

Domestic violence in Australia

Children by Choice Submission to the Finance
and Public Administration References committee

July 2014



CHILDREN BY CHOICE
ASSOCIATION INCORPORATED

40 Years • 200,000 Women • Still Supporting Choice

About Children by Choice

Children by Choice provides counselling, information and education services on all options with an unplanned pregnancy, including abortion, adoption and parenting. We provide a Queensland-wide counselling, information and referral service to women experiencing unplanned pregnancy, deliver sexual and reproductive health education sessions in schools, and offer training for GPs and other health and community professionals on unplanned pregnancy options. We also advocate for improvements to law and policy that would increase women's access to reproductive health services.

Children by Choice supports women's access to all options with an unplanned pregnancy, including abortion, and have been involved in helping women access these options since the service began operation in 1972. Children by Choice is the only stand-alone pro-choice women's service dedicated to unplanned pregnancy in Australia. We are recognised nationally and internationally as a key advocacy group for the needs and rights of women in relation to access to reproductive health services with regard to unplanned pregnancy.

In 2012-13 we received a total of 2937 client contacts, ranging in age from under 14 to over 50.

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About this submission

This submission will examine issues relating to the adequacy and effects of policy responses to domestic violence in Australia – items c) and d) of the terms of reference – with particular reference to reproductive coercion and the impact of violence on women’s bodily autonomy and sexual and reproductive health rights.

The provision of all options unplanned pregnancy counselling and support services is the core business of Children by Choice. Recent years have seen an increase in the number of women we support who disclose domestic and/or sexual violence. Our experience and expertise in supporting women in these situations around pregnancy options informs this submission.

The majority of this submission will be in relation to women experiencing domestic violence and unwanted pregnancy. It is important to note that some women in violent relationships will experience coerced abortion; although there is some available evidence relating to poor mental health outcomes for women in these circumstances (American Psychological Association 2008), there is little data on the prevalence of coerced abortion in Australia, and what exists is largely anecdotal. Children by Choice is a pro-choice service and under no circumstances would support a pregnancy termination without the express wish and consent of the pregnant woman herself. However, given the lack of data, this will not be the subject of this submission. This submission will focus on women in violent relationships who are unable to exercise their desire to use contraception, avoid pregnancy, or access termination.

Violence and reproductive health: what the evidence says

The relationship between domestic violence and poor reproductive health outcomes is well established in the literature and research.

The Committee will be aware of the large evidence base establishing the prevalence of domestic violence in Australia. As well as the other outcomes of domestic violence for women and children, it has a particular reproductive health context.

The World Health Organization (2012) reports that intimate partner violence may lead to a host of negative sexual and reproductive health consequences for women, including unintended and unwanted pregnancy, abortion and unsafe abortion, and pregnancy complications.

Miller and Silverman (2010) contend that unintended pregnancies are two to three times more likely to be associated with intimate partner violence than planned pregnancies.

Reproductive coercion may be one mechanism that helps to explain the known association between intimate partner violence and unintended pregnancy. Reproductive coercion refers to a range of male partner pregnancy-controlling behaviours. Recent publications (Miller and Silverman 2010; Miller and Decker 2010; de Bocanegra et al 2010) offer the following descriptions of some of these practices of reproductive coercion:

- Birth control sabotage such as throwing away contraception and the intentional breakage of condoms;
- Forced sex;
- Refusal by their partner to use condoms;
- Being threatened with consequences if they use birth control; and
- Prevention from obtaining birth control.

Case study 1:

Z, 23, had recently moved in with her new partner but things had started to change very quickly. He would flush her contraceptive pills down the toilet and force her to have sex with him. She relied on emergency contraception for a few months when she could. Discovering her unwanted pregnancy was the catalyst to ending the relationship, and she called us for help to access a pregnancy termination.

In relationships where reproductive coercion is present, men may exert control over their female partners by the use of physical violence, emotional manipulation, threats of reprisals, social isolation, or financial control. Women with no access to their own finances find it extremely difficult to access contraception, for example, even if they may be in a position to negotiate its use with a controlling partner.

Consequently women in violent relationships have higher rates of poor reproductive health outcomes including unplanned pregnancies and sexually transmitted infections. Where this leads to a pregnancy unwanted by the female partner, there may then be:

- Pressure to carry the pregnancy full term; or
- Prevention from accessing abortion by such actions such as refusal to provide childcare to allow woman to attend clinic and refusal of money towards the cost.

