

SCREENING TO SAFETY PROJECT

Funded by the Samuel and Eileen Gluyas Charitable Trust
managed by Perpetual

FINAL PROJECT REPORT

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CONTACT

Liz Price

Project Officer

Screening to Safety

07 3357 9933 (ext 2)

lizp@childrenbychoice.org.au

THANKS

Thanks to all who supported me during this project; there are too many to thank individually but please know that your enthusiasm, generosity, willingness, challenges, concerns, creativity, time, energy, dogs, humour and tea were greatly appreciated.

[A note about language](#)

Whilst the term “woman” is used throughout this report to reference those impacted by gendered violence such as reproductive coercion, it is recognised that people who are gender diverse, sexually diverse and/or live with intersex variation(s) can experience unintended pregnancies, and often higher rates of violence and control.

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INTRODUCTION

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, offer financial assistance for contraceptive and abortion access, deliver sexual and reproductive health education sessions in schools and community settings, 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 and information. We are recognised nationally and internationally as a key advocacy group for the needs and rights of women in relation to reproductive and sexual health.

In 2016-17 we received a total of 4039 contacts with or regarding 1678 clients, ranging in age from under 14 to over 50, and provided almost \$130,000 in financial assistance for contraceptive and abortion access. Our Annual Reports are available on our website at www.childrenbychoice.org.au

Over one third of our counselling work involves contacts with or on behalf of women subjected to violence and control, reflecting the prevalence of the issue in Queensland, as well as our commitment to a holistic response for these women. To extend our initiatives in this area Children by Choice commenced a state-wide Screening to Safety project in September of 2016 with the assistance of funds from the Samuel and Eileen Gluyas Charitable Trust managed by Perpetual.

PROJECT AIMS

The principal aim of the Screening to Safety project was to build the capacity of private abortion providers in Queensland to identify and respond to domestic violence with a particular focus on reproductive coercion. The project also sought to build the capacity of domestic violence and sexual assault service providers in Queensland to identify and respond to reproductive coercion and unplanned pregnancy risk.

PROJECT INITIATIVES

Project initiatives aimed at abortion providers were designed to offer a tailored response, recognising the wide range of provider settings. Children by Choice has a long history of working closely with abortion providers and early consultations with providers were met with enthusiastic responses. Providers recognised that they offer medical services for women subjected to violence and control, and were motivated to enhance their responses. The project gave priority to abortion providers in designing initiatives.

Early consultations with the domestic violence and sexual assault sector revealed challenges in engaging with a sector stretched in its capacity to respond to increasing workload and complexity. Early in the project it was recognised that there would be limitations to the

extent that the sector could be involved. As such it was important to focus the initiatives where the greatest opportunities lay, with individual services most interested in the project's initiatives and on geographic areas where abortion providers were located to make the most of the project's limited operational resources.

This project report contains an account of the initiatives undertaken by the project along with recommendations for consideration at research, sector, service and government levels. These initiatives included:

- The development of a domestic and sexual violence screening tool for Queensland abortion providers.
- Supporting abortion providers to establish environments that support disclosure.
- Enlisting knowledge of indicators of violence in women attending for abortion care into abortion provision setting.
- Supporting abortion providers to respond to disclosures of violence and reproductive coercion through knowledge of referral pathways.
- Supporting abortion providers to respond to disclosures of violence and reproductive coercion through contraceptive information and access.
- Training and education for abortion providers and other health care practitioners to increase knowledge and skills.
- Training for the women's sector to increase knowledge and skills.
- Awareness raising in the women's sector.
- Training and education initiatives for the youth sector and young people.

PROJECT RATIONALE

Research shows a strong link between domestic violence, unplanned pregnancy and abortion, with unintended pregnancies and abortion two to three times more likely to be associated with intimate partner violence than planned pregnancies.¹ Reproductive coercion by male partners is a causal factor in this link. Identifying and responding to reproductive coercion is an emergent issue in domestic violence practice, research and literature.

Domestic violence screening is becoming a more regular feature of antenatal care. However, identifying and responding to domestic violence in abortion provision settings has not been consistently resourced in Queensland.

