Reproductive coercion and safety planning:

Sexual and reproductive health care within contexts of coercive control

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Sexual and reproductive health care in situations of family, domestic and sexual violence can influence client agency and autonomy. Clinicians and other health professionals are in unique positions to identify, respond to and prevent sexual and reproductive health coercion.

Marie Stopes Australia conducted a two year national consultation on reproductive coercion in Australia. Doctors, nurses, midwives, clinicians, social workers and counsellors, policy makers, educators, academics and researchers from 80 organisations shared their experiences working at intersections of sexual and reproductive health, pregnancy and violence. The resulting White Paper *Hidden Forces: Shining a Light on Reproductive Coercion in Australia* was published in November 2018.[1]

Reproductive coercion was defined in the White Paper as any behaviour that has the intention of controlling or constraining another person's reproductive health decision-making. It can include:

- sabotage of another person's contraception,
- pressuring another person into pregnancy,
- controlling the outcome of another person's pregnancy,
- forcing or coercing another person into sterilisation, and
- any other behaviour that interferes with the autonomy of a person to make decisions about their reproductive health.

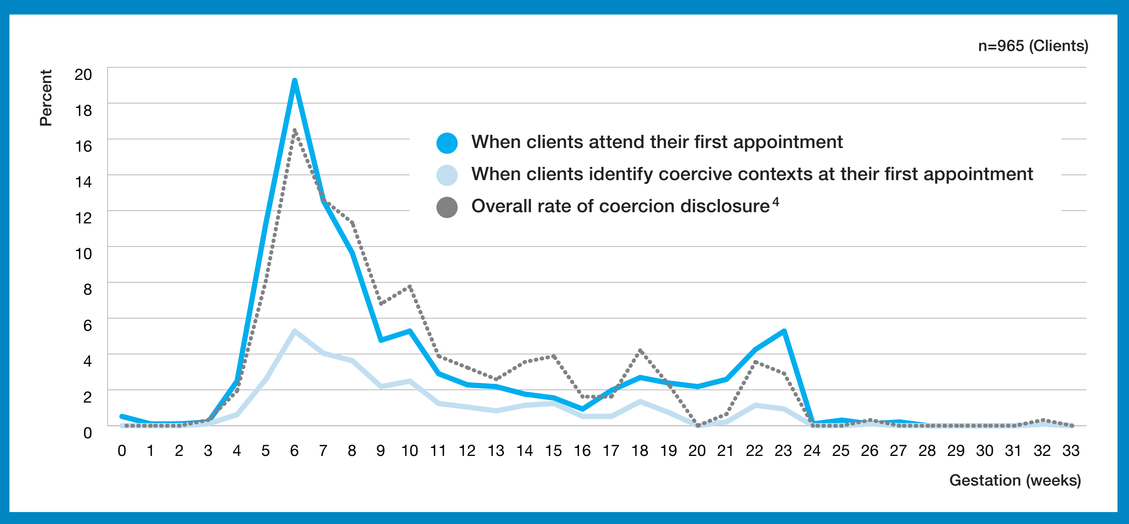
Reproductive coercion can be interpersonal and structural. Interpersonal coercion is more likely to occur within contexts of structural coercion.

Prevalence

In an American study, 'Reproductive control by others' was identified by 1 in 4 women accessing sexual and reproductive health services. The most accurate prevalence currently available at Marie Stopes Australia is counselling data:

- In 2018, 965 women and pregnant people attended pregnancy choices counselling appointments.
- 50% of Aboriginal and Torres Strait Islander clients identify as living in coercive contexts, as compared to 32% of the overall sample group.
- Clients are more likely to identify coercive contexts at certain weeks of gestation. This pattern is consistent regardless of whether it is the first or a subsequent appointment, so a client can attend any number of appointments however are more likely to identify coercion at particular gestations.
- Coercive contexts are more likely to be identified between weeks 10 and 17 gestation.
- Coercive contexts are less likely to be identified prior to 8 weeks gestation, or post 20 weeks gestation.
- Clients who access pregnancy options of adoption, care or parenting continue to access counselling throughout the pregnancy. Whilst new clients do identify coercive contexts post 24 weeks, the rate is similar to overall averages.

Figure 1. Counselling clients experiencing coercive contexts by gestation.



