How can we improve the health systems response to reproductive coercion in the Australian context?

Safer Families Centre of Research Excellence Discussion Paper #1

Dr. Laura Tarzia
Senior Research Fellow
The University of Melbourne
laura.tarzia@unimelb.edu.au

Suggested citation:
Tarzia, L. (2018) "How can we improve the health systems response to reproductive coercion in the Australian context?: Safer Families Centre of Research Excellence Discussion Paper #1" *Safer Families Centre of Research Excellence Discussion Paper Series,* Available from: https://www.saferfamilies.org.au/discuss/

How can we improve the health systems response to reproductive coercion in the Australian context?

The problem

Reproductive coercion is defined as behaviour that interferes with the autonomous decision-making of a woman with regards to reproductive health [1]. It is primarily perpetrated by a male intimate partner, however, it can also be perpetrated by other family members [2, 3]. There are three main types of behaviours that encompass reproductive coercion:

1. contraceptive sabotage (such as removing a condom, damaging a condom, removing a contraceptive patch, forcibly removing an intrauterine device (IUD), or throwing away oral contraceptives);
2. pregnancy coercion (pressure to become pregnant) and
3. pregnancy outcome control (pressure to continue an unwanted pregnancy or to terminate a wanted pregnancy) [4].

These behaviours often, but not always, occur concurrently with physical violence [1, 5] and other forms of coercive control [6]. The prevalence of reproductive coercion is unclear, although studies in the US have reported rates of between 8% [7]and 24% [8] depending on the setting. These figures, however, are likely to be underestimations, since, like other forms of violence against women, reproductive coercion may not be reported or disclosed when it occurs. There are no large-scale studies on the prevalence of reproductive coercion in Australia, although research has shown that women seeking terminations are more likely to be experiencing intimate partner violence (IPV) more generally [9]. A recent Australian cross-sectional study in general practice found that 10% of women had experienced contraceptive sabotage or pregnancy coercion at the hands of an intimate partner [10], although the full spectrum of behaviours that encompass reproductive coercion were not explored. Anecdotal evidence from service providers suggests that reproductive coercion is an issue they see regularly in female patients [11], however, it has often been overlooked in studies of IPV and sexual violence (SV).

Despite the numerous health impacts of reproductive coercion [12-14], and the fact that health practitioners are well-placed to respond to women experiencing it [15-17], little is known about what an effective health systems response might look like. We have scant evidence to help inform 'best practice', and there is a dearth of rigorously-evaluated interventions for reproductive coercion specifically that have been successfully implemented in the health care context. This lack of robust evidence, as well as poor levels of understanding and awareness within the community, have contributed towards the issue of reproductive coercion being neglected in policy, research and practice.

Potential actions

1. Develop a clear understanding around how reproductive coercion is defined and situated within a broader framework of violence against women

Discussion points:

- Reproductive coercion is often referred to in research and practice as a form of IPV, yet studies suggest that it ought to be considered its own form of violence against women [4] that intersects with IPV [13], family violence [2, 18], and sexual violence [19]. In particular, the intersections with sexual violence are often overlooked, despite the fact that unwanted pregnancies can often occur in the context of rape within a relationship [20].

Contact: Dr Laura Tarzia
Senior Research Fellow
The University of Melbourne
Ph: (03) 9035 8604
laura.tarzia@unimelb.edu.au

- There is currently a lack of clarity around how reproductive coercion is defined in practice, including in health settings. Submissions to a recent White Paper developed by Marie Stopes [21] suggest that there are discrepancies in how reproductive coercion is understood. For instance, there was a diversity of views on whether coercive behaviours by Governments, religious groups, or health practitioners constitute 'reproductive coercion' (e.g. policies that impede access to abortion; marginalisation of transgender individuals in health care settings). We suggest that it is not useful to include these behaviours under the remit of reproductive coercion, although they certainly contribute to a cultural climate that is hostile to women's reproductive autonomy and cause harm to individuals or groups.
- Reproductive coercion ought to be defined only as the use of mechanisms of fear and control to deliberately influence a woman's reproductive outcomes. This type of violence is mostly perpetrated by male intimate partners (or ex-partners) or other members of the broader family unit (e.g. mothers-in-law).
- Figure 1 below outlines a suggested framework for understanding how reproductive coercion fits within a broader ecological framework of violence against women.

Considerations for future research and practice:

- Women's voices have not been adequately heard in regards to reproductive coercion. There is a dearth of qualitative research exploring the lived experiences of women in this context. It may be that they have different interpretations of how reproductive coercion sits within this ecological model.
- In some low and middle income countries or countries experiencing internal conflict it may well be that there are mechanisms of fear, control and power that motivate government/political/religious coercion around reproduction. More research is needed to understand whether this is the case, and how this experience might differ from reproductive abuse perpetrated by a partner or family member.

