SPHERE
NHMRC Centre of Research Excellence in Sexual and Reproductive Health for Women in Primary Care

Women's Sexual and Reproductive Health COVID-19 Coalition

A Consensus Statement on Reproductive Coercion

The Coalition makes the following recommendations in relation to reproductive coercion in Australia:

Practice

- ***Sensitive enquiry for reproductive coercion of people at risk should be embedded in the provision of primary care****, particularly in sexual and reproductive health services, the provision of Domestic and Family Violence (DFV) support, and Maternal and Child Health (MCH) services.*

  Sensitive enquiry, routine screening or safety planning should not be undertaken without adequate supports, i.e., regular training of health providers, supervision and support from managers, and other best practice health system supports as outlined by the World Health Organization (WHO).

  Organisations utilising routine screening should align the practice with appropriate training aimed at building confidence and knowledge to respond to reproductive coercion by supporting client access to safety planning and relevant resources.

Professional education and training

- ***Primary care organisations and others involved in DFV response should integrate mandatory DFV (including reproductive coercion) training.***

  For health professionals, training should commence in undergraduate education, continue across accreditation, and be included in continuing professional education. Training should consider the following: the need to safely speak alone with the woman, legal obligations, and safeguarding issues for staff.*

  Best practice with diverse (such as Aboriginal and Torres Strait Islander, migrant, refugee and LGBTQI+) communities should include standards for identity affirmation and cultural safety and competency, as understanding of coercion differs greatly across cultures and contexts. For example, access to appropriately trained first-language interpreters and/or cultural liaisons should be ensured where applicable.

Community education and training

- ***Relationships and sexuality education should be offered throughout the lifespan*** *to empower individuals and communities to reduce the risk of reproductive coercion, or ideally prevent it from occurring.*

- ***DFV community awareness campaigns should include reproductive coercion and be based on meaningful community engagement and community identified priority needs.***

Policy and legislation

- ***Reproductive coercion should remain outside of the criminal code and mandatory reporting of reproductive coercion should not be a requirement of health providers.***

  If coercive control is criminalised, definitions of coercive control within criminal law should omit any reference to sexual and reproductive health, as this would significantly hamper disclosure and the woman's agency. While reproductive coercion is a form of coercive control and can be a factor in DFV, to respond in clinical settings, reproductive coercion should remain outside of the criminal code.

Background

Domestic and family violence (DFV) is prevalent globally and can severely damage the health of women and families. Intimate partner violence, the most prevalent form of DFV can damage women's sexual and reproductive health specifically (WHO, 2021). Reproductive coercion (RC) is a distinct form of DFV associated with other forms of gender-based violence, including coercive control, and intimate partner and sexual violence (Tarzia & Hegarty, 2021). RC is a public health problem of global concern associated with higher rates of unintended pregnancies, abortion, and negative reproductive, maternal, parental, and child health outcomes (Grace and Anderson, 2018). Whilst not isolated to the pandemic, COVID-19 is likely to have exacerbated RC, as evidenced by an increase in recorded unwanted pregnancies, increased alcohol and other drug consumption, and other factors linked to DFV (Bourgault et al., 2021).

Definitions and prevalence

RC is a highly contested term and there is no agreed definition or measurement tool, nor strong evidence of its prevalence and impact on society. Although a widely accepted and clear definition of RC is lacking, there is consensus that RC encompasses behaviours that interfere with a person's reproductive autonomy (Grace and Anderson, 2018; Marie Stopes, 2020) and include behaviours which extend beyond rape. Some definitions describe RC as actions at the interpersonal level to control pregnancy outcomes against a person's will. The intent of RC is either to:

- *prevent pregnancy* by means such as:
  - forcing a termination of pregnancy (i.e., abortion); and
  - forced contraception use (e.g., intrauterine (IUD) insertion); or
- *promote pregnancy* by means such as:
  - contraceptive sabotage (deliberately tampering with a condom or oral contraception to decrease effectiveness); and
  - forcing a continuation of an unwanted pregnancy (Tarzia and Hegarty, 2021).

At an interpersonal level, RC may be perpetrated by an intimate partner or a family member, such as a mother-in-law (Grace and Anderson, 2016). Some definitions suggest RC cannot occur without abuse, thus emphasising the inclusion of 'abuse' in any definition (Tarzia, 2019), and there are debates about whether both women and men can be victims of RC (Tarzia & Hegarty, 2021). Other definitions include structural aspects, such as socioeconomic, political, and cultural norms, practices, and polices, or highlight intersectionality, such as the dual experience of racism and homophobia, which may interfere with a person's reproductive decision making (Marie Stopes, 2020). System level examples of RC extend to women with disabilities (e.g., forced sterilisation or use of a intrauterine device or contraceptive

implant), or those culturally and individually embedded such as coerced or implied female feticide (termination of a female foetus because of its sex). Other examples include health providers' beliefs about parenthood for individuals with mental health disabilities or same-sex couples that may lead to gatekeeping appropriate preconception services. These structural and systemic issues as described above can create an environment within society that allows for and perpetuates RC (Marie Stopes, 2020). However, some of the current definitions are imprecise and thus difficult to operationalise. A shared definition/consensus on definitions, rigorous prevalence data and well evaluated intervention data is urgently needed to advance the RC agenda.

