

Call for papers - Special Taskforce on Domestic and Family Violence Cover Sheet

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Children by Choice Submission to the Special Taskforce on Domestic and Family Violence in Queensland

November 2014



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 work 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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Introduction

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

The Taskforce 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.

This submission will examine issues relating to the adequacy and effects of policy responses to domestic violence in Australia, with particular reference to and focus on 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 supports a pregnancy termination without the express wish and consent of the pregnant woman herself.

However, this submission's main focus is on women in violent relationships who are unable to exercise their desire to use contraception, avoid pregnancy, or access termination.

Of the Taskforce's terms of reference, there are three we will respond to as part of this submission. They are:

- Defining the scope of violence, assault and abuse to be addressed in a domestic and family violence strategy and whether it would be appropriate for such a strategy to focus on particular or defined sections of the community in order to have the most impact;
- Holistic, coordinated and timely responses to domestic violence, including building community confidence in the reporting and investigation of domestic and family violence and ensuring that those who are subject to domestic and family violence receive immediate and effective protection and support; and
- Educating and engaging Queenslanders to create a community that supports respectful relationships, practices positive attitudes and behaviours and promotes a culture of nonviolence.

Defining the scope of violence, assault and abuse to be addressed in a domestic and family violence strategy and whether it would be appropriate for such a strategy to focus on particular or defined sections of the community in order to have the most impact.

Defining the scope of violence to be addressed in a domestic violence strategy

It is Children by Choice's submission that reproductive coercion must be recognised as a common marker of domestic violence, and that any future domestic violence strategy must take steps to address both the perpetrator's behaviour itself and the risks that reproductive coercion places on women.

Reproductive coercion is a relatively new term which has emerged to describe a range of violent and controlling behaviours relating to fertility and reproduction. Terms used throughout this submission are defined as follows:

Domestic violence: behaviour within an intimate partner relationship that is used to entrench power and control over the other person. This behaviour may manifest in a number of physical, sexual, emotional, financial, or psychological ways

Reproductive autonomy: the ability to make independent decisions about reproductive health, including use of a form of contraception that is suitable to that person, access to reproductive health services including doctors for treatment and information, and determining whether, when and how many children to have.

Reproductive coercion: 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.

Indirect reproductive coercion includes physical or financial control which limits a woman's ability to purchase contraceptives, or access appointments for treatments or prescriptions.

Deliberate reproductive coercion explicitly seeks to impose the perpetrator's power over the woman by impacting, and impeding, her capacity to make her own decisions regarding her fertility and reproduction. These behaviours include:

- the denial or prevention of a woman's want to fall pregnant;
- compromising a woman's ability to provide or withdraw consent to sex;
- forced sex;
- rape;
- threats and use of physical violence if sex is refused;
- injuring a partner in a way that she may have a miscarriage
- lying about being infertile, had undergone a vasectomy, or miraculously was on the not-yet-developed male contraceptive pill

- birth control sabotage.

Coerced pregnancy: is both a form of and consequence of reproductive coercion, where a pregnancy is deliberately intended or used by the perpetrator as a tool of control over the woman, and any decision-making regarding the pregnancy outcomes are removed from her.

Pregnancy promoting behaviours are intended to pressure a partner to become pregnant or continue with a pregnancy when she does not want to. These behaviours include:

- threats of violence if she does not fall pregnant, or agree to try and fall pregnant
- refusing to assist financially or practically with access to abortion
- repeatedly offering money for an abortion and then not having it on the day, until the prices for the procedure increase beyond the woman's ability to afford it
- accusing her of being a "baby murderer"
- threatening to end the relationship if she has an abortion
- calling her on the morning of her clinic appointment to beg or threaten her not to proceed with the abortion, or calling the clinic to cancel or attempt to cancel her appointment

Pregnancy and co-parenting may also impact on a woman's capacity or willingness to leave the relationship due to:

- a fear she may lose her children in a custody battle, or that her partner will then have court-ordered unsupervised contact time with them without her there to intervene and potentially protect them from physical violence or worse;
- a fear that he may carry out threats to harm her, their children or himself if she leaves;
- a concern that she won't be able to take care of herself and the children alone, either economically or psychologically after being subjected to the perpetrator's emotional abuse undermining her belief in herself and her abilities;
- an awareness that she will need to find accommodation suitable for children, and financially support herself; and
- a belief that children need two parents.

All these practical factors work together to support the perpetrator's control and manipulation over the woman to cripple her belief in her ability to leave, and to maintain that power and control over her if she does leave through family court processes or using the children as pawns.

