Public Health Association of Australia
submission on reproductive coercion

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Introduction

The Public Health Association of Australia

The Public Health Association of Australia (PHAA) is recognised as the principal non-government organisation for public health in Australia working to promote the health and well-being of all Australians. It is the pre-eminent voice for the public’s health in Australia. The PHAA works to ensure that the public’s health is improved through sustained and determined efforts of the Board, the National Office, the State and Territory Branches, the Special Interest Groups and members.

The efforts of the PHAA are enhanced by our vision for a healthy Australia and by engaging with like-minded stakeholders in order to build coalitions of interest that influence public opinion, the media, political parties and governments.

Health is a human right, a vital resource for everyday life, and key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions that underpin people’s health. The health status of all people is impacted by the social, cultural, political, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease. These determinants underpin the strategic direction of the Association.

All members of the Association are committed to better health outcomes based on these principles.

Vision for a healthy population

A healthy region, a healthy nation, healthy people: living in an equitable society underpinned by a well-functioning ecosystem and a healthy environment, improving and promoting health for all.

Mission for the Public Health Association of Australia

As the leading national peak body for public health representation and advocacy, to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.

Preamble

PHAA welcomes the opportunity to provide input to the Marie Stopes Australia White Paper on Reproductive Coercion. The reduction of social and health inequities should be an over-arching goal of national policy and recognised as a key measure of our progress as a society. The Australian Government, in collaboration with the States/Territories, should outline a comprehensive national cross-government framework on promoting a healthy ecosystem and reducing social and health inequities. All public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.
PHAA Response to the terms of reference

Reproductive coercion is a serious public health concern with many facets – it is a term used to define a range of pregnancy-controlling behaviours intended to maintain power and control over reproductive rights. This is usually described as including birth control sabotage; and threats and use of physical violence related to sex, the use of contraception, pregnancy and abortion. A broader view of reproductive coercion also recognises the importance of cultural and community values and norms related to sex, contraception, pregnancy and access to and use of reproductive health services.

This broader definition of reproductive coercion is therefore multifaceted. There is a connection to the spectrum of behaviours associated with family violence and the difficulties involved in preventing, identifying and addressing those behaviours. Another element relates to access to services for sexual and reproductive health that are available, affordable, and culturally safe.

Existing knowledge, practices, networks that address reproductive coercion including:

International examples, models, screening tools

The Sustainable Development Goals

The Sustainable Development Goals (SDGs), adopted by the United Nations General Assembly in September 2015 provide a global development agenda for the next 15 years – a plan of action for “people, planet and prosperity”. Included in the SDGs are goals and targets specifically relating to women’s and girls’ sexual and reproductive health and rights:

SDG 3: Ensure healthy lives and promote well-being for all at all ages
Target 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 programs. This includes a focus on contraception, sexual and reproductive health service availability, knowledge about sexual and reproductive health and rights, adolescent fertility, quality of care including respect for rights, prevention of sexually transmitted infections, and abortion.

SDG 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all
Target 4.7: By 2030, ensure that all learners acquire 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. This includes a focus on comprehensive sexuality education.

SDG 5: Achieve gender equality and empower all women and girls
Target 5.6: Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the ICPD and the Beijing Platform for Action and the outcomes documents of their review conferences. This includes a focus on gender equity in sexual and reproductive health rights.
World Health Organization tools and guidelines

The WHO has numerous resources relevant to the prevention of reproductive coercion. These include Family Planning: A global handbook for providers; International technical guidance on sexuality education; Sexual health, human right and the law; Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook and Eliminating forced, coercive and otherwise involuntary sterilization: An interagency statement.

Existing research (local or international) on reproductive coercion

Violence against women and girls

The United Nations defines violence against women and girls as “any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life”. Women and girls are affected by different forms of gender-based violence at different stages of their lives, with much of it directly impacting their sexual and reproductive health and rights. Some examples are provided below.

Female genital mutilation and/or cutting (FGM/C) – Mainly occurring during childhood or adolescence, FGM/C, while concentrated in approximately 29 countries in Africa and the Middle East, also occurs elsewhere around the globe, in developing and developed countries (including Australia) with migrant and refugee populations.

Child, early and forced marriage – Despite laws against it, the practice of child marriage remains widespread, in part due to poverty and culturally entrenched gender inequality. Worldwide, almost 750 million women and girls alive today were married before their 18th birthday, with 1 in 9 girls in developing countries married before they are 15 years old. While a global issue, the majority of child marriages occur in South and Central Asia and parts of sub-Saharan Africa and is increasing in some regions. Girls who are forced into child marriage often become pregnant while still adolescents, increasing the risk of complications in pregnancy and childbirth. Such complications are a leading cause of death among older adolescents in developing countries.

