Reproductive Coercion

Submission to

Marie Stopes Australia

Victorian Rural Women's Health Organisations

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WOMEN'S HEALTH GOULBURN NORTH EAST
Challenging inequity, embracing diversity.

gippsland women's health

WOMEN'S HEALTH AND WELLBEING
Barwon South West Inc.

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This submission is a joint initiative of the five Victorian rural women's health organisations: Women's Health Goulburn North East, Women's Health Loddon Mallee, Gippsland Women's Health, Women's Health Grampians and Women's Health and Wellbeing Barwon South West.

The rural women's health organisations commend Marie Stopes Australia for providing the opportunity to contribute our collective knowledge and understanding of rural and regional women's lived experience of reproductive coercion through an intersectional lens.

Through critical analysis of international and emerging Australian studies *and* rural women's stories, the submission aims to highlight the impact of reproductive coercion and other factors on women's sexual and reproductive health choices, decisions and autonomy.

Recommendations to Marie Stopes Australia are based on promising practice to build workforce knowledge and sector capacity to:

- sensitively screen for women's lived experience of all forms of reproductive coercion;
- provide support aligned to diverse women's individual needs and priorities to empower their sexual and reproductive health choices and decision making;
- Build knowledge and evidence of reproductive coercion in different Australian contexts through an intersectional approach to identify the short and long- term impacts of reproductive coercion on women's sexual and reproductive health and wellbeing.

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Women's sexual and reproductive health and reproductive coercion

Sexual and reproductive health is a fundamental issue for all women, affecting them at every life stage. It is an important factor in shaping how women develop and maintain meaningful interpersonal relationships, appreciate their bodies, interact with others, express affection, love and intimacy, and by choice, bear children. The human rights of women include their right to have control over and decide freely on matters related to their sexuality, including their sexual and reproductive health, free of coercion, discrimination and violence (Women's Health Victoria, 2009).

Due to biological, social and economic factors, the impact of poor sexual and reproductive health is greater on women. It is now recognised that a woman's experience of coercion and sexual violence has long term consequences for her sexual and reproductive health, from "unintended pregnancy and unsafe abortion, to gynaecological disorders and sexually transmitted infections including HIV/AIDS" (WHO, 2010, p.135). Originally defined as "sexual coercion", (Heise, Moore and Toubia, 1995), coercion referred to a wide range of sexualised behaviours including verbal harassment, intimidation, physical force, social pressure and intimidation of all kinds (WHO, 2010, p.136).

In USA analyses of World Health Organisation international research into violence against women (2005), male intimate partner violence, defined as physical, sexual, emotional and financial abuse, led to poor sexual and reproductive health outcomes for women including:

> *decreased control over one's sexuality*
> *as well as decreased contraceptive use…*
> *increased unplanned pregnancy and…*
> *sexually transmitted infections…*
> *unsafe sexual behaviour, pregnancy*
> *complications, unwanted pregnancy and*
> *unsafe abortion* (Moore, Frohwirth, Miller, 2010, p.2).

Common to USA studies of women with a history of intimate partner violence (IPV) was the mechanism of male reproductive control, which encompasses "pregnancy promoting behaviours" as well as control and abuse during pregnancy in an attempt to influence the pregnancy outcome (Moore et al, 2010, p.1).

Examples of male reproductive control can be found in violent and non- violent relationships can be described as pregnancy promotion behaviours, to exert further control and power over women's choices and decision making.
These forms of reproductive coercion include:

- destroying contraception or preventing any form of contraception;
- refusal to use condoms, threats against a woman who insists on condoms;
- *stealthing*, removing condoms before or during sexual intercourse;
- coercing a woman to have sex, become pregnant and continue a pregnancy as a sign of her love or fidelity;
- denying or preventing access to unbiased pregnancy choices counselling and fertility control service; and
- rape (Children by Choice, 2017).

Other forms of pregnancy controlling behaviours in the context of women's relationships with a partner, family members and others, include coercing or forcing a woman to use contraception, have an abortion or be involuntarily sterilised.

Women living with disabilities in Australia experience reproductive coercion from family members and others through manipulation, intimidation and force. The 2013 Senate inquiry into the sterilisation of Australian girls and women with disabilities 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 (Fromader, 2014).

The recent Royal Commission into Institutional Responses to Child Sexual Abuse exposed reproductive coercion from state authorities overseeing girls and young women detained at Winlatan Children's Home, including forced administration of Depo Provera contraceptive injections and gynaecological examinations (Hall, 2015).

Definition of reproductive coercion as a continuum

Reproductive coercion refers to the attitudes and behaviours of individuals as well as state policy and legislation aimed at establishing and maintaining power and control of a woman's sexual and reproductive autonomy (Walsh, 2016).