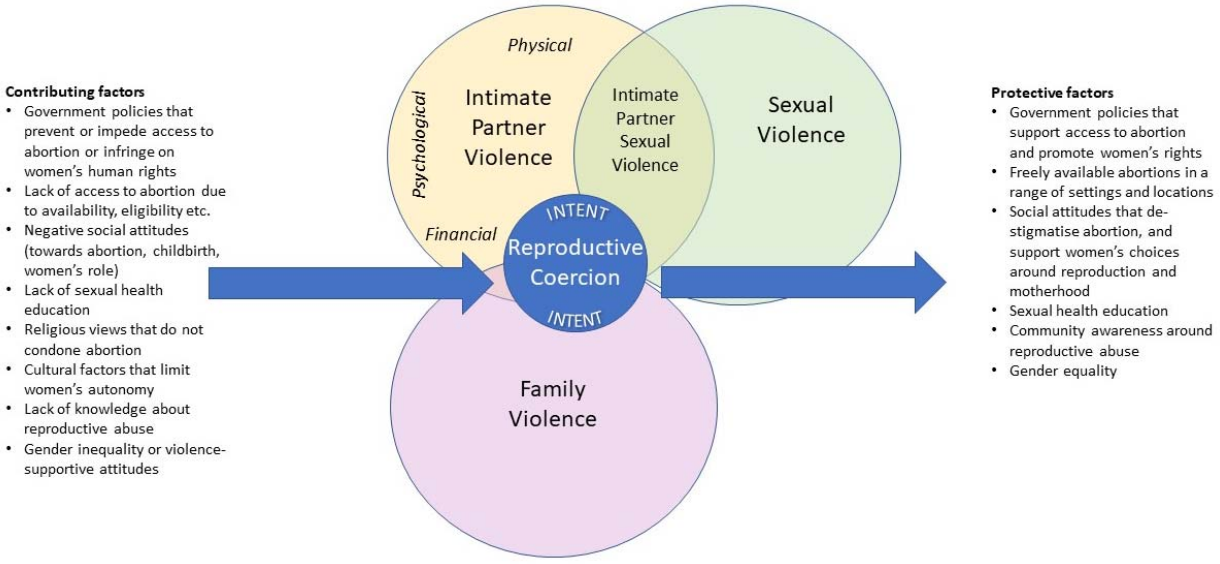

Figure 1 – Intersections between reproductive coercion, intimate partner violence, family violence and sexual violence

Contact: Dr Laura Tarzia
Senior Research Fellow
The University of Melbourne
Ph: (03) 9035 8604
laura.tarzia@unimelb.edu.au

2. Encourage multi-sectoral and multi-disciplinary collaborations within and between health settings to tackle reproductive abuse

Discussion points:

- Women experiencing multiple forms of violence often 'fall through the cracks' in health settings [22]. The 'No Wrong Door' approach – where women receive the services they need no matter which point they enter the system – has been suggested as a way to better respond to women with co-occurring issues[23].
- Women may need both medical (e.g. abortion, contraception, antenatal care) and psychosocial support when experiencing reproductive coercion [17], as well as referrals to specialist services.
- Family violence services, sexual assault services, sexual and reproductive health, antenatal and abortion settings may all see high numbers of women experiencing reproductive coercion. It is critical that these services develop processes and policies around collaboration and warm referral that are responsive to women's needs.
- Within health settings, there is a need to foster cooperation and multi-disciplinary collaboration (e.g. social work or counselling support on site for terminations). The *Strengthening Hospitals Response to Family Violence* model [24]currently in place across Victorian public hospitals provides an example of a collaborative systems model in practice (although it does not address reproductive coercion specifically).

Considerations for future research and practice:

- To date, there are no robust evaluations of any collaborative models of care or referral pathways for reproductive coercion. We do not yet have evidence to support the theory that a collaborative multi-sectoral and multi-disciplinary response to reproductive coercion leads to improved outcomes for women.
- There is a lack of qualitative data on what women want from health practitioners when they are experiencing reproductive coercion.
- Different paradigms across health settings may impede collaboration (e.g. medical model / psychosocial model / feminist model) [22].
- There is a lack of data from health practitioners to inform what might work realistically in practice. Implementation Science highlights the need for staff within organisations to understand why, how, and who needs to do the work within a new systems model [25], as well as how the work fits in with existing practices.