Sexual abuse and trafficking – Girls are more likely than boys to experience sexual abuse or be trafficked for sex, and trafficking for sexual exploitation and forced marriage has increased in recent years.

Intimate partner violence – globally, almost one third (30%) of women who have been in an intimate relationship report that they have experienced some form of physical and/or sexual violence by their partner in their lifetime, with adolescent girls at increased risk.

Sexual coercion or violence is a key factor for unplanned pregnancy, miscarriage and the need for emergency contraception and abortion along with other health and social services in Australian and internationally.

Research shows that multi-sector culturally appropriate rights-based approaches at primary, secondary and tertiary prevention levels are required to address the complex factors that determine reproductive coercion.
Guidelines: Breaking Ground 2018 – Treatment Monitoring Bodies on Reproductive Rights

The Centre for Reproductive Rights report Breaking Ground 2018 summarises the jurisprudence from global United Nations treaty monitoring bodies on reproductive rights, particularly the standards on reproductive health information and contraception, maternal health care, and abortion. This report highlights that while gender equality is essential to the realisation of human rights, in many countries, traditional models and patriarchal systems have failed to address the historical roots of gender inequality, gender discrimination, gender stereotypes, and traditional understandings of gender roles that continue to enable discrimination and inequality.

Gender discrimination and inequality continues to inhibit the ability for 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 their 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.

Women and girls must have access to sexual and reproductive health information and education including information about modern contraceptive methods, emergency contraception and safe abortion. Access to accurate and timely information, including sexuality education, is essential to making informed choices and decisions about sexual and reproductive health and rights. Particular attention needs to be given to ensuring women and girls from marginalised and minority groups have access to information and services. This includes communities such as adolescents, rural and remote areas, women and girls with disabilities, refugees and migrant women, and in Australia, Aboriginal and Torres Strait Islander women and girls.

The denial of abortion information and service intensely impacts women’s lives and health, and inhibits the fulfillment of a range of civil, political, economic and social rights including to exercise their preference on the number and spacing of their children. It is estimated that 45% of the abortions taking place worldwide each year are unsafe, with the majority of unsafe abortions occurring in developing countries in Africa, Asia and Latin America.

Key recommendations and actions to address gaps in:

Research including compilation of data to assess the scope, scale and concentration of reproductive coercion across the nation
A recent Australia wide study found that sexual coercion, social disadvantage, rural residence and overseas birth are independently associated with unintended pregnancy. A study by Taft et. al using data from the Australian Longitudinal Study of Women’s Health shows that women who reported partner violence were significantly more likely to have had one or more pregnancies. This study also found that having had a pregnancy was associated with an 80% increase in prevalence of any violence and a 230% increase in partner violence. Among women who had a pregnancy, having had a miscarriage or termination was associated with violence.
PHAA submission on reproductive coercion

The workplace

The Australian Human Rights Commission 2012 survey of sexual harassment in Australian workplaces\(^\text{30}\) shows concerning levels of coercion indicating little change since the previous survey in 2003. Between 2008 and 2012 one in four women (24%) and one in six men (16%) experienced sexual harassment in the workplace. Over a person’s lifetime the gender gap is even more profound with a third of women (33%) and less than one in ten men (9%) experiencing sexual harassment. Women under 40 are most likely to experience sexual harassment and harassers are most likely to be male co-workers. A report by the Federal Police shows that 46% of women employees and 20% of men had been sexually harassed in the police workplace.\(^\text{31}\)

Education settings

A recent survey depicts the serious levels of sexual harassment in universities. Of the 300,000 students who responded to the Australian Human Rights Commission survey of 39 universities in Australia.\(^\text{32}\) Around half of all university students (51%) were sexually harassed on at least one occasion in 2016, and 6.9% of students were sexually assaulted on at least one occasion in 2015 or 2016. A significant proportion of the sexual harassment experienced by students in 2015 and 2016 occurred in university settings. The survey results indicated that only 6% of students thought that their university was currently doing enough to provide and promote clear and accessible information on sexual harassment procedures, policies and support services, and only 4% thought this was the case in relation to sexual assault.