Central to this definition of reproductive coercion is the loss of conditions that enable autonomy in women's sexual and reproductive decision making, often in relation to their socioeconomic conditions, available social supports and exposure to violence, as well as policy and legislative contexts.

Intersections between a woman's individual circumstances and structural issues related to gender, (dis)ability, ethnicity and class lead us to understand 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 governments and the state" (Walsh, 2016, p. 91).

According to the Guttmacher Institute, a peak USA reproductive advocate, coercion can take many forms and includes the behaviours of individuals, faith- based groups and the state aimed at withholding information and/or contraceptives and "obstructing access to health services or providers, attempting to ban services outright and empowering third parties to impose their views on others" (Dreweke, Guttmacher Institute, 2018).

The Guttmacher Institute argues that these forms of coercive measures particularly target people who are already experiencing multiple forms of disadvantage, such as women who have a history of intimate partner and family violence, those who are homeless or experiencing financial insecurity, women who are living with disability, women within minority groups such as Aboriginal or Torres Strait Islander communities, refugees and newly arrived immigrants, young women, and women living in rural and remote areas. An example of how state forms of reproductive coercion limit the reproductive choices and decisions of those who already experience disadvantage can be evidenced in Queensland and New South Wales, where abortion remains on the books as a crime, and access to a safe abortion often "remains out-

of-reach for poorer women and women from regional and remote areas…" (Boyce, Pro Choice Queensland).

As a form of gender- based violence, reproductive coercion gets in the way of women being able to freely and meaningfully consent to sex, or to control decisions related to their sexual and reproductive health and wellbeing (Children by Choice, 2017; White Ribbon Australia, 2017).

Prevalence

International research of reproductive coercion focuses on pregnancy controlling behaviours within intimate partner relationships. Studies in the United States highlight high rates of reproductive coercion for women with a history of intimate partner violence (IPV), one study finding almost three quarters of seventy-one women experiencing IPV had described some form of reproductive coercion (Moore et al 2010).

While reproductive coercion is an emerging area of research in Australia, there is a growing body of information and evidence being collected by women's sexual and reproductive health advocates and service providers. Research by Women's Health Goulburn North East focusing on the experiences of rural women, Aboriginal women and partner rape, confirmed that pregnancy was a time of increased risk for women experiencing violence from a partner, including sexual violence and rape (WHGNE, 2008).

The independent, non-profit organisation Children by Choice (CBC) provides unplanned pregnancy counselling, information and referral services for women living in Queensland. Through analysis of client data since 2015, CBC has identified clear trends for reproductive coercion amongst women accessing their services including:

- *Around one in eight CBC contacts are with women experiencing reproductive coercion;*
- *Women from culturally and linguistically diverse (CALD) and Aboriginal and Torres Strait Islander (ATSI) backgrounds are over-represented, with up to one in five CALD and ATSI contacts reporting reproductive coercion;*
- *Up to 60% of contacts experiencing reproductive coercion are aged in their 20s;*
- *A quarter of those experiencing reproductive coercion don't report any other form of violence or control, but 74% report domestic violence and 24% sexual violence (with some overlap between these groups); and*
- *Contacts reporting reproductive coercion were more than three times more likely to experience suicidality as our general contact base, and almost twice as likely to experience mental health problems* (Children by Choice, 2017).

Research into unintended pregnancy and fertility management in Australia measured participants' experiences of "sexual coercion" in two of the survey questions completed by 2,225 male and female respondents aged between 18 and 51 years. Of the 1,543 women

respondents, 27% reported experiencing “sexual coercion”, where they recorded being “forced or frightened by someone into doing something sexually that you did not want to do”.
“Forced sex, presumably rape” was endorsed by 6 women or 2.8% of all respondents as “a specific reason for an unintended pregnancy (Rowe et al. 2015).

Reproductive coercion as a ‘hidden’ experience

There is a clear need for more research into women’s lived experience of reproductive coercion to inform prevention and service response, as coercion is often ‘hidden’ within the complexity of issues influencing women’s lives. Violence support, sexual assault and sexual and reproductive health sectors respond to immediate and presenting issues, and women’s experience of layers of reproductive coercion may be overlooked or unseen. All sectors including women’s health, violence prevention, academic, policy and law reform have a role to play to:

- increase knowledge about women’s lived experience of reproductive coercion from individuals and the state;
- build evidence regarding the impact of the continuum of reproductive coercion on women’s health and wellbeing throughout life;
- develop a range of women centered strategies to support and empower women experiencing reproductive coercion.