Abortion provision in Queensland

Approximately 98% of Queensland's abortions are provided in the private health sector. All (seven) of Queensland's licensed day surgeries providing surgical and medical abortion participated in the project, and approximately 11 medical abortion providers were directly supported by the project.

These abortion provision settings vary markedly and include:

- Specialised private clinics offering both medical and surgical abortion in which intake and admissions processes are conducted by nursing staff, and the woman attend the clinic only once or twice depending on the method used to terminate the pregnancy,
- Sexual and reproductive health services offering medical abortion as part of a suite of services in which intake and admissions is done collaboratively by nurses and doctors over several appointments,
- General practitioners offering medical abortion as part of a mainstream medical practice, in which the prescribing doctor leads the consultations, and
- Telehealth Services providing medical abortion with nurses leading the intake process.

Justifications for screening:

While there is continuing debate about the justifications for screening for violence, the project sought to encourage abortion providers to engage in domestic and sexual violence screening for the following specific reasons:

- Women experiencing violence and control are over-represented in those attending for abortion care.²
- Research demonstrates that reproductive coercion can be reduced through screening, educating, responding and referring around these issues.³
- Pregnancy may act as an impetus to end an abusive relationship, or inform a decision to access an abortion. Women in these circumstances may be highly motivated to take action on a range of issues at the time of presentation for an abortion.⁴

PROJECT EVIDENCE BASE

The project initiatives were informed by four key elements:

1. Background research into domestic violence screening in health care settings was carried out and more specifically in abortion provision settings.⁵
2. A literature review of reproductive coercion was carried out.
3. An analysis of the Children by Choice reproductive coercion data collected from January 2015 was conducted. A comprehensive account of this is contained in the Children by Choice submission to the Marie Stopes Australia White Paper on reproductive coercion, available for download at: https://www.childrenbychoice.org.au/images/downloads/CbyCSubmission_MSA_ReproductiveCoercionWhitePaper.pdf The prevalence of this issue shaped the decision to focus the project on reproductive coercion as an issue of direct relevance to abortion provision settings.
4. Consultations with stakeholders and observations of clinical flow in surgical abortion settings helped to ground the ideas from research and data into the realities of abortion provision in Queensland.

SUMMARY OF RECOMMENDATIONS

These recommendations are drawn together from this report as well as from the Children by Choice submission to the Marie Stopes Australia White Paper on reproductive coercion:

Recommendations for research

1. The establishment of a national clearinghouse for emerging research and service delivery data relating to reproductive coercion.
2. Research grant organisations prioritise initiatives which could help further illuminate issues of reproductive coercion in an Australian context.
3. Development of a structured reproductive coercion measurement scale which includes pregnancy outcome coercion.
4. That the temporal relationship between reproductive coercion and domestic violence be fully explored in future Australian research.
5. Future research explore patterns of reproductive coercion in young people with a focus on pregnancy outcomes.
6. Future research prioritises the further understanding of the unique cultural dimensions to reproductive coercion in Australia.
7. That existing population studies already examining the prevalence of domestic violence or those with a reproductive health component, incorporate questions specific to reproductive coercion.

Recommendations for abortion providers

8. Abortion care settings universally screen for coerced pregnancy and coerced abortion.
9. Repeat reproductive coercion screening is incorporated in all contexts where medical abortion is provided.
10. That all women are seen alone for at least part of each consultation with an abortion provider regardless of age, culture or capacity.
11. That abortion providers display signs in reception areas advising patients that they will be seen on their own for part of the intake and admission process.
12. Abortion providers provide suitable induction to all new staff in relation to issues of violence and reproductive coercion.
13. Abortion providers update information on their websites about discrete contraception options or place a link on their websites to the up-to-date contraception information on the Children by Choice website.
14. Abortion providers, especially public and not-for-profits, facilitate access to long acting reversible contraception (LARC) at time of abortion for women experiencing reproductive coercion.