3. Develop clear, evidence-based guidelines for all health practitioners potentially seeing women experiencing reproductive abuse

Discussion points:

- Internationally, there is a lack of evidence-based guidelines for health practitioners responding to reproductive coercion.
- The American College of Obstetricians and Gynaecologists has released a position statement for its members with recommendations for practice (including routine screening of all women), however, it is unclear to what extent these are based on robust research evidence [26]. A related document is the Futures Without Violence guideline for obstetric, gynaecologic and reproductive health settings [19], which provides a more detailed outline of how practitioners should respond.
- There is an urgent need to develop guidelines for the Australian context that are based on robust research evidence and implementation trials. These should be developed in close consultation with survivors and health practitioners.

Contact: Dr Laura Tarzia
Senior Research Fellow
The University of Melbourne
Ph: (03) 9035 8604
laura.tarzia@unimelb.edu.au

Considerations for future research and practice:

- The research base from which to develop future guidelines is lacking. This needs to be strengthened prior to guideline development.
- Future guidelines would need to be flexible across different settings (antenatal, abortion, sexual/reproductive health) and applicable to different types of practitioners and their role in supporting women.
- Future guidelines would need to be accompanied by practitioner training and education, particularly if the evidence suggests that, as is the case with IPV more broadly[27], women are happy for health practitioners to provide counselling and support as well as referrals to specialist services.

4. Develop a strong evidence base through rigorous evaluations of interventions to help understand what a 'best practice response' looks like, and how to implement it

Discussion points:

- A recent Cochrane Systematic Review of universal screening for IPV in health settings suggests that antenatal care is the only setting where there is evidence for the effectiveness of this approach [28]. The review suggests that there is also a good case to be made for universal screening for IPV in other high-risk settings such as abortion care, however, to date there is no robust evidence to support whether or to what extent this might be the case.
- To date, there is no robust evidence to support the effectiveness of universal screening specifically for reproductive coercion in any setting.
- Case-finding, where health practitioners enquire about reproductive coercion only when warning signs are detected, may also be an effective response in health settings. Again, however, there is no evidence to support this approach.
- There have been some evaluations of reproductive coercion interventions in US family planning clinics. One cluster randomised controlled trial compared a screening, brief education/counselling, and supported referral intervention (ARCHES) to usual care [29]. However, the trial showed no increased improvement on the study outcomes (reproductive coercion/IPV).

Considerations for future research and practice:

- Women may not feel ready to disclose complex issues such as reproductive coercion after being screened. There is a lack of evidence for how to screen, what to ask, and what to do after screening takes place.
- Promising interventions need to be comprehensively evaluated via randomised controlled trials, so that there is evidence to support their effectiveness over usual care.
- Future intervention trials need to consider 'meaningful outcomes' for reproductive coercion when developing an evaluation plan. It may be unrealistic to reduce or prevent reproductive coercion via an intervention (just as it is often unrealistic for interventions addressing IPV to address women's victimisation [30]). Consultation with women can help to understand what an intervention ought to target.

Contact: Dr Laura Tarzia
Senior Research Fellow
The University of Melbourne
Ph: (03) 9035 8604
laura.tarzia@unimelb.edu.au