An intersectional approach to reproductive coercion

Working from a feminist informed social model of health, women’s health organisations are uniquely positioned to understand the impact of different forms of reproductive coercion and their intersections on women’s health and wellbeing. Overarched by a rights-based lens, our work aims to understand and address intersections between key determinants including women’s experience of gender based violence, and factors impacting outcomes for their sexual and reproductive health.

The following case studies are based on a range of women’s stories shared with rural women’s health organisations. As a snapshot of women’s diverse lived experience, the stories highlight how intersections between different forms of reproductive coercion and issues identified in rural settings including privacy, availability and access, can police women’s sexual and reproductive health choices and decision making. Pseudonyms have been used to protect the identity of women and other individuals.

Case Study 1

Wendy is 16 and lives in a small rural town. She was reluctant to see a local doctor for contraception because an extended family member worked at reception. There were two private GP clinics in town but neither advertised bulk billing and she couldn't afford the upfront cost of a medical appointment. She and her boyfriend normally use condoms but after unprotected sex, Wendy went to the local pharmacy for emergency contraception. She knew all the staff and felt embarrassed asking for the 'Morning After Pill'. When the pharmacist came to the counter he lectured her saying she was too young for him to provide emergency contraception.

When Wendy found she was pregnant, her boyfriend said she had to have an abortion or everyone would think she was 'sleeping around'. Her mother offered to drive her to a clinic in another town to see a newly arrived GP. This doctor said he couldn't refer her for an abortion because of conscious objection and suggested she see a doctor in her own town. Wendy was 9 weeks pregnant when she visited the regional community health centre, a two-hour return drive. The sexual health nurse discussed pregnancy options with Wendy, explaining that additional time needed for blood tests and screening ruled out medical termination. Wendy's parents were angry with her and demanded she organise a surgical termination in Melbourne, 300 kilometres away.

Despite abortion reform and safe access legislation ensuring that Victorian women have a right to legal abortion services without fear of intimidation and loss of privacy, women living in rural and regional Victoria do not have timely access to sexual and reproductive health care and termination of pregnancy services (WHAV, 2012; Victorian State Government, 2017; Keogh et al, 2017).

Women living in rural and regional communities can experience reproductive coercion as a continuum from individuals and the state through lack of availability and privacy, 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 contraception*" was rated as the "top" issue affecting young people's sexual health by 72% of 453 young women and men surveyed in regional Victoria (WHGNE, 2013).

Case Study 2

Maria is 44 with mild intellectual disability. She lives independently in supported accommodation in a large regional town. Her elderly mother lives a few blocks away and Maria relies on her help with transport and household management. Maria had little education about sexuality or sexual health when she attended a 'special school' in rural Victoria. She does a couple of activities each week with other people living with disabilities.

Since his wife died, the older man in the unit next door offered to help Maria with repair jobs. Maria enjoys the company but became frightened when he said he wanted to sleep with her. When Maria told her mother, she said she'd have nothing to do with Maria if she became pregnant.

Maria's mother organised a medical appointment with the family GP who arranged for Maria to have a tubal ligation at the local hospital. Maria was confused about what was going to happen, but she didn't want to cause trouble with her mother. Maria felt miserable after the surgery and the man next door visited more to help out. He told Maria that the operation was good because he could stay overnight and look after her and she wouldn't 'get into trouble'.

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

Evaluation of a community leadership program for rural women living with disabilities, highlighted women's lack of knowledge about their basic right to be safe, free from all forms of abuse and violence. The study found that women living with cognitive and intellectual disability were particularly vulnerable to coercion and abuse where family members, guardians and others in positions of authority provided no or limited choices for social interaction and community participation. Barriers to health and other services, education and employment were exacerbated by the lack of safe, accessible transport in rural and regional communities (WHGNE, 2017).

Case Study 3

Josie and her partner have three young children and live in a regional town in North East Victoria. The family has limited income but receive practical support from the church community they belong to. Josie and her partner decided on an abortion when she discovered she was 10 weeks pregnant. The closest fertility control clinic for surgical abortions was in Albury NSW, a 35 km drive from Josie's town. As Josie approached the clinic, she recognised a member of her church amongst the protesters. The woman called out Josie's name and thrust a small doll into her hand, saying abortion was murder. Josie felt humiliated and left the clinic in tears.

Travelling to Melbourne for a surgical abortion was the only option left that gave Josie privacy and safety without judgement, but she felt overwhelmed by the 7 hours return travel on top of the cost of the abortion. The community health centre put her in touch with the regional Women's Health organisation, who helped her organise a No Interest Loan to cover the cost of an abortion with a Melbourne provider. Loan repayments were negotiated with Josie to suit existing financial commitments and family circumstances. Josie's additional costs for the train travel and one night's accommodation were subsidised by the rural Women's Health organisation through a fund specifically established to address barriers to sexual and reproductive health services for women in regional areas.

