	WHAT IS IT?	HOW DOES IT WORK?	HOW EFFECTIVE IS IT?	WHAT ARE ITS ADVANTAGES?	WHAT ARE ITS DISADVANTAGES?	WILL SOMEONE ELSE KNOW I'M USING IT?	COULD SOMEONE ELSE TAMPER WITH IT?
 **HORMONAL IUD** ALSO CALLED BY ITS BRAND NAME, MIRENA	Small plastic device which releases low doses of progesterone and is fitted into the uterus.	Makes the lining of the uterus unsuitable for a pregnancy, and prevents sperm from reaching the egg.	99.9%	Lasts for five years. Cost effective over time.	Not all nurses and doctors are trained to do insertion. The cost of having one inserted can be expensive.	The strings may be detectable but can be trimmed short by the doctor doing the insertion (although this may cause difficulties in removal). If the device is correctly fitted, the stem should not be detectable. Menstruation may be disrupted.	Could be forcibly removed, especially if the strings are not cut off at the opening of the cervical canal.
COPPER IUD	Small plastic and copper device fitted into the uterus.	Makes the lining of the uterus unsuitable for a pregnancy and hostile to sperm.	99%	Lasts five to ten years. Cost effective over time.	Not all nurses and doctors are trained to do insertion. The device is not listed on the PBS so both it and insertion can be expensive.	The strings may be detectable but can be trimmed short by the doctor doing the insertion (although this may cause difficulties in removal). If the device is correctly fitted, the stem should not be detectable. Menstruation may be disrupted.	Could be forcibly removed, especially if the strings are not cut off at the opening of the cervical canal.
 **INJECTION** ALSO CALLED DEPO OR DMPA	Three monthly injection of the hormone progesterone by a nurse or doctor.	Prevents egg from being released and sperm from reaching the egg.	99% perfect use 94% typical use	Each injection lasts 12 weeks.	Bleeding can be unpredictable to start with. After usage stops, return to fertility may be delayed. Has been linked with weight gain and lowered bone density.	The only signs of use are the injection site on the day of each injection, and the ceasing of regular menstruation. Medicare records of regular three-monthly doctor visits may be an issue for women experiencing high levels of surveillance or monitoring.	Once injected it cannot be tampered with for that 12 week period.
 **IMPLANT** ALSO CALLED THE ROD, THE BAR, OR BY ITS BRAND NAME, IMPLANON	Small rod which releases the hormone progesterone inserted under the skin by a nurse or doctor.	Prevents egg from being released and sperm from reaching the egg.	99.9%	Lasts for three years. Cost effective over time.	Some women experience unpredictable bleeding. Not all nurses and doctors are trained to do insertion. Can be expensive to have one inserted.	The bandaging post-insertion can make it obvious that it has been done, and it is possible to feel the rod at the insertion site. It is usually inserted in the upper arm but may be less detectable by others if it is inserted in another place, eg leg.	It could be forcibly removed so may not be suitable in situations of more extreme violence. If it is cracked whilst in place it may shorten the life of the rod, so risk of damage due to physical violence or assault could be a consideration for some women.
 **STERILISATION** ALSO CALLED TUBAL LIGATION OR OCCLUSION	Surgical procedure to permanently clip, block or tie the fallopian tubes so eggs and sperm cannot meet.	Prevents the sperm from reaching the egg.	99.5%	It is permanent and so cost effective over time. It does not interfere with the woman's hormones.	It can be expensive to have it done privately, and is not widely available. In the public health system, wait lists are long and criteria, such as the woman's age, are often stringent.	Depending on the method, there may be a need for incisions and anaesthesia, and/or a follow up at three months, which can make it hard to have it done discreetly. Menstruation is maintained. No ongoing signs of use once any incision scars are healed.	It cannot be tampered with.
 **VAGINAL RING** ALSO CALLED BY ITS BRAND NAME, NUVARING	Flexible plastic ring inserted into the vagina (for three weeks at a time) which releases the hormones oestrogen and progesterone.	Prevents egg from being released.	99% perfect use 91% typical use	Can help regulate the menstrual cycle, reduce PMS and reduce period pain. Easier to use correctly than the combined pill.	Not suitable for women with some medical conditions. Not listed on PBS so more expensive than other combined hormonal methods.	Easily detected, although it can be removed for short periods of time (maximum three hours) without becoming less effective, so could be discreetly removed just before sex and reinserted immediately afterwards.	Easily removed so may not be suitable for women who have little control over if, when or how sex happens. Emergency contraception may need to be accessed in these circumstances.
DIAPHRAGM ALSO CALLED THE CAP	Rubber dome inserted into the vagina to cover the cervix.	Prevents sperm from entering the uterus.	95% perfect use 85% typical use	Only needs to be used during sexual activity. Can be put in place ahead of time.	Spermicide may be needed to ensure effectiveness. Needs to be left in place for at least six hours after penetrative sex.	It may be detectable during sex, particularly by fingers but less so by penile penetration. It is fairly distinguishable in shape due to the lipped rim so may be obvious to others when not in use.	Needs forward planning so may not be suitable for women who have little control over if, when or how sex happens. Can be easily removed by another person before or during sex.
