Reproductive coercion is defined by Chamberlain and Levenson as “behaviours to maintain power and control in a relationship related to reproductive health by someone who is, was, or wishes to be involved in an intimate or dating relationship”. 1 Coercive techniques may include birth control sabotage, forced sex, refusal by the man to use birth control, threats if the woman used birth control, prevention from obtaining birth control, pressure to carry the pregnancy full term or abort, and prevention from accessing abortion or ante-natal care.

Violence and abortion access in Queensland

Access to abortion remains limited in Queensland, largely due to its standing criminalisation. 2 Nevertheless, while the laws may be complex, it is generally accepted that a medical practitioner can lawfully perform termination of pregnancy in Queensland when he/she has formed an honest and reasonable belief that the woman’s physical and/or mental health is at risk of serious harm if the pregnancy continues. Sexual or domestic violence are not grounds in and of themselves for a termination of pregnancy (TOP). It is estimated that around 1% of all terminations in Queensland are performed in public hospitals. The rest are provided through private clinics, the majority of which are based in the southeast corner of the state, at considerable out of pocket expense to women. Procedures range in cost from $410 - $5880 (current as at November 2014).

Domestic and sexual violence support services are provided by experienced professionals across Queensland, mostly funded by government. These services have limited financial support to offer clients, and not at all with emergency relief funds provide assistance for health and medical expenses. Additionally, some are run by faith-based organisations and therefore have policies preventing their workers from providing abortion access support to clients.

Our research

In early 2014 we commenced a literature review in partnership with the University of Queensland Pro Bono Legal Centre, TC Beirne School of Law, to clearly articulate and define the link between unplanned pregnancy, domestic violence and reproductive coercion.

Key findings

Literature confirmed that unplanned pregnancy is more common among women who identify as being in a relationship marked by domestic violence. 3 This correlation is often because of “reproductive coercion” within an abusive relationship. 4 Reproductive coercion may manifest as emotional and physical conduct, which can include:

- The male partner convincing the woman that she will leave her if she does not become pregnant;
- The male partner engaging in birth control sabotage (such as destroying birth control pills, pulling out vaginal rings etc);
- The male partner enforcing financial control, so as to limit access to birth control;
- The male partner insisting on unprotected sex or rape.

These forms of behaviour can be seen as a deliberate strategy to entrench power and control by a male partner, which strongly resonates with definitions of domestic violence more broadly. 5

The effective use of medical coercion as a strategy to retain reproductive integrity and to prevent pregnancy is not straightforward in a domestic violence context. 6 Reproductive coercion may manifest as emotional and physical conduct, which can include:

- The male partner persuading the woman to carry the pregnancy full term or abort;
- The male partner insisting on unprotected sex or rape.

There is an increased likelihood of violence towards a woman during pregnancy which poses significant health risks, 7 and abortion could therefore be categorised as a safety mechanism for women in domestic violence relationships. Termination may be appropriate to prevent the woman from being further entangled with the perpetrator in a co-parenting situation or to prevent further harm to herself or her child. 8

Current abortion provision is particularly problematic for women in rural or isolated areas, whose physical distance may be further hindered by behaviour characteristic of any domestic violence relationship. Moreover, the substantial out of pocket cost associated with an abortion at a private clinic also presents a major barrier to women, particularly to those who may be under financial control by an abusive partner. 9

References

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