Case study 2:

L, 34, discovered herself pregnant some weeks after ending her relationship on account of violence. Her decision to end the pregnancy was in part about wanting to end all ties with this man in order to feel more certain that she could be freed from the ongoing abuse. He had offered her money to end the pregnancy on several occasions, but each time she asked him to make good on his promise he said “next week”. As the weeks went by she came closer and closer to the cut off point for having the procedure done at the base-line price of \$400 at the clinic nearest to her. Having booked in for the last possible date at this price she asked again for him to make good on his promise. He declined, but offered a new promise, that he would punch her in the stomach until she had a miscarriage unless she got it “sorted”.

What our client data shows regarding violence

Children by Choice is a Queensland-only service. In 2013-14 financial year we received 2724 contacts to our counselling, information and referral team. Of those contacts, just over 17% reported

domestic violence. Of contacts relating to sexual violence, 38% also reported domestic violence, highlighting the prevalence of forced sex and sexual abuse in the context of violent relationships.

Contacts reporting Aboriginal or Torres Strait Islander backgrounds are over-represented in our domestic violence statistics from 2013-14, making up 13% of contacts reporting domestic violence but only 7.8% of the population.

Clients reporting domestic violence were also more likely to present at a more advanced gestation than the general client base. In many cases this led to higher costs to access termination services, as procedures start to rise in price from around 11 weeks gestation.

Gestation	All contacts (per cent)	Contacts reporting domestic violence (per cent)
Under 6 weeks	22.9	6.5
6 to 11 weeks	40	37.2
12 to 15 weeks	10.6	18.2
16 to 19 weeks	6.5	6.5
20 weeks and over	3.3	4.8

We offer limited financial assistance for disadvantaged women in Queensland to assist them to access abortion, where that is their desired option but they are financially unable to do so. These funds are from donations and targeted fundraising, and are in no way provided for by our government funding. In 2013-14, 30% of all funds provided to women were to assist those reporting domestic violence to access a termination; these women received an average of \$380 each, compared to an overall average of \$270 to our general financial assistance clients. The difference in the level of support reflects the impact of higher gestation at presentation among women reporting domestic violence.

What do women experiencing violence tell us?

A pregnancy in the context of a violent relationship which is unwanted by the pregnant woman herself can be extremely distressing. Certain themes are recurring in the conversations we have with clients who report violence:

- Overall strain and distress as a result of the violence: women say they are 'at breaking point'. The children they have are as much as they can handle given what they have been through.
- Child Safety involvement as a result of the violence: women report that they can't handle the mental health impact of having another child removed like they did the last one, due to violence in the relationship.

- A desire to escape a relationship due to violence: women see ending the pregnancy as another strategy for cutting ties with the man involved, and of being less likely to be subjected to further violence if there is no child connecting them.

In these circumstances a termination may be the preferred option of the pregnant woman directly as a result of the violence she experiences, in terms of not wanting to parent with the perpetrator and therefore expose a child to potential violence also, or wanting to make her ability to disentangle from the perpetrator easier. Continuing a pregnancy to become 'co-parents' can further entrench a connection between the woman and the perpetrator, which may continue regardless of the context of the relationship itself and can become a tool for further manipulation through family court proceedings.

Given this, access to and affordability of termination procedures can be entwined with a woman's ability to escape domestic violence. Issues that are so often present in violent relationships, including surveillance, manipulation, and financial or other control, further restrict a woman's capacity to access a termination, even if she is doing so to attempt greater safety for herself and any existing children.

As co-parents in a domestic violence context, a woman's ability to ever be safe from that perpetrator's violence against her and/or her children is significantly compromised. If women choose to access abortion in the context of domestic violence, it needs to be available.

Access to pregnancy termination in cases of violence

Law

Despite the estimate that one in three Australian women will decide to terminate a pregnancy at least once during their lifetime, abortion remains the subject of criminal law in most states and territories:

Queensland & New South Wales: Abortion a crime for women and doctors. Legal when doctor believes a woman's physical and/or mental health is in serious danger. In NSW social, economic and medical factors may be taken into account.

Australian Capital Territory: Legal, must be provided by medical doctor.

Victoria: Legal to 24 weeks. Legal post-24 weeks with two doctors' approval.

South Australia: Legal if two doctors agree that a woman's physical and/or mental health endangered by pregnancy, or for serious foetal abnormality. Unlawful abortion a crime.

Tasmania: Legal to 16 weeks on request, and after that point with the approval of two doctors.

Western Australia: Legal up to 20 weeks, some restrictions particularly for under 16s. Very restricted after 20 weeks.

Northern Territory: Legal to 14 weeks if 2 doctors agree that woman's physical and/or mental health endangered by pregnancy, or for serious foetal abnormality. Up to 23 weeks in an emergency.