 **CONDOMS**	Male condoms are a latex or non-latex sheath that is put over the penis. Female condoms are a thin sheath inserted into the vagina before sex.	Prevents sperm from entering the vagina by trapping ejaculate.	98% perfect use 85% typical use Female condoms vary from 80-95%	Male condoms are readily available and only need to be used during sex. Can be used as a backup for other contraceptives. Protects against sexually transmitted infections.	Can reduce spontaneity.	Condoms are one of the most obvious forms of contraception and need to be negotiated each time penetrative sex takes place.	The man can easily take control of putting on a male condom or removing a female condom so this method is very open to sabotage. Condoms can be damaged or removed, or the man may not put one on after promising to.
 **FERTILITY AWARENESS METHODS**	Woman monitors her fertility cycle through temperature and mucus changes to identify fertile days.	By avoiding sex, using alternatives to penis-in-vagina sex or using a barrier method during fertile days.	Varies from 75 - 99% effective	Does not require any device or access to medical care.	Requires training and practice for greatest effectiveness. Alternatives to penis-in-vagina sex may have other risks of harm for women.	Fertility awareness methods, when used properly, require record keeping about cyclical changes. These could be concealed in code in a diary or on a fertility app, but may still be risky for women experiencing high levels of monitoring and surveillance.	Not suitable for women who have little or no control over if, when or how sex happens. Emergency contraception may need to be accessed in these circumstances.
 **COMBINED PILL**	Pill containing oestrogen and progesterone, must be taken once every 24 hours.	Prevents the egg from being released.	99% perfect use 92% typical use	Can help regulate the menstrual cycle, reduce PMS and reduce period pain.	Not suitable for women with some medical conditions. If pills are missed, extra contraception methods may be necessary as a back up.	Pills in their packaging can be easily recognisable. They could be removed from their packaging and hidden elsewhere to reduce this risk, but this could alter their effectiveness if they're hidden in places exposed to heat, light or moisture.	Pills can be easily disposed of by anyone with access to them. Instructions about what to do if a pill is missed are easily available online if it's unsafe to keep that information in printed form.
PROGESTERONE ONLY PILL OFTEN CALLED THE MINI PILL	Pill containing progesterone, must be taken at the same time each day.	Prevents the egg from being released.	98% perfect use 92% typical use	Alternative to the combined pill for women who can't take oestrogen due to medical conditions.	Not suitable for women with some medical conditions. If pills are missed or taken more than three hours late, extra contraception may be necessary as a back up.	Pills in their packaging can be easily recognisable. They could be removed from their packaging and hidden elsewhere to reduce this risk, but this could alter their effectiveness if they're hidden in places exposed to heat, light or moisture.	Pills can be easily disposed of by anyone with access to them. Instructions about what to do if a pill is missed are easily available online if it's unsafe to keep that information in printed form.
 **WITHDRAWAL**	The penis is withdrawn from the vagina prior to ejaculation.	Prevents the sperm from entering the vagina and reaching the egg.	96% perfect use 78% typical use	It can be used in combination with any other method. No scripts or devices are required and it only needs to be used at the time of intercourse.	As sperm can be present in pre-ejaculation fluid there is a risk of pregnancy even if the man withdraws before ejaculation. If the man has failed to withdraw in time emergency contraception will be a necessary back up.	Because this method relies almost entirely on the man's skill and motivation, they will have full knowledge of this form of contraception.	Not suitable for women who have little or no control over if, when or how sex happens. Emergency contraception may need to be accessed in these circumstances.