15. That all abortion providers modify intake and admissions processes to make use of information about indicators for violence and control in women attending for abortion care that would inform screening.
16. That abortion providers maintain domestic violence referral resources at the clinic level and that new staff are provided appropriate induction around this.
17. That the use of technology such as iPads to assist screening be revisited as abortion providers move towards incorporating information technology into their intake and admissions processes.
18. MSHealth, as the licensed distributor of the MS2Step, continue to integrate training and resources relevant to the area reproductive coercion to health care practitioners licenced to provide medical abortion

Recommendations for other health settings and domestic violence service provision settings

19. Information on discrete contraception be included in contraceptive information and education provided in all settings.
20. Reproductive coercion screening is implemented as a universal standalone aspect of violence screening, not only where other forms of domestic violence have been disclosed.
21. Specialist support services for pregnant and parenting young women build their capacity to screen for violence and pregnancy coercion among their clients and increase the support they are able to provide young women.
22. Specialist domestic violence services evaluate their referral protocols to ensure that they are accessible to referrals from within a health care setting, such as emailed or faxed referrals.
23. All services and professionals involved in responding to the needs of women experiencing violence must be resourced and informed about reproductive coercion.
24. The Royal Australian College of General Practitioners clinical guideline on abuse and violence be updated to include a section on reproductive coercion and contraceptive counselling in the context of violence and control, to ensure that this information is readily available to health care practitioners in a wide range of settings.

Recommendations for Children by Choice

25. Additional Screening to Safety project funds be allocated to the LARC scheme at the project's completion.
26. Children by Choice carry out a thorough evaluation of this scheme at the expenditure of funds.
27. That reproductive coercion and perpetrator behaviour awareness be included in sexuality education provided to young people.
28. The organisation seek resources to deliver training to youth sector workers to complement the additions in content to sexuality education with young people

29. The training modules developed by the Screening to Safety project be added to the suite of professional training offered by Children by Choice.
30. Children by Choice seek additional resources to extend the training offered to abortion providers.
31. Existing Children by Choice training continue to include content around the intersection of unplanned pregnancy, abortion, domestic violence and reproductive coercion, including content on decision making in the context of violence and reproductive coercion.
32. Children by Choice continue to advocate for change at the broader level as outlined in the recommendations below.

Recommendations for Government

33. Domestic violence funding bodies provide brokerage direct to Children by Choice to continue their work in supporting abortion access and appropriate contraception access for women experiencing violence.
34. Antenatal and maternity services include reproductive coercion screening as part of broader violence screening, especially with young women.
35. The designated resources be provided to continue to build the domestic violence sector's knowledge of and response to issues of reproductive coercion.
36. Access to termination of pregnancy and contraception be viewed as a domestic violence safety strategy for women subjected to reproductive coercion.
37. The upcoming Queensland Health review of the Therapeutic Termination of Pregnancy Guideline consider issues of violence, control and reproductive coercion.
38. Medicare funding for termination of pregnancy be increased, particularly in relation to second trimester procedures.
39. A Medicare item number for domestic violence screening be introduced.
40. The Medicare Benefits Schedule Review include research and understandings of reproductive coercion as relevant contemporary clinical evidence to all Medicare items related to abortion and contraception.
41. The cost of copper IUDs be subsidised.
42. All states and territories decriminalise abortion, and work to improve equity of access to abortion services.

PROJECT INITIATIVES

1. Development of a domestic and sexual violence screening tool for Queensland abortion providers

Consultations with Queensland's private abortion providers identified that none were routinely screening women for domestic and sexual violence. A key initiative in enhancing the capacity of abortion providers to identify and respond to issues of violence and control was to develop a screening tool.

A review of available screening tools and literature was carried out and a screening tool for abortion providers was drafted with feedback from Children by Choice staff. Feedback was then sought from a group of eight experts external to the organisation including:

- Mainstream domestic violence workers,
- Workers from specialist services including those supporting women from culturally and linguistically diverse backgrounds, women who identified as Aboriginal and/or Torres Strait Islander, women living with disabilities and young women
- Researchers and academics with a special interest in domestic violence screening in health care settings.
- Social workers in a South Australian abortion provision settings where domestic violence screening is currently done.

Feedback was received from six of the eight group members and incorporated into the draft which helped to improve the tool. The tool* was further refined to fit the context by observing clinical flow in two private day hospitals providing abortion and consultations with staff across a number of different abortion provision settings.