Consequently, a pregnancy can be an impetus to end or leave an abusive relationship when considering the possibility of a child being exposed to his violence and control, or inform a decision to terminate when considering the life-long connection that a child would create between them.

Recommendation: That any future domestic and family violence strategy explicitly recognise reproductive coercion as a marker of domestic violence and include measures to increase the support available to women experiencing reproductive coercion in relationships.

Data on reproductive coercion and domestic violence

As mentioned above, reproductive coercion is an emerging area of study and therefore data can be hard to find. However, enough exists to be able to paint a picture of the prevalence of this issue.

International evidence

In the United States, the rate of reproductive coercion is suspected to be so large and yet so hidden that the American College of Obstetricians and Gynaecologists is recommending doctors screen for reproductive coercion alongside domestic violence.

Several studies into the rates of reproductive coercion have taken place, also in the US, with frightening results: one found that among 71 women with a history of intimate partner abuse, almost three quarters had experienced some form of reproductive control.

Australian evidence

Many women face an increased risk of intimate partner abuse, and unintended pregnancy occurs more commonly for women in abusive relationships.

Data also shows that using medical contraception to control fertility is often complicated for women in abusive relationships.

While national data exists to show one in three women has experienced physical and/or sexual violence, we have to ask why more work has not been done in shining the light on the overlap between the two.

Our service data

In contacts to our counselling and information service in Queensland, 17.5% of our clients disclosed violence in 2013-14. This figure has almost tripled in four years, from 6% in 2009-10.

Almost 40% of our clients reporting sexual violence also report domestic violence, highlighting the prevalence of forced sex within ongoing relationships that are also abusive in other ways.

D, 22, was brought to Australia by her 50 year old boyfriend after an online relationship lasting some years. He told her he would help her go to university in Australia and after her parents died, she had no family left at home to support her. When she arrived in Australia her boyfriend took her to a caravan park in a regional Queensland town – her new home. Far from sending her to university and supporting her to find work, he locked her in the caravan and wouldn't allow her out except to go to church and the store. The only money she had was what he gave her. He made her have sex with him every day, even though she told him she didn't want to. He refused to use contraception and she had no access to any, but even so he told her if she became pregnant he would send her back home to her poverty-stricken country, where her extended family wanted her to undergo female genital circumcision against her will. When she became pregnant she was too afraid to tell him in case he 'hurt' her. A friend from church gave her our number and we helped her financially and logistically

to figure out how she was going to access the abortion she needed – the first step to escaping her relationship. She’s now in Brisbane receiving the help of specialist services for survivors of violence who are also helping navigate her immigration status.

Recommendation: That any future domestic and family violence strategy include measures for better data collection on reproductive coercion, in order to better inform effective policy and practice responses to women experiencing reproductive coercion.

Identifying particular populations for a domestic violence strategy to focus on

Given the statistics on victims of domestic violence, Children by Choice submit that any future strategy aimed at addressing domestic and family violence must acknowledge the disproportionate impact that this type of violence has on women and their children, and take appropriate measures to target support at women and children as a priority. This includes the funding of women-only spaces and services.

Recommendation: That any future domestic and family violence strategy acknowledge that the majority of domestic violence survivors are women who have had violence perpetrated against them by male partners or ex-partners, and that the gendered nature of domestic and family violence is reflected in the aims and measures included in an anti-violence strategy.

Holistic, coordinated and timely responses to domestic violence, including building community confidence in the reporting and investigation of domestic and family violence and ensuring that those who are subject to domestic and family violence receive immediate and effective protection and support

As the above data shows, access to contraceptive, antenatal and/or abortion care can be significantly compromised for women experiencing reproductive coercion.

Contraception

Definitions of reproductive coercion behaviours include a variety of methods of birth control sabotage. These include:

- disposal or destruction of birth control pills,
- refusal to wear a condom, poking holes in them, or removing the condom during sex,
- not withdrawing as agreed,
- refusing to provide money for emergency contraception,
- tearing off contraceptive patches, and
- even more unpleasantly: the forceful removal of intrauterine devices (mirenas), vaginal rings and implanons.

These are supported by anecdotal evidence supplied by our clients.

While some of these practices are only avoidable for women by the physical fact of leaving a relationship, there are also measures that can be taken to reduce women's vulnerability to contraceptive interference.