This disparity in state based law causes large inequities in access to termination services. In South Australia, over 95% of terminations are provided through public hospitals, while in 2010 Queensland Health estimated that only around one percent of all terminations in this state were performed in public hospitals. Other states have varying levels of public access, and availability of services is also affected by whether women live in metropolitan or regional areas. In addition, some public hospitals across Australia are run by Catholic Health Australia, with government funding. Although these hospitals are part of the public system, they are subject to Catholic Health Australia's Code of Ethics, which stipulates that:

- Patients are not to be provided with abortion services in any circumstance, nor a referral to another service that may provide them with abortion services;
- Patients are not to be provided with contraceptive advice or prescription, even in cases of sexual assault. Women presenting after sexual assault are not only denied immediate access to emergency contraception; the Guidelines explicitly forbid the provision of information about emergency contraception or a referral to a service which may provide the patient with emergency contraception outside the hospital premises, until 'the likelihood of pregnancy has been excluded'.

Termination access through the public system is therefore somewhat of a postcode lottery, making private termination providers the only option for many women. Procedures offered through private clinics or day surgeries have out-of-pocket costs attached, and these costs have risen sharply over recent years.

In no state where abortion is still largely governed by criminal law is sexual or domestic violence alone grounds for a lawful procedure. This is reflected in the lack of systemic support by public health systems in cases like T's.

Case study 3:

T, 17, was pregnant as a result of repeated sexual assaults by her stepfather. Her mother had temporarily relocated with her children in order to keep them safe from further harm. At this time the step-father accessed and emptied all shared bank accounts, leaving the family no access to income until Centrelink payments could be established. This can take a few weeks. A public hospitals social worker advised us that despite the pregnancy being as a result of incest the hospital would be unlikely to view the impact of this as serious enough to warrant a publicly provided termination unless the young woman's mental health deteriorated to the point where she required hospitalisation.

Cost

The cost of surgical termination procedures has more than quadrupled since 2000 in Queensland. Then, a termination prior to 11 weeks gestation, provided in Brisbane, had an out-of-pocket cost of

\$120. Now, costs for the same procedure start at around \$500. Prices rise after 11 weeks gestation, and are higher again in regional clinics, and can reach as high as \$3800 out-of-pocket for women with access to Medicare, depending on gestation and location. Increasing numbers of women experience financial difficulties in raising the fee for a pregnancy termination.

In August 2013, it was announced that mifepristone (also known as RU486) would be listed on the pharmaceutical benefits scheme for use in early medical abortion. It was hoped that this listing, combined with Therapeutic Goods Administration's decision to licence the drug for prescription by GPs, would increase the availability and affordability of early medication abortion (before 7 weeks gestation). However, the PBS listing has had little to no impact on the cost of medication abortion provided through private clinics, which has a higher out-of-pocket cost than early surgical termination through the same providers; and no public list of GPs prescribing mifepristone is available.

Around half of contacts to the Children by Choice counselling and information service in 2013-14 identified the cost of abortion as a barrier, and around 39 per cent related to financial assistance to pay for a termination.

The impact of costs on women's ability to access termination

Some populations experience higher risk of poor reproductive health outcomes, including Indigenous women, women from non-English speaking backgrounds, regional and remote women, younger women, and women experiencing violence. The risks are exacerbated for these groups by the high out-of-pocket costs of reproductive health services in Queensland.

Compared to our broader client base, women who received financial assistance from us in 2012 were:

- More likely to report domestic and/or sexual violence;
- More likely to identify as Aboriginal or Torres Strait Islander;
- More likely to report mental health issues;
- More likely to be parents; and
- Less likely to receive any support from the man involved in their pregnancy.

Case study 4:

S, 19, already has one child and is pregnant again to the same partner. She reports that this relationship is not good, with him being incredibly controlling. She indicates that she plans to end the relationship but is not in a position to do so at this time. She wants our support to access a termination under the radar. He would not approve of her decision to end the pregnancy and at the time of calling, was not aware of the pregnancy. She sees having another child to him as making it even harder for her to leave the violence in the future.

Women experiencing domestic or sexual violence

Children by Choice speak regularly to pregnant women who report sexual and domestic violence who are unable to afford a privately provided abortion but have been turned away from public hospitals.

For women experiencing domestic violence, further hurdles may be encountered by the failure of some DV support services to provide assistance around abortion access.

Case study 5:

G, aged 31, lived in a regional centre and was into her second trimester when she discovered the pregnancy. Her decision to end the pregnancy hinged on the extreme violence she had experienced the hands of the man involved and a desire to cut all ties with him for the sake of her safety and that of her other children. The out of pocket costs for the procedure and associated travel amounted to approximately \$3000. Although she was already accessing a domestic violence support service in her local town, and that service had brokerage funds available for client support, the service decided to ask their funding body, the Queensland Department of Communities, for permission to use this brokerage to assist their client to access a pregnancy termination. The Department denied permission as the procedure was 'illegal'. Children by Choice counsellors provided both a donation and a no interest loan from our service as well as significant staff time in advocacy to other services and clinics, in order to assist this woman to access a termination and cut ties with her perpetrator.