Consultations established that 'intake and admissions' is the most likely place for violence screening. However intake and admissions processes vary markedly across different provider settings. These consultations cover a wide range of areas including establishing pregnancy gestation, obtaining informed consent, contraceptive counselling, application of the legal test, gathering medical history to inform suitability of abortion method and assessment of anaesthetic risks.

Limited physical space, particularly in settings providing surgical abortion, also required that patients be moved through the intake process so as not to hold up the flow of patients to be seen that day. These issues combine to place significant time pressure on the intake and admissions process and had implications for how violence screening can be incorporated.

* All tools, factsheets and other resources referred to in this report are available on request, and many can be downloaded from our website www.childrenbychoice.org.au

As a result a shorter screening tool was created which focussed on sexual violence and reproductive coercion as two issues of particular relevance to abortion providers, to reduce the amount of time needed for screening process.

All participating abortion providers have been provided with the screening tools. Training modules and reproductive coercion resources were also developed to assist with the implementation of the tool. During the project a day surgery took the initiative to implement universal screening of all patients attending for abortion care. Other providers added selected questions from the screening tools into their existing intake and admissions proforma, particularly those focussing on reproductive coercion.

Recommendation: At a minimum, all Queensland abortion providers should screen for coerced pregnancy and coerced abortion.

2. Supporting abortion providers to establish an environment that supports disclosure

The literature reviews carried out at the beginning of the project identified the importance of establishing an environment that supports disclosures of violence and control. Consultation explored a range of options and practical steps were taken to support abortion providers to make small changes:

- All abortion providers have been given posters on domestic and sexual violence for display in the reception areas and women's only spaces.
- The project has developed a set of [five reproductive coercion specific posters](#)⁶ with funds from the Queensland Government and the YWCA Queensland. Approximately 250 sets have been distributed to 50 services including the women's sector and abortion providers.
- The importance of seeing all women alone has been reiterated during training and consultations with clinic staff. Instructions about seeing patients alone and how to manage exceptions have been included in the screening tools developed by the project.
- Clinics have been encouraged to advise women at the time of booking that they will be seen on their own for part of the consultation.
- Clinics have been given signs to display advising patients that they will be seen on their own for part of the intake and admission process.

Using technology such as iPads for violence screening has been shown to increase disclosure rates. Providers were asked about the availability of technology such as this, but no providers were using devices for this purpose at the time of consultations so this idea was not explored further.

Recommendation: The use of technology such as iPads to assist screening be revisited as clinics move towards incorporating more information technology into their intake and admissions processes.

3. Enlisting knowledge of indicators of violence in women attending for abortion care into abortion provision setting

The Screening to Safety project carried out a literature review to identify indicators of women experiencing domestic violence who present for termination of pregnancy. Knowledge of these indicators can provide conversational points of entry into a universal screening processes, and can help inform selective domestic violence screening.

These indicators were explored in consultations with abortion providers. Intake and admissions protocols were examined to see if the information was routinely collected, if not how additional intake and admissions questions could elicit this information and importantly, how staff draw on this information in their intake consultations.

The project has:

- Increased provider awareness of the indicators of violence and control in women presenting for abortion through the provision of training, factsheets and resources.
- Made recommendations about modifications to intake and admissions protocols which have been incorporated by a number of participating abortion providers.
- Developed a version of the screening tool that prompts staff to undertake a review of the relevant information gathered in the intake and admissions process.

Recommendation: All abortion providers modify intake and admissions processes consider how to make use of information about indicators for violence and control in women attending for abortion care to inform screening.

4. Responding to disclosures of violence and reproductive coercion: referral pathways

It is important that clinical staff are aware of referral options to specialist domestic and sexual violence services for women seeking additional support around issues of violence and control. Clinic staff are busy with intake and admissions, and ensuring patient flow. Limited physical space in the clinics make it difficult to spend additional time with a patient without impacting on the flow of patients through the clinic. This reduces the clinic's capacity to make telephone referrals, especially to services with high demand where call wait times may be lengthy. Many domestic and sexual violence services had the option of faxed or emailed referrals.