References

1. Miller, E., et al., *Pregnancy coercion, intimate partner violence and unintended pregnancy.* Contraception, 2010. **81**(4): p. 316-322.
2. Grace, K.T. and C. Fleming, *A Systematic Review of Reproductive Coercion in International Settings.* World Medical & Health Policy, 2016. **8**(4): p. 382-408.
3. Char, A., M. Saavala, and T. Kulmala, *Influence of mothers-in-law on young couples' family planning decisions in rural India.* Reproductive Health Matters, 2010. **18**(35): p. 154-162.
4. Grace, K.T. and J.C. Anderson, *Reproductive Coercion: A Systematic Review.* Trauma Violence & Abuse, 2016. **16**: p. 16.
5. Sutherland, M., H.C. Fantasia, and H.B. Fontenot, *Reproductive Coercion and Partner Violence Among College Women.* JOGNN: Journal of Obstetric, Gynecologic & Neonatal Nursing, 2015. **44**: p. S56.
6. Moore, A., L. Frohwirth, and E. Miller, *Male reproductive control of women who have experienced intimate partner violence in the United States.* Social Science & Medicine, 2010. **70**(11): p. 1737-1744.
7. Black, M.C., et al., *The National Intimate Partner and Sexual Violence Survey: 2010 Summary Report*. 2010, National Center for Injury Prevention and Control Centers for Disease Control and Prevention,: Atlanta USA.
8. Phillips, S., et al., *Reproductive coercion: an under-recognized challenge for primary care patients.* Family Practice, 2016. **33**(3): p. 286-289.
9. Taft, A. and L. Watson, *Termination of pregnancy: Associations with partner violence and other factors in a national cohort of young Australian women* Australian & New Zealand Journal of Public Health, 2007. **31**(2): p. 135-142.
10. Tarzia, L., et al., *Sexual violence associated with poor mental health in women attending Australian general practices.* Australian & New Zealand Journal of Public Health, 2017. **41**(5): p. 518-523.
11. Children by Choice *Reproductive Coercion*. 2017.
12. McCauley, H., et al., *Mental health impacts of reproductive coercion among women in Cote d'Ivoire.* International Journal of Gynaecology & Obstetrics, 2014. **127**(1): p. 55-59.
13. Miller, E., et al., *Reproductive coercion: connecting the dots between partner violence and unintended pregnancy.* Contraception, 2010. **81**(6): p. 457-9.
14. Northridge, J.L., et al., *Reproductive Coercion in High School-Aged Girls: Associations with Reproductive Health Risk and Intimate Partner Violence.* Journal of Pediatric and Adolescent Gynecology, 2017.
15. Feder, G., et al., *Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies.* Archives of Internal Medicine, 2006. **166**(1): p. 22-37.
16. Cox, P., *Violence against women in Australia: Additional analysis of the Australian Bureau of Statistics' Personal Safety Survey 2012. ANROWS Horizons: 01/2015.* 2015, Australia's National Research Organisation for Women's Safety Limited (ANROWS): Sydney, Australia.
17. Grace, K.T., *Caring for Women Experiencing Reproductive Coercion.* Journal of Midwifery and Women's Health, 2016. **61**(1): p. 112-115.
18. Silverman, J. and A. Raj, *Intimate Partner Violence and Reproductive Coercion: Global Barriers to Women's Reproductive Control.* PLos Med, 2014. **11**(9): p. e1001723.
19. Chamberlain, L. and R.R. Levenson, *Addressing Intimate Partner Violence Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic, Reproductive Health Care Settings*. 2013, Futures Without Violence: Duluth, USA.
20. McFarlane, J., *Pregnancy Following Partner Rape: What We Know and What We Need To Know.* Trauma, Violence and Abuse, 2007. **8**(2): p. 127-134.
21. Marie Stopes, *Hidden Forces: Shining a light on reproductive coercion. Draft White Paper for comment*. 2018, Marie Stopes Australia: Melbourne.
22. Hegarty, K., et al., *Women's Input into a Trauma-informed systems model of care in Health settings (The WITH Study) Final report (ANROWS Horizons 02/2017)*. 2017, Sydney: ANROWS.
23. Whitten, L. *"No wrong door" for People with Co-Occurring Disorders*. Research News 2004 [cited 2014 July]; 19 (4):[Available from: http://archives.drugabuse.gov/NIDA_Notes/NNVol19N4/No.html.

Contact: Dr Laura Tarzia
Senior Research Fellow
The University of Melbourne
Ph: (03) 9035 8604
laura.tarzia@unimelb.edu.au

24. Victorian Government, The Royal Women's Hospital, and Bendigo Health, *Strengthening hospital responses to family violence: Project overview*. 2018, Victorian Government: Melbourne.
25. May, C., et al., *Understanding the implementation of complex interventions in health care: the normalization process model.* BMC Health Services Research, 2007. **7**: p. 148.
26. American College of Obstetricians and Gynecologists, *Committee Opinion No.554: Reproductive and Sexual Coercion.* Obstetrics & Gynecology, 2013. **121**(2): p. 411-415.
27. Hegarty, K., et al., *Screening and counselling in the primary care setting for women who have experienced intimate partner violence (WEAVE): a cluster randomised controlled trial.* The Lancet, 2013. **382**(9888): p. 249-58.
28. O'Doherty, L., et al., *Screening women for intimate partner violence in healtcare settings.* Cochrane Database of Systematic Reviews, 2015(7 Art No CD007007).
29. Miller, E., et al., *A family planning clinic-based intervention to address reproductive coercion: a cluster randomized controlled trial.* Contraception, 2016. **94**(1): p. 58-67.
30. O'Doherty, L., et al., *Selecting outcomes for intimate partner violence intervention trials: Overview and recommendations.* Aggression and Violent Behavior, 2014. **19**: p. 663-672.

Contact: Dr Laura Tarzia
Senior Research Fellow
The University of Melbourne
Ph: (03) 9035 8604
laura.tarzia@unimelb.edu.au