This resource is intended as a guide only and should not replace a full consultation with a medical professional. Published March 2017 by Children by Choice Association Inc. Visit our website for more information on your contraceptive or pregnancy options, at www.childrenbychoice.org.au.

EMERGENCY CONTRACEPTION

For women with compromised access to regular effective contraception, emergency contraception can play an important part in supporting some level of reproductive autonomy. Research shows that repeat use of the emergency contraceptive pill (ECP) is medically safe and effective for the woman[1] and:

- will not harm the embryo if the woman is already pregnant;
- is safe to use more than once within the same menstrual cycle; and
- is not linked to increase risks of ectopic pregnancy.

The ECP works by delaying the release of an egg from the ovary, thereby preventing the sperm from reaching the egg. There are two different types of ECP available in Australia as over the counter medications:

1. A 1.5mg single dose levonorgestrel pill (LNG-ECP), licensed for use up to 72 hours (three days) after unprotected sex. It is approximately 85% effective if taken within this timeframe. There are many brands and generic versions available in Australia.
2. A 30mg single dose ulipristal acetate (UPA) pill, licensed for use up to 120 hours (five days) after unprotected sex. It is approximately 98% effective if taken within this timeframe. There is currently only one brand of ulipristal acetate on the market, EllaOne®.

A copper IUD (intrauterine contraceptive device) can also be used as emergency contraception if it is inserted within five days of unprotected sex. It is more effective than the emergency contraceptive pill but it can be more difficult and more expensive to access. IUDs need to be inserted by trained GPs or sexual health professionals.

SAFETY CONSIDERATIONS

Because the ECP does not usually require a prescription it will not appear on a woman's medical records. The single dose can be taken immediately at the time of supply so it does not need to be hidden. If the woman needs to delay taking the dose after supply, the single tablet is easy to hide and could be removed from its packaging, although once removed from the blister pack the effectiveness of the medication can be reduced. Once digested the effectiveness of the medication cannot be tampered with. When suggesting a woman access the emergency contraceptive pill:

- Consider the safety implications unique to her circumstances;
- Refer her to a pharmacist known to dispense emergency contraception as some refuse on moral grounds;
- Advise her that she may need to complete a form or answer questions at the pharmacy. Suggest that she request a confidential space in the pharmacy if needed;
- If the woman is under 16 years of age, ECP access is best done through a sexual health service, emergency department of a public hospital, and/or with a prescription from a doctor; and/or
- If the woman would benefit from advance supply this is most easily obtained with a prescription from a doctor. Provide a prescription or refer to a sympathetic doctor.[2]

REFERENCES

1. International Consortium on Emergency Contraception *Repeated use of emergency contraceptive pills: The facts*, October 2015. http://www.cecinfo.org/custom-content/uploads/2015/10/ICEC_Repeat-Use_Oct-2015.pdf
2. Rowlands, S., Gemzell-Danielsson, K., f or and on behalf of the European Society of Contraception Expert Group on Abortion (2017) "Post-abortion contraception" *European Journal of Contraception & Reproductive Health Care* 22:2, 162-163, DOI: 10.1080/13625187.2017.1287352

A RESOURCE FOR ENHANCING WOMEN'S REPRODUCTIVE AUTONOMY

This resource is intended to assist professionals who support women experiencing reproductive coercion as a form of domestic violence. It can be used to consider safety issues around contraception and to identify suitable contraception that may be less vulnerable to detection and sabotage. This in turn will enhance the woman's reproductive autonomy and prevent unwanted pregnancy.

This resource does not replace a fuller medical consideration of the suitability of any contraceptive in the context of a woman's medical history.[1]

WHAT IS REPRODUCTIVE COERCION?

Reproductive coercion is any perpetrator behaviour aimed at establishing and maintaining power and control over a woman by interfering with her reproductive autonomy. This can occur regardless of whether a woman is in a relationship with the perpetrator. His strategies may include denying her control, decision-making and access to options regarding reproductive health. Perpetrators' behaviours include pressure to become pregnant, contraceptive sabotage, and pregnancy outcome pressure.[2, 3]

Overall rates of reproductive coercion are unclear with 12% to 20% of women seeking sexual and reproductive health services reporting reproductive coercion in some studies. Research shows that young women, women from culturally and linguistically diverse backgrounds, and Aboriginal and Torres Strait Islander women are at higher risk.[4, 5] Preventing unplanned and coerced pregnancy is important particularly as perpetration of violence and control against a woman may start or become more frequent and more intense during pregnancy.[6, 7]

Women experiencing reproductive coercion may do so in proportion with the severity of other abuse to which they are subjected.[8] This is important in considering any option for supporting the woman to have greater reproductive autonomy. Some women name reproductive coercion as their first experience of control by a male partner.[5, 9] As patterns of violence shift and change, arrangements around contraception may need to be reviewed. Encourage the woman to recontact if she becomes concerned about the safety of the option she chooses.