Project response: At a minimum, training to clinics provided information about the Queensland state wide DV crisis line and the national website for locating a woman's closest DV support service. Where possible information about local domestic and sexual violence service referral processes, along with service pamphlets and business cards were provided. The project will distribute business cards for the state wide crisis line to all Queensland clinics.

Recommendation: Abortion providers maintain these referral resources at the clinic level and that new staff are provided appropriate induction about referral pathways.

Recommendation: Specialist domestic violence services evaluate their referral protocols to ensure that they are accessible to referrals from within busy health care setting, such as emailed or faxed referral options.

5. Responding to disclosures of violence and reproductive coercion: contraception

Abortion providers have an important role to play in responding to disclosures of coerced pregnancy through the provision of abortion and appropriate responses to contraception issues, including offering contraceptive counselling and information about contraception options sensitive to issues of violence. For women with no plans for contraception immediately after abortion it is considered best practice to provide advice and access to emergency contraception options.⁷ Some clinics have been doing this already.

Access to information about suitable contraception at the time of abortion

A number of the project initiatives addressed this issue including:

- **Updating the Children by Choice website:** resources on contraception in our “for women” section now include information about each contraception and how vulnerable to detection and sabotage it is. This can be viewed at: www.childrenbychoice.org.au/forwomen/contraception Information on the discretion of each contraceptive type is also provided in a summarised form at: www.childrenbychoice.org.au/forprofessionals/recognisingviolenceandcoercion/contraception-and-violence
- **Developing a tri-fold practitioner resource:** “A resource for enhancing women’s reproductive autonomy”. This was designed to be a stand-alone resource containing all of the basic information required for a health practitioner or women’s sector worker in exploring contraceptive options with women at risk of coerced pregnancy. It can also be used as a displayed contraceptive chart in medical settings. Many abortion providers now have these displayed in the women’s only spaces of their clinics. Approximately 2000 copies of this resource have been distributed to abortion providers and women’s services.
- **Producing a palm sized leaflet:** “Who controls pregnancy decisions in your relationship?” This leaflet invites women to self-evaluate the extent of their reproductive autonomy and offers points of contact for additional assistance. Approximately 6500 copies of this resource have been distributed to abortion providers and women’s services.

Recommendation: Abortion providers should update information on their website about discrete contraception options or place a link on their websites to the contraception information on the Children by Choice website.

Recommendation: Abortion providers should stock oral emergency contraceptive pills.

Responding to disclosures of violence and reproductive coercion: access to contraception at the time of abortion

Abortion providers can provide immediate access to contraception including long acting reversible contraception (LARC) to enhance the reproductive autonomy of women subjected to violence and control. It is common practice in Queensland for medical abortion providers in general practice and in specialist sexual and reproductive health settings to routinely offer bulk billed LARC insertion. Additionally some medical practitioners will provide *Implanon* insertion at the time of administering the mifepristone where there is concern that the woman may not attend for follow up. These initiatives help facilitate LARC access for all women regardless of violence and control disclosures.

Whilst none of the day surgeries providing abortion routinely offered bulk billed LARC insertion, advocacy on behalf of women at risk does result in reduced costs on a case by case base for women who have had contact with the Children by Choice counselling service.

Consultations during the Screening to Safety project have resulted in:

- Day surgeries reviewing their price structure of LARC insertion for disadvantaged women.
- More clinics have taken up the option of stocking oral emergency contraception.
- Larger not for profit abortion providers have been encouraged to consider a discretionary fund at each clinic to streamline LARC access at the time of abortion for women experiencing/or at risk of coerced pregnancy.

The Screening to Safety project has also established a LARC program to streamline access to LARC for women seeking abortion care where domestic violence and/or reproductive coercion is identified. Criteria for the fund are that:

1. The woman has disclosed domestic violence and/or reproductive coercion OR has not disclosed in response to direct questioning, but is presenting with injuries or signs that are consistent with domestic violence and/or reproductive coercion.
and
2. An assessment has been made to ensure that the contraceptive type offered is safe given the nature of the violence and/or reproductive control she is experiencing.
and
3. The woman needs this financial assistance in order to access LARC at the time of abortion.