In the half of 2014, Children by Choice has had contacts from or in relation to 19 self-abortion attempts. Some of these were in a context of a violent relationship where the violence was exacerbated by the pregnancy, others in relation to women unable to access a safely provided procedure because of a violent and controlling partner. We remain extremely concerned that women are putting their lives and health at risk due to the inaccessibility of abortion procedures in Queensland.

Case study 6:

T, aged 30, was supporting her unemployed partner on her Centrelink benefit, as well as her three children, when she found out she was pregnant. T told us she was already struggling financially and had been relying on food vouchers from the Salvation Army to get by, making the required \$450 seem an impossible target. She said the stress of trying to find the money for an abortion had her punching herself repeatedly in the stomach in the hope of giving herself a miscarriage, and that the stress was also causing more arguments and violence in her relationship. We gave her a donation from our Women's Access Fund as well as a No Interest Loan which together covered half the cost of the procedure.

Case study 7:

H is a married mother of two young children, the youngest just a year old, who called us for help with her unplanned pregnancy. H estimated her gestation to be at 5-6 weeks. Her husband was raised a strict Catholic and against using any form of contraception; he also refused to discuss the option of abortion with her despite being aware of H's reluctance to

parent again so soon. He also worked out of town, and was not actively involved in parenting. In attempts to induce a miscarriage H had starved herself and consumed very high levels of caffeine and alcoholic spirits. This had been unsuccessful, although it had made her very ill. H had tried home methods of abortion as she was unaware of the private clinics providing medication abortion in Queensland until her phone call to us, and the availability (albeit limited) of medication abortion – which seemed to her “more natural”. She thought if she had been able to access a medication abortion she would have been able to pass it off to her husband as a miscarriage; there was no likelihood the same would be possible with a surgical procedure.

Recommendations:

1. Take a leadership role in addressing laws and policies which impact women in violent relationships and their reproductive autonomy

Abortion law is state based and therefore beyond the remit of the Commonwealth Government. However, a strong position on the necessity of reproductive health and family planning service accessibility for women in violent relationships could facilitate a more coordinated response by state governments, and help address the inequities caused by the current difference in state laws and policies around abortion access. Some examples of this are:

- a. Ensure that national approaches to domestic violence include specific strategies for improving reproductive health outcomes for women experiencing violence;
- b. Specify minimum requirements for public hospital provision of reproductive health services;
- c. Earmark specific Emergency Relief funds for women experiencing or escaping domestic violence, and ensure these may be used for contraceptive or abortion services where this is the woman’s request.

2. Address the inadequacy of Medicare coverage of medication termination of pregnancy

Despite the fact that mifepristone is listed on the PBS for use in early medication termination of pregnancy, significant out-of-pocket costs remain a barrier for women wishing to access this service. As well as the subsidised cost of the medication itself (if a GP can be found to provide it), are the costs associated with GP visits, including follow up to ensure the termination is complete and that there is no risk of infection, as well as ultrasounds and potentially other diagnostic tests. With no Medicare item number covering the provision of medication abortion, most women accessing this option in Queensland still face upfront costs of over \$350, not including the cost of the medication itself. Although a Medicare rebate for the consultation is available, some women choose not to access this due to privacy concerns and fear of judgement.

3. Increase Medicare coverage of surgical termination of pregnancy

As detailed in this submission, Medicare subsidies available for surgical abortion procedures fall staggeringly short of covering the cost for women seeking them. The current rebate for first trimester procedures is under \$300; the out-of-pocket costs faced by women are high in Queensland – a minimum of \$450 – and public provision is virtually non-existent even for women experiencing domestic violence. Increasing the rebate would ease the financial stress on women in these difficult circumstances.

References

Miller E, Decker M, McCauley H, et al., “Pregnancy coercion, intimate partner violence and unintended pregnancy,” *Contraception* 2010; 81/4/316-322.

Miller, E. and Silverman, J. (2010). Reproductive Coercion and Partner Violence: Implications for clinical assessment of unintended pregnancy. *Expert Reviews: Obstet Gynecol.* 5(5), 511-515.

Theil de Bocanegra, H. et al (2010). “Birth Control Sabotage and Forced Sex: Experiences Reported by Women in Domestic Violence Shelters” *Violence Against Women*, 16(5) pp 601-612.

WHO (2012) ‘Understanding and addressing violence against women’ – Intimate partner violence http://apps.who.int/iris/bitstream/10665/77432/1/WHO_RHR_12.36_eng.pdf