Policy that is evidence-based and provides for practical actions that will address the issue throughout the health system and community sector

Leadership and governance at all levels is necessary to prevent reproductive coercion and assist those affected by it. The importance of policy can be highlighted by the changes attributed to the Violence against Women Act introduced in the United States in 1994. According to the US Bureau of Justice, the rate of intimate partner violence in the USA fell by 53% and the number of intimate partner homicides of women decreased by 26% between the introduction of the Act and 2008.\(^\text{33}\) Negative consequences from policy decisions are also important to consider. This is exemplified by the Global Gag Rule (or Mexico City Policy) in the USA. This rule bans foreign nongovernmental organisations receiving US aid funding from providing abortion services, counselling or referrals, or participating in abortion legislation advocacy.\(^\text{34, 35}\) This policy has been in place in the USA multiple times previously, with documented negative health outcomes. Previous enactments of the rule have seen the rate of unsafe abortion and number of unwanted pregnancies increase. Also, international health services providing a range of sexual, reproductive, maternal and child health care; HIV and sexually transmissible infections testing and counselling; and cervical cancer screening were forced to close, as were outreach health programs to isolated populations, and access to contraceptives were severely limited.\(^\text{36, 37}\)

Politically motivated reproductive coercion can take many forms including withholding sexual and reproductive health and rights information, obstructing access to health services or providers, attempting to ban services outright and empowering third parties to impose their views on others.\(^\text{38}\)
PHAA submission on reproductive coercion

Policy to address reproductive coercion must be underpinned by a comprehensive, multi-sector rights-based approach to sexual and reproductive health. Policy must encompass the three levels of prevention and not focus solely on response programming. These policies must consider universal (population level), selective (targeted at specific communities or settings of need) and indicated (targeted to individuals and families) approaches and the needs of priority populations including adolescents and women from ethno-cultural minorities, low incomes, and those living in rural or remote areas.

Evidence to inform policy for primary level prevention

Policy is necessary to ensure the implementation of universal school-based prevention programs in all States and territories and both primary and secondary schools.

Policy should support the trial of School-based interventions that have shown promise. These include group training interventions to reduce both perpetration and victimisation of dating violence interventions to reduce non-partner sexual assault.

Universities must adopt preventative policies in line with the recommendations of the Australian Human Rights Commission including demonstrable commitment to programs that focus on changing attitudes and behaviours and preventing harassment in residential colleges and university residences.

Evidence shows that community-managed projects involving multi-level empowerment-based interventions prevent domestic violence and should therefore be supported by policy.

Parenting programs can reduce child abuse and intimate partner violence and must be enshrined in health and community services policy, adequately funded for all new parents and tailored to the needs of specific communities. However, they must be delivered according to strict standards.

Evidence to inform policy for secondary prevention

Policy should support the screening of women of childbearing age for intimate partner violence, particularly those who are pregnant, seeking abortions and presenting with miscarriage, and provide or refer women who screen positive to adequately funded services that are integrated into the public system. Women experiencing intimate partner violence should be counselled and prescribed contraception that is not partner dependant. Doctors, midwives and nurses should be well supported to identify and manage violence among women of reproductive age.

Universities must adopt secondary preventative policies in line with the recommendations of the Australian Human Rights Commission and improve responses to sexual assault and sexual harassment.

Policy should focus on supporting alcohol reduction programmes that show promise, particularly structural, group and self-help interventions that are effective in reducing alcohol abuse and intimate partner violence. There should be legal restrictions on the number of alcohol outlets in communities as this has been found to be associated with domestic violence rates.

Evidence to inform policy for tertiary prevention

Policy focused at the tertiary prevention level is required to help minimise the long-term consequences faced by survivors of violence, including those that focus on rehabilitation and
reintegration. Provision of support services for survivors must be available across multiple sectors, including health, legal, and workplace.

Policy to support microfinance and gender transformative approaches, particularly amongst older women is required in line with the effectiveness evidence.23

Service delivery, particularly with abortion providers so that women requiring assistance have clear, supportive and consistently quality referral pathways

In line with a rights-based approach to sexual and reproductive health services, as recommended by the World Health Organization, all Australian women should have universal access to the full complement of services that includes safe abortion options, contraception and intimate partner violence counselling. Service delivery should take a life course perspective recognising the differing needs of people at various life stages. PHAA supports continuation of funding for women’s health centres across the country.

All women seeking abortions should be screened for intimate partner violence, provided with information about available services, referred when appropriate and offered contraceptive counselling.47

The public sector provisions of abortion must be increased to ensure access to affordable services. Protesters should be restricted from protesting within a certain distance of abortion clinics to minimise intimidation and violence towards patients, their supporters and clinical staff. Such ‘safe access zones’ are currently available in only 3 jurisdictions in Australia48 and should be legislated across the country to ensure protection for those entering abortion clinics.

