce Development, Education and Training

To build the capacity of healthcare professionals to appropriately respond to reproductive coercion it is important that the subject is embedded in training programs across medical colleges and in undergraduate and graduate degree curriculum (e.g. medicine, psychology, social work and public health).

Marie Stopes Australia commits to engaging with training colleges including RANZCOG, RACGP and ACN as well as relevant universities.

Marie Stopes Australia acknowledges that these recommendations, particularly those classified as external, need to be subjected to greater scrutiny from other expert stakeholders. The organisation welcomes further comment on these recommendations throughout the forthcoming consultation process.

8. Timeline for Action

- **1 June 2018 – release of Hidden Forces: Shining a Light on Reproductive Coercion (draft)**
  Draft of the White Paper is released for comment and further consultation. Marie Stopes Australia will seek comment from stakeholders across Australia and will undertake targeted face-to-face and phone interviews with relevant experts and specialists.

- **17 August 2018 – White Paper consultation closes**
  Consultation period for White Paper concludes.

- **19 October 2018 – release of Hidden Forces: Shining a Light on Reproductive Coercion (final)**
  Final White Paper will be released with series of targeted briefing sessions and public relations activity.

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10. Table of questions

Introduction

1. What are examples of how the health, sexual and reproductive health and family violence sectors can collaborate to address reproductive coercion in Australia?
2. What are some best practice examples of how other heath sectors have engaged with abortion providers to address reproductive coercion?

Evidence section

3. What are the critical elements that need to be included in the definition of reproductive coercion?
4. What are the means by which to bring together multiple sectors to develop and reach consensus on a definition?
5. What are the means by which the voices of those experiencing or at risk of experiencing reproductive coercion are captured in the process of defining reproductive coercion?
6. How can we begin to understand the multiple experiences of reproductive coercion along different population groups?
7. What research methods should be employed to capture these experiences?
8. What are the key research partnerships that need to be established?
9. What role do health literacy programs play in addressing the issue of reproductive coercion?
10. How can reproductive coercion be included in existing health literacy programs?
11. What else should be covered when considering the research gaps and requirements to address reproductive coercion?

Policy section

12. What are the mechanisms by which a national sexual and reproductive health strategy can be developed and funded?
13. How do we ensure such a strategy is funded and provides for uniform, non-discriminatory service provision of sexual and reproductive health services (including abortion provision) across the country?
14. What are some of the other political drivers of reproductive coercion?
15. What are some of the other religious drivers of reproductive coercion?

Practice section

16. What are the most relevant cultural training programs that exist to help equip sexual and reproductive health providers respond to reproductive coercion in culturally-appropriate ways?
17. What are some of the existing tools, training and practices that can be used to help shape healthcare provider responses to reproductive coercion?
18. How can reproductive screening and response training be incorporated into existing clinician training programs?

19. How can healthcare providers tap into existing family violence and intimate partner violence programs for victims and perpetrators of reproductive coercion?
20. How can family violence and sexual and reproductive health providers better work together in responding to reproductive coercion?

Priority population section

21. What are some best practice examples of how community-led initiatives have improved the ability of Indigenous women to take control over their reproductive autonomy?
22. What are some best practice examples of initiatives that have improved the ability of LGBTIQ+ people to take control over their reproductive autonomy?
23. What information is given to women with a disability on contraceptive options and their role in the decision making process?
24. What is the best way to inform women with a disability about reproductive coercion and how to prevent it?
25. What is the best way to include sexual and reproductive health promotion in resettlement processes?
26. What are some best practice examples of how women living in rural and regional Australia can improve their ability to control their reproductive autonomy?
27. What is the best way to collect and disseminate data on the sexual health of young Australians and best practice interventions?

Extension topics section

28. What are the key social norms that can impact on a person's reproductive autonomy?
29. What research and evidence exists that links social norms to the issue of coercion?
30. Are there examples of research, policy and/ or practice that show how communities have identified and addressed social norms as barriers to reproductive autonomy?
31. To what extend does media influence reproductive autonomy?
32. What role can media play in addressing the issue of reproductive coercion at a societal level?
33. To what extent do workplaces cultures and practice influence reproductive autonomy and cause coercion?
34. Are there inherent biases in workplace legislation including the payroll tax system that could drive a decision not to have children or to delay having children?
35. What, if any, evidence, policy and practice examples exists that shows how workplace cultures and practices can hamper reproductive autonomy?
36. What, if any, are the current laws that relate to reproductive coercion?
37. What impact will a definition of reproductive coercion have from a legal perspective?
38. What are intersecting legal dimensions of reproductive coercion with consent laws?
39. What evidence is available to help determine the prevalence of reproductive coercion in instances where women continue their pregnancies?
40. What role does (or should) the neo-natal and post-natal medical professional play in identifying and addressing reproductive coercion?
41. What are the structural barriers to neo-natal and post-natal medical professionals in addressing reproductive coercion?

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