The funds can be accessed through two pathways:

1. **Internal pathway:** the Children by Choice counselling service can include no cost or subsidised contraception in their response to women who seek assistance with abortion and contraception.
2. **External pathway:** abortion providers signed up to the Screening to Safety LARC access fund can provide no or low cost immediate LARC access to women at the time of their abortion where there has been no prior contact with the Children by Choice, with the abortion provider being reimbursed by the LARC program.

Twelve abortion providers partnered with the LARC access program. Relevant staff of the abortion providers were required to have knowledge of the intersection of domestic violence and abortion as well as skills in identifying and responding to reproductive coercion. Training around these issues was provided. A simple form was developed for clinic staff to ensure that the administrative requirements of the fund could be incorporated into intake and admissions processes.

To date 107 women have been supported by the fund, with 91 women assisted through the internal pathway, and 16 through the external pathway. Eleven of those from the external pathway came from the one clinic where universal screening for domestic and sexual violence screening had been implemented. The other five came from three different providers. It is noted that abortion providers utilised the LARC access fund shortly after receiving training and becoming partners to the scheme. However, this was not maintained over time. Eight of the partners to the scheme have not made use of it yet. There are several possible explanations for these trends:

1. With most use of the scheme coming from one provider that had implemented universal screening for violence, this would suggest that direct questioning about experiences of violence and control is most effective in identifying and responding to these issues in a clinic setting.
2. Several partners to the scheme bulk billed LARC insertion at the time of follow up appointment, and as such women attending these services face less barriers to LARC access at the time of abortion. The only women who might benefit from the scheme in these circumstances would be those without Medicare or those seeking Copper IUDs which are more expensive as they are not subsidised by the Pharmaceutical Benefits Scheme.
3. Attention to issues of violence and awareness of the scheme may get lost amidst workload demands and competing priorities
4. Some abortion providers had only been signed up to the LARC access program for a few weeks at the time of writing.

The **internal pathway** has assisted a significant number of women, attesting to the outcomes from attention to exploring contraception options in the context of violence. In the financial year 2014-15 less than 2% of women we supported to access an abortion, were supported to access contraception. This has been steadily rising with early trends in the 2017-18 year standing at 44% of all women being assisted to directly access contraception at the time of abortion. This increase has in part been due to the establishment of the LARC access fund as part of our current Screening to Safety project.

Funds remain in the LARC scheme and it will remain active after the completion of the project to facilitate the **internal pathway** and to provide an opportunity to monitor trends in the **external pathway**.

Recommendation: Additional Screening to Safety project funds be allocated to the LARC scheme at the project's completion.

Recommendation: Children by Choice carry out a thorough evaluation of this scheme at the expenditure of funds.

Recommendation: Domestic violence funding bodies provide brokerage direct to Children by Choice to continue their work in supporting abortion access and appropriate contraception access for women experiencing violence.

6. Training modules for abortion providers and other health care practitioners

Training needs were identified through the consultation process and in consideration of the implementation of tools and resources. The sequential modules were designed for a range of abortion provision settings, leading to full implementation of the screening tools.

It was hoped that some modules could be co-developed and delivered in partnership with workers in the domestic violence and sexual assault sector. The purpose of that would have been two fold; to enrich the content of the training and to build relationships between the sectors. However, due to workload demand in the women's sector this was not possible in a timely way.

Because of the direct relevance of reproductive coercion and sexual assault to sexual and reproductive health care provision such as abortion, priority was given to modules with this focus. Abortion providers involved in the project were offered the following training modules, and were delivered as follows:

Module	Number of times delivered
Intersection of unplanned pregnancy, abortion, domestic violence and reproductive coercion.	12
Reproductive coercion: coerced pregnancy	12
Reproductive coercion: coerced abortion	6
Sexual assault: enquiring about sexual assault and responding to disclosures	1
Documenting disclosures and other evidence of violence	1
Using the screening tool	0

Some challenges were faced in the delivery of the training modules:

- The casual and part time work force of many surgical abortion providers limited time and incurred costs to clinics,
- Having to pull staff out of limited clinic time in salaried settings to participate,
- Competing priorities such as clinic auditing processes,
- Some provider settings did not include doctors in the training sessions,

- Limited travel budget meant some sessions have to be provided using IT platforms rather than face-to-face, and
- Large number of providers interested in what the project could offer gave rise to competing project priorities, with a focus shifting to ensuring all providers received some training rather than being able to offer more intensive training to a smaller number of providers.