The third case study highlights reproductive coercion from members of faith-based communities who continue to intimidate and harass women attending abortion services in NSW. Women's loss of privacy and reproductive autonomy is exacerbated by state perpetuated reproductive coercion, as successive NSW governments continue to 'criminalise' abortion and condone reproductive coercion through lack of *safe access* legislation.

The case studies highlight how women's lived experience of reproductive coercion from individuals and the state can exist as a continuum to influence their sexual and reproductive autonomy and decision making at different life stages. An intersectional understanding of reproductive coercion allows consideration of different forms of reproduction coercion with other issues impacting woman's lives to shape outcomes for their sexual and reproductive health and wellbeing. Women's health organisations and service providers in violence support, justice and sexual and reproductive health who adopt a woman centred, intersectional approach, can create opportunities to consider the layers of sexual and reproductive coercion impacting women's safety, health and wellbeing to enable holistic support appropriate to each woman's needs.

Case study 3 demonstrates the value of cross sector partnerships between Women's Health organisations and sexual and reproductive health service providers in private and public health sectors. Partnerships based on women's rights and the shared goal to enable women's sexual and reproductive health choices and access, can galvanise co design with government, organisations, diverse women and communities to build new knowledge about women's experiences of reproductive coercion. Partnerships for collective and transformative action can provide opportunities to develop a range of interventions informed by women's lived experience that support and empower women.

What can Marie Stopes Australia (MSA) do?

- Build workforce knowledge and skills with MSA staff and partners to sensitively screen for and respond to women's experiences of all forms of violence, including sexual and reproductive coercion from individuals: intimate partners, family members, peers and those providing services and support from private, public sector, community and faith based organisations.

- Ensure screening, response and referral procedures are consistent, private and safe for women to access MSA services on site, and by phone. Provide options to women that ensure their safety for service contact, remote access and delivery of medication. Primary Health Networks in partnership with MSA could play an important role in building workforce knowledge, skills and referral pathways in rural areas.

- Build workforce knowledge and skills to sensitively screen for and respond to women's experiences of sexual and reproductive coercion in 'non-violent' relationships, including pregnancy controlling behaviours from intimate partners, family members, disability workers and others that coerce or control women's decisions regarding their sexual and reproductive health.

- Increase women's access to MSA services through the provision of additional support that considers women's individual needs for privacy, safety and accessibility. Additional support should enable women's privacy and safety for on-site and remote MSA services and could include:
  - financial assistance with travel, childcare and accommodation costs;
  - female translators and support staff trained in violence awareness and referral pathways;

- Safe on site and remote access sites to enable private MSA screening, counselling and referral services with women. MSA partnerships with women's health organisations and sexual and reproductive health service providers in public and private sectors (Community Health, Hospitals, GP clinics) could identify a range of safe, remote access sites in metropolitan and rural settings, to enable women's choice and privacy for telephone screening, counselling and referrals. In partnership with MSA, Primary Health Networks could undertake a direct advocacy role to identify a range of safe, accessible remote sites, and provide workforce training to support women's privacy.

- Develop cross sector partnerships with Primary Health Networks, women's health and violence support sectors to build capacity to adopt intersectional approaches to sexual and reproductive coercion that support and empower women of all abilities. Collaborative partnerships in rural and metropolitan settings could include women's health organisations and sexual and reproductive health service providers, sexual assault, domestic and family violence support organisations.

- Establish additional No Interest Loan Scheme (NILS) partnerships with women's health organisations and advocacy groups in rural and metropolitan areas. MSA partnerships based on enabling women's sexual and reproductive rights would provide women experiencing coercion and disadvantage with increased options and choice through timely and affordable access. Existing MSA partnerships with Children By Choice and Women's Health Goulburn North East are models that improve choice and access for women who are most disadvantaged.

- Collect and review data on the prevalence of Australian women's experience of reproductive coercion from individuals and the state. Critically examine rates of long acting reversible contraception prescription for women with disabilities and Aboriginal women, as well as rates of sterilisation of girls and women living with disabilities.

- Work in partnership with women's health, violence support and disability sectors to research the prevalence and lived experience of sexual and reproductive coercion amongst diverse girls and women living with disabilities in metropolitan and rural settings. Include coercive behaviours from individuals and the state that deny or prevent the sexual and reproductive rights of people with disabilities, including withholding access to accessible, rights based sexual health, sexuality and relationships information.

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