Long acting reversible contraceptives (LARCs) have relatively low levels of use in Australia compared to other developed countries. LARCs are more effective contraceptive than the pill or condoms and have less potential for human error interfering in their efficacy. However, LARCs do have larger upfront costs attached to them and this makes them less available for some groups of women. This is particularly true for women in violent relationships, who may be experiencing financial control or surveillance, or whose visits to health professionals may be accompanied by her partner. Free or low cost LARC provision through sexual health clinics and GPs should be a strategy for improved sexual health and lower unplanned pregnancy rates across the population, but must be prioritised for women in violent relationships and other vulnerable groups.

Recommendation: That Long Acting Reversible Contraception (LARCs) be provided free or at low cost for women experiencing violence.

Pregnancy termination

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.

As can be seen from this overview, Queensland remains the most restrictive state in terms of abortion law, with our 1899 Criminal Code statutes relating to abortion out of step with not only our interstate counterparts but also with clinical practice and community expectation. Around 80% of

Australians support women's right to choose abortion and it is time for this to be reflected in Queensland legislation.

Recommendation: That the Taskforce recommend the decriminalisation of abortion in Queensland.

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 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 abortion and contraceptive services are not to be provided to any patient under any circumstances.

N was a refugee who was diagnosed with a pregnancy at a Catholic public hospital. She disclosed to the hospital social worker that she had been sexually assaulted by a friend of her family; she was 13 at the time of the assault and had turned 14 only a week before her presentation at the hospital. N had been a virgin before the assault and the social worker was concerned she was suffering from post-traumatic stress from her refugee experiences, now compounded by the sexual assault. The hospital had refused to offer a termination or refer her to any facility that may have provided one for her. The social worker was extremely distressed at the hospital's treatment of her patient and called us to help facilitate access to a privately provided termination. Funds were provided to the patient from Children by Choice and other community organisations in order to pay for this procedure.

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. The minimum out-of-pocket cost for a first trimester abortion in Brisbane is now approaching \$500, and later procedures can cost in excess of \$3000.

Our client data from 2013-14 shows that women reporting violence are over-represented in later gestation presentation, which has repercussions no matter which pregnancy option they choose: if they wish to continue the pregnancy, they will have missed vital early antenatal care and testing, while if they would prefer to terminate the pregnancy, abortion procedures are more costly and harder to access in the second trimester.

The Turnaway Study being conducted by the University of Southern California examines the impact of being denied abortion for women in the United States. This longitudinal study shows that women who seek and are denied an abortion are [more likely to remain in violent relationships](#) than women who are granted access. There is no reason to suggest the results would be different in an Australian study of the same type, although no local data exists.

In 2012, Queensland Health released the Maternal and Neonatal Clinical Guideline of the provision of Therapeutic Termination of Pregnancy (TTOP), the first statewide guideline on the public provision of abortion services in Queensland. As noted above, publicly provided abortion services are very difficult to access in Queensland, despite the release of the guideline. Women reporting domestic and/or sexual violence should meet the criteria in the guideline for a publicly provided procedure, however our clients are regularly denied even an assessment at their local hospital without onerous requirements which can include independent psychiatric assessment outside the hospital. These barriers are often too high for women in violent relationships to navigate.

Recommendation: That the implementation of the Maternal and Neonatal Clinical Guideline of the provision of Therapeutic Termination of Pregnancy be monitored and enforced by Queensland Health to ensure women entitled to publicly provided abortion procedures are able to access them, with specific focus on women reporting domestic and/or sexual violence.

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

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.

Further barriers are also faced by women who are being supported by domestic violence services run by faith-based organisations. Such organisations will not use their government-supplied Emergency Relief funding for abortion procedures for clients, placing greater pressure on these women to come with funds elsewhere. Women in or escaping violent relationships are often socially isolated and financially vulnerable.

Recommendation: That Emergency Relief funds are dedicated to women escaping violence, and that these funds are administered by organisations which will support all options a woman may consider when facing an unplanned pregnancy, including abortion access.

Children by Choice is also concerned by interstate attempts to move funding for domestic and sexual violence support groups and women's refuges from feminist women-centred organisations to larger generalist or faith-based organisations. Woman-centred care is vital to support women experiencing

domestic and/or sexual violence, as are dedicated women's-only spaces to prevent unnecessary trauma for women who have experienced men's violence.

Recommendation: That dedicated domestic and sexual violence services and women's refuges are fully funded by government and run by specialist feminist organisations with the necessary expertise to best support vulnerable women. We also urge the preservation of women's-only spaces and services where appropriate to best provide safe spaces for women who have experienced men's violence.