Some women experiencing reproductive coercion may choose not to take up advice about contraception that is less vulnerable to detection or sabotage. Having this conversation with her still communicates your concern, validates her experience and affirms her rights. It also lets her know that help is out there, and provides her with knowledge and information that she could use at another time.

REFERENCES

1. Additional information about each contraceptive type is available at: http://www.true.org.au/
2. Chamberlain, L., & Levenson, R. (2013). *Addressing intimate partner violence, reproductive and sexual coercion: a guide for obstetric, gynecologic, reproductive health care settings*. San Francisco: Futures Without Violence.
3. Miller, E., Jordan, B., Levenson, R., & Silverman, J.G. (2010). "Reproductive Coercion: Connecting the Dots Between Partner Violence and Unintended Pregnancy." *Contraception*, 81, 457.
4. Miller, E., Decker, M., McCauley, H., Tancredi, D., Levenson, R., Waldman, J., Schoenwald, P., Silverman, J.G. (2010). "Pregnancy Coercion, Intimate Partner Violence and Unintended Pregnancy." *Contraception*, 81, 316;
5. Children by Choice. (2017) Reproductive Coercion. Retrieved 31 March 2017 from https://www.childrenbychoice.org.au/factsandfigures/reproductivecoercion.
6. Australian Bureau of Statistics (ABS). (2012). 4906.0 - *Personal Safety, Australia, 2012*. Australian Bureau of Statistics. Retrieved 2 July 2015, from http://www.abs.gov.au/ausstats/abs@.nsf/mf/4906.0;
7. Burch, R. L., & Gallup, G. G. (2004). "Pregnancy as a stimulus for domestic violence." *Journal of Family Violence*, 243-47.
8. Taft, A. (2002). "Violence against women in pregnancy and after childbirth: Current knowledge and issues in healthcare responses." *Australian Domestic & Family Violence Clearinghouse*, 6.
9. Miller, E., & Silverman, J.G. (2010). "Reproductive coercion and partner violence: Implications for clinical assessment of unintended pregnancy." *Expert Review: Obstetric Gynecology*, 5(5), 511-515.
10. On, M. L., Ayre, J., Webster, K., & Moon, L. (2016). *Examination of the health outcomes of intimate partner violence against women: State of knowledge paper*. Alexandria: Australia's National Research Organisation for Women's Safety Limited.
11. World Health Organisation. 2016. *Violence against women: Intimate partner and sexual violence against women*. Retrieved 10 May 2017 from: http://www.who.int/mediacentre/factsheets/fs239/en/.

FOR WOMEN: WHO IS IN CONTROL?

The following questions may assist women to recognise perpetrator behaviours and intentions.

- Do you feel confident talking to your partner/sexual partners about using contraception like condoms or the pill?
- Has anyone ever messed or tampered with your contraception to try to make you become pregnant? Do condoms seem to break often or your pills go missing?
- Does your partner respect your decision if you do not want to have sex?
- Have you ever been forced to have sex when you did not want to?
- Do you feel okay about talking to your partner about if or when you might want to get pregnant? Would he always respect your wishes about this?
- Has anyone ever made you feel afraid if you didn't do what they wanted you to do with a pregnancy – whether forcing you to continue OR end your pregnancy?

FOR PRACTITIONERS: ENHANCING WOMEN'S AUTONOMY

Contraceptive options that are safe and appropriate for one woman may not work for another. Explore each woman's unique circumstances and draw on her knowledge to assess the degree of comfort and safety with her contraceptive options.

Important factors to consider include whether the perpetrator is likely to:

- Monitor the woman's Medicare or prescription records through her MyGov account;
- Restrict or monitor access to health care professionals;
- Monitor menstruation and fertility patterns;
- Engage in severe physical assaults;
- Be actively searching for the use of contraceptive drugs or devices; and/or
- Engage in rape and other forms of sexual assault.

Other factors for consideration may include:

- If you need to resolve the issue for the woman in a single contact, when she is unlikely or unable to return for follow up;
- If the woman is living with the perpetrator; and/or
- The impact of violence and control on the woman's daily routine.

Consider referring to or consulting with a specialist domestic violence service to assist with risk assessment and safety planning (you can find your nearest service at www.1800respect.org.au/service-support/).

FOR PRACTITIONERS: SEXUALLY TRANSMITTED INFECTION SCREENING

While this resource focuses on the risks of pregnancy for women experiencing reproductive coercion, these women are also at increased risk of sexually transmitted infections.[10, 11] For women not using or not in control of barrier methods of contraception, consider providing or referring for opportunistic STI screening and treatment.

CHILDRENBYCHOICE.ORG.AU
ASSOCIATION INCORPORATED