Future opportunities including:

Cross-sectoral collaboration
Adequate funding should be made available to develop and test interventions across the education, health, legal and community service sector. This should include public, private and non-government organisation partnership efforts that engage consumers in designing, implementing and evaluating interventions.

Application of innovative models, approaches from other fields
Adequate funding by the government must be provided to pilot and rigorously evaluate innovative approaches that should contribute to the development of a national quality framework for addressing reproductive coercion. All programs must be evaluated according to national reporting standards49 and the results disseminated to ensure accountability and responsive policy.

Issues and solutions for particular population groups

Aboriginal and Torres Strait Islander people
There is a well-established evidence base on the increased risk for Aboriginal and Torres Strait Islander women and girls of experiencing family violence.50,51 The challenge now is finding appropriate solutions.
Access to culturally safe services for sexual and reproductive health is essential, and must be part of a holistic primary health care system.\textsuperscript{52} The Aboriginal Community Controlled Health Organisations have a key role in providing appropriate services. While access to such services in remote areas is difficult anyway, for sexual and reproductive health services especially, access to female health professionals is important in more traditional Aboriginal and Torres Strait Islander communities with strict adherence to men’s business and women’s business.

Family violence in Aboriginal and Torres Strait Islander communities is both a cause and effect of social disadvantage and intergenerational trauma.\textsuperscript{53} Ending reproductive coercion in Aboriginal and Torres Strait Islander communities, and empowering women to reclaim their reproductive health rights opens range of health and life choices, which will be an important step in closing the gap in health outcomes between Indigenous and non-Indigenous Australians.\textsuperscript{52} Community-led strategies with holistic, integrated approaches working with the whole family and community from a strengths base are required to address the complexities involved.\textsuperscript{54}

A joint policy paper from 2017 recommends systematic support for community-controlled organisations to provide national coverage of holistic and culturally safe services, as well as empowerment for active involvement in policy and practice change with equitable representation from Aboriginal and Torres Strait Islander women on decision-making bodies.\textsuperscript{54}

The Royal Australian College of General Practitioners’ Practice Guidelines 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.\textsuperscript{55}

**Culturally and linguistically diverse communities including refugees and migrant women**

There is a paucity of data available on the prevalence of family violence and other forms of reproductive coercion within culturally and linguistically diverse communities in Australia.\textsuperscript{51} A similar lack of research on the prevalence of reproductive coercion in migrant and refugee communities exists.\textsuperscript{56} Domestic assault is considered a private matter and seldom discussed in public settings therefore it is likely that intimate partner violence is unreported alongside associated reproductive coercion. Changing gender norms post-resettlement, and exposure to war and conflict in their country of origin may increase the vulnerability of women and adolescent girls to violence.\textsuperscript{57} The ASPIRE project\textsuperscript{58} identified factors such as changes in gender roles and the family, mistrust and/or lack of information about services and resources for domestic violence, isolation, community and personal attitudes toward domestic violence, and language barriers in Victoria and Tasmania.

The United Nations Office of the High Commissioner for Human Rights notes that despite the legally enshrined human rights protections:

\begin{quote}
“Violations of women’s sexual and reproductive health rights are frequent. These take many forms including denial of access to services that only women require, or poor quality services, subjecting women’s access to services to third party authorization, and performance of procedures related to women’s reproductive
\end{quote}
and sexual health without the woman’s consent, including forced sterilization, forced virginity examinations, and forced abortions. Women’s sexual and reproductive health rights are also at risk when they are subjected to female genital mutilation (FGM) and early marriage. Violations of women’s sexual and reproductive health rights are often 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 because of the preference for sons, has a devastating impact on women’s health with sometimes fatal consequences”.

The provision of reproductive and sexual health services to culturally and linguistically diverse 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’s Facilitator’s Kit: Community Preparedness for Reproductive Health and Gender.

Conclusion

PHAA supports the development of a white paper on reproductive coercion. We are particularly keen that the following points are highlighted:

- A broad view of the definition of reproductive coercion includes family and sexual violence, and cultural and societal coercion
- Reproductive coercion takes many forms and is found throughout the world as part of power and control over women
- The needs of minority and disadvantaged groups in addressing reproductive coercion must be considered

The PHAA appreciates the opportunity to make this submission and the opportunity to contribute to Marie Stopes Australia’s white paper on reproductive coercion.

Please do not hesitate to contact us should you require additional information or have any queries in relation to this submission.

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References