Feedback on the training sessions showed that whilst the overall satisfaction with the quality of the training was high, the extent to which participants felt equipped with knowledge and skills in the areas varied. Two factors seemed to drive this:

- The longer the time allowed for training the more equipped people reported feeling. Case study activities often had to be simplified or skipped if time did not allow and may have played a critical role in consolidating learning.
- The participation of staff not involved in direct patient care also impacted on the degree to which participants felt equipped.

Whilst all of Queensland's day surgeries providing abortion and five other abortion providers have received two of the training modules as outlined above, no single provider has been provided with all modules. This has held short the implementation of the screening tool as originally developed. However the combined initiatives of the project have seen modifications in intake processes across many of the participating abortion providers, all of which it is hoped will contribute to the increased identification of women experiencing violence and control, and improve the quality of the responses from health care practitioners.

Recommendation: Modified training be offered to staff in abortion provision settings not involved in direct patient care.

Recommendation: Clinics provide suitable induction to all new staff in relation to these issues. (A suggested induction checklist has been developed.)

Recommendation: Clinics include refresher training for all staff on the modules when possible. This could be offered by Children by Choice on a fee for service basis at the completion of the project.

Recommendation: Children by Choice seek additional resources to extend the training offered to abortion providers.

7. Education for abortion providers and health care practitioners: other initiatives

Children by Choice is aware of and works closely with approximately 15 general practitioners that offer medical abortion. It is thought that a much larger number of GPs are registered to provide medical abortion but remain unknown to Children by Choice. In order to ensure ongoing access to and extend the reach of the project's training initiatives, other initiatives were undertaken as follows:

- A brief training module on contraceptive counselling in the context of violence for health care practitioners suitable for a wider range of health care provision settings delivered to the Brisbane South Primary Health Care Network.
- A Presentation was given at the Marie Stopes Australia Roundtable on reproductive coercion in Brisbane in August 2017 and a comprehensive submission to the Marie Stopes Australia White Paper on reproductive coercion was made.
- A presentation on the Screening to Safety project at the “Unplanned pregnancy and abortion in Australia” Conference in Brisbane, August 2017 was made.
- In collaboration with *TRUE Relationships and Reproductive Health*, a one day training package was developed. It has been delivered twice and will continue to be offered on a fee for service basis in partnership between the two organisations.
- Three short online videos were produced by the project, aimed at medical abortion providers, but with relevance to other abortion providers. They will be available to all doctors registered to prescribe the medical abortion drugs in Australia via the MS Health online support platform, and are now available via links on the Children by Choice website. These modules are:
 1. The intersection of domestic violence and unplanned pregnancy and abortion: implications for MTOP providers (7 minutes)
<https://youtu.be/t4TsTRmW8vQ>
 2. Reproductive coercion and forced pregnancy: the role of MTOP providers in enhancing women’s reproductive autonomy (9 minutes)
<https://youtu.be/PKoLo3CTtU8>
 3. Reproductive coercion and forced abortion: practice tips for MTOP providers in enhancing women’s reproductive autonomy (6 minutes)
<https://youtu.be/3BwnYgDi1ug>

8. Training modules for the women’s sector

A smaller series of training modules were tailored for the women’s sector. Service-specific sessions were carried out in the south east corner of Queensland to six domestic violence and women’s health services. Cross agency training was delivered in regional centres including Gladstone, Bundaberg, Rockhampton, Mackay and Townsville.