Practice

Some women are more likely to disclose DFV to a primary care provider such as a general practitioner (GP), rather than presenting to DFV services (Cox, 2016). Primary care providers, however, have identified lack of training and adequate referral services, particularly in rural settings, as barriers to responding to DFV/RC (Wellington et al., 2021). Across global settings, women experiencing RC are reported as more likely to use effective, female-controlled forms of contraception to reduce unwanted pregnancies given male partners are less likely to use condoms, signalling the role of effective contraception counselling as a component of the clinician's response (Silverman & Raj, 2014). Therefore, all people experiencing contraceptive sabotage or RC to force a pregnancy should be offered counselling for and access to effective contraception methods (such as long-acting reversible contraception (LARC)) from a qualified health provider. RC should also be considered in the case of all women who present frequently for STI screening, pregnancy testing, and/or abortion care. The role of reproductive technologies (e.g., prenatal testing or the identification of foetal sex or anomalies by ultrasound) has not yet been included within the RC conversation. However, this may potentially affect aspects of RC such as forced, sex-selective abortions (Edvardsson et al., 2021).

Sensitive enquiry and screening

It is important to distinguish between universal screening for DFV (the application of a standardised question to all according to a procedure that does not vary from place to place), selective screening (where high-risk groups, such as pregnant women or those seeking pregnancy terminations, are screened), routine enquiry (when all women are asked, but the method or question varies according to the health provider or the individual situation), and case-finding (asking questions if certain indicators are present) (O'Doherty et al., 2015). Where DFV screening or routine inquiry is mandated, RC should be considered and, if disclosed, careful documentation of the type and direction (i.e., to stop or force a pregnancy) should be noted. It is important to consider that those of low-socio economic status are less likely to be screened for DFV in primary care settings (Hooker and Taft, 2021), in addition to being hidden from statistics used to inform health policies about DFV (Vaughan et al., 2015). Accurate, valid and reliable measurement of RC is therefore important for population level estimates, and of crucial importance for any evaluation of novel interventions. Currently, validated screening tools are rare and those available do not cover the range of behaviours or aspects that may infringe upon a person's reproductive decision making (Tarzia & Hegarty, 2021).

Education and training

Inclusion of RC prevention and response in curriculum and in-service training is inconsistent across primary care settings. When there is better evidence for definitions, prevalence and good practice, RC

education should be incorporated into all DFV curriculum. As with DFV, training should commence in undergraduate studies, be mandatory for accreditation of health providers likely to see people experiencing DFV and/or RC (e.g., primary care, ante, postnatal, MCH, family planning and abortion services), and be included in Continuing Professional Development. Recommendations for health providers should promote case finding broadly but routine inquiry in at-risk populations. Education and training must acknowledge intersectionality (the intersection of identity constructs, e.g., race, gender, and sexuality which can influence experiences of discrimination and privilege) (Crenshaw, 1989), identity affirmation, and cultural safety and competency, in addition to addressing the needs of more vulnerable and disadvantaged communities (Tajfel & Turner, 1986; Vaughan, 2015). Aspects of such training should be led by community members or peers and avoid tokenism. Current best practice for DFV/RC should be defined within a WHO framework, as a whole system approach that is woman and person-centred and moves through the health provider and health service out to the health system and society/polity (WHO, 2007; 2019).

Policy and legislation

Legislation is currently before several state parliaments to criminalise coercive control in Australia, but this Coalition does not believe inclusion of RC within the criminal code would assist in the WHO recommended best practice of 'woman-centred care' for those disempowered by DFV (WHO, 2019). Criminalising RC would create additional barriers to disclosure if the affected person were concerned their partner would be incarcerated or that a legal response would endanger their individual or family's safety (Heron & Eisma, 2021). A person who may not otherwise disclose RC might tell a health provider within a therapeutic setting about an unwanted pregnancy or one too close to a previous pregnancy. A discussion about these RC signs may be a sign to prompt further enquiry about all aspects of DFV given the association with other forms. Growing public interest, policy formulation, and legislature is ahead of expert consensus and a strong evidence base for RC public health policies and interventions.

Referral resources:

- The White Book: Abuse and violence Working with our patients in general practice (4th edition), RAGCP Accessed from: https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/white-book
  **See chapters 11 and 12 for recommendations specific to Aboriginal and Torres Strait Islander people and migrant and refugee communities.*
- Hidden forces: A white paper on reproductive coercion in contexts of family and domestic violence (Second edition), Marie Stopes Accessed from: https://www.mariestopes.org.au/wp-content/uploads/Hidden-Forces-Second-Edition-.pdf
- Key Contacts in Migrant Women's Prevention of Violence, Multicultural Centre for Women's Health Accessed from: https://www.mcwh.com.au/wp-content/uploads/Key-Contacts-Directory-official_Apr-2021-update-4.pdf
- Children by Choice education programs. For more information: https://www.childrenbychoice.org.au/forprofessionals/oureducation

*The Coalition acknowledges the diversity in needs and experiences of all people who may access and use abortion and women's sexual and reproductive health services including people who do not identify as women but can experience pregnancy and abortion and may need to access these. Use of the term woman or women without gender-inclusive terminology in the above statement reflects language used within the cited reference(s) and/or that RC is currently understood to affect by majority those who identify as women. Use of this terminology does not necessarily imply a binary view of gender or reflect the views of the Coalition.

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