Module	Number of times delivered
Intersection of unplanned pregnancy, abortion, domestic violence and reproductive coercion.	11
Reproductive coercion: coerced pregnancy	11
Patterns of violence in pregnancy	2
Supporting women’s pregnancy decision making in the context of domestic violence	2

The training sessions, particularly the service specific events, provided a useful springboard for consideration of content and issues for practice and organisational procedures and policies such as:

- Adding specific questions about reproductive coercion into safety planning tools
- Extending intake questioning about pregnancy and the risk of pregnancy
- Consideration of the interplay between abortion and contraceptive access, and safety responses such as refuge placement
- Clarification of how brokerage may be used to support abortion and contraception access.

Recommendation: The training modules be added to the suite of professional training offered by Children by Choice.

Recommendation: The Children by Choice full day unplanned pregnancy training continue to include content around decision making in the context of violence and reproductive coercion.

9. Women's sector: additional platforms

Conference presentations were used as an additional platform for sharing knowledge and ideas of relevance to the domestic violence and broader women's sector:

- The 2016 STOP Domestic Violence Conference, Brisbane (poster presentation): Recognising the link: Unplanned Pregnancy and Reproductive Coercion.
- Queensland Centre for Domestic and Family Violence Research (QCDFVR) Not Now, Not Ever Research Symposium, Mackay, 2017: "Screening to Safety": a Children by Choice initiative responding to the intersection of domestic violence, reproductive coercion, unplanned pregnancy and abortion.
- True Relationships & Reproductive Health and Multicultural Centre for Women's Health, Evidence for Equity, Brisbane, 2017: The migrant woman's experience of reproductive coercion, unplanned pregnancy and abortion: enhancing reproductive autonomy.
- Queensland Centre for Domestic and Family Violence Research, New ways of working: Queensland Gendered Violence Practitioner Forum, Brisbane, 2017: Women's reproductive autonomy in the context of gendered violence: Resources for enhancing practice.

The project findings and initiatives will also be presented at the upcoming ANROWS conference (Sydney May 2018) as part of a panel of speakers addressing the issue of the need for improved responses to reproductive coercion.

10. Training initiatives for the youth sector and young people

Given the patterns and prevalence of reproductive coercion facing young people that emerged from the Children by Choice data analysis and the impact of the intersection of

violence and contraception for young women as identified in the literature, the Screening to Safety project has supported Children by Choice to:

- Include youth specific resources within the reproductive coercion posters,
- Identify them as a group of special concern within women's sector and abortion provider training,
- Tailored training to professionals working with young people, and
- Modified existing sex education resources for young people.

CONCLUSION

This project has made significant inroads into enhancing the capacity of private abortion providers to identify and respond to the needs of women experiencing violence and control who attend for abortion care. The combined project initiatives have:

- Increased knowledge among medical professionals regarding the link between domestic violence, reproductive coercion and unplanned pregnancy and abortion.
- Increased skills and confidence among abortion providers and other health care professionals to screen women for domestic violence and reproductive coercion.
- Increased skills and confidence among abortion providers and other health care professionals to provide referrals to specialist domestic and sexual violence services, and contraceptive support to women.

It is hoped that the impact of these initiatives has:

- Increased the opportunities for women experiencing domestic violence and reproductive coercion to disclose and/or access support.
- Increased reproductive autonomy for women experiencing domestic violence and reproductive coercion.
- Increased knowledge among young women to recognise and understand reproductive coercion.

The suite of resources developed by the project will continue to be available to abortion providers. A major challenge is maintaining the profile of these issues and to retaining the skills and knowledge within abortion provision settings. A challenge for Children by Choice is to continue to build on this work in the absence of designated resources.

The funding of this project has been timely. It has both contributed to and benefited from the increasing profile of reproductive coercion as a domestic violence issue. Project initiatives have raised awareness of the issue and have increased skills, knowledge and resources in the women's sector.

We continue to hope that the decriminalisation of abortion in Queensland is imminent, to enable us as a community to accord reproductive justice to those who experience unplanned pregnancy and abortion as a direct impact of domestic violence and reproductive coercion.

“If you care about Intimate Partner Violence, you should care about Reproductive Justice because a woman’s reproductive capacity can be used by her abuser to assert further control as a component of all possible forms of abuse—sexual, physical, emotional and economic.”

- Jill C. Morrison, National Women’s Law Center, USA. [2009].

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