Safety Planning

Client safety planning can follow similar steps for anyone in contexts of coercion, whether they are a victim, survivor or perpetrator of coercive behaviours. If sexual and reproductive health coercion is suspected:

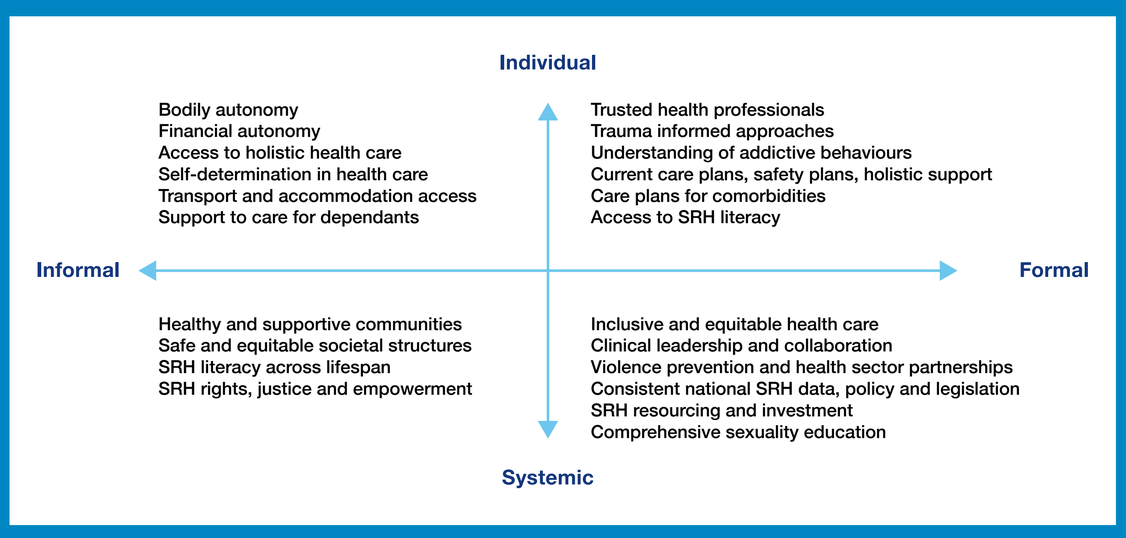
- **Affirm** the client's decision to trust you
- **Ask** engaging questions to keep the conversation open
- **Believe** the client
- **Be** mindful of your role, your bias or any conflict of interest
- **Consider** who in the client's life is at risk of harm
- **Complete** a safety planning process

Key steps of a safety planning process are risk assessment, safety planning, referral mapping, documenting (recording and if required reporting), monitoring and following up.[5] Clinics may tailor the details of their safety planning process to respond to the diversity of the local population, geographical barriers and referral pathways unique to their specific region. Keep in mind that violence can escalate when a client is increasing discretion and gaining autonomy, or when a perpetrator in their life feels that their power or control is being threatened.

Prevention

Preventing coercion requires unpacking the barriers to and enablers of sexual and reproductive health care for clients living in coercive contexts.[6] Some barriers and enablers are present in clinical settings, while others are broader.

Figure 2. Enablers of sexual & reproductive health care for clients living with reproductive coercion.



At an operational level, prevention can be integrated into processes such as comprehensive care plans, screening mechanisms, bookings processes and referral pathways. This includes maximising opportunities for reproductive autonomy and client or community centred care.

The Marie Stopes Australia advocacy strategy incorporates individual and systemic enablers to prevent coercion, including work towards national and international advocacy to amend ICD coding to improve abortion data collection.

Advocacy for the provision of safe access zones continues to be critical for client safety in service access and the prevention of systemic reproductive coercion. In 2018, protesters spent 2,295 hours outside of the Marie Stopes Australia Midland Clinic, affecting health services access for approximately 2,300 clients. These impacts vary in nature and severity but were all most certainly negative.

Preventing and challenging coercion in sexual and reproductive health requires a diversity of collaborative partnerships. Marie Stopes Australia has formed an internal research committee with clinical representation. New opportunities for collaboration are welcome.

1. Marie Stopes Australia (2018), *Hidden Forces: Shining a Light on Reproductive Coercion in Australia,* < https://www.mariestopes.org.au/advocacy-policy/reproductive-coercion/ >.
2. Rowlands S, Walker S (2019), 'Reproductive control by others: means, perpetrators and effects', BMJ Sexual & Reproductive Health 2019; 45:61-67.
3. In this data, coercive contexts include clients who are pregnant due to sexual violence, who consider their conception partner to be unsupportive, and/or who identify that they are being coerced towards an abortion, adoption or parenting option that they would not choose themselves.
4. This percentage is calculated by dividing the number of clients who identify coercive contexts at their first appointment at a particular gestation by the overall number of clients who identify coercive contexts at their first appointment.
5. For further information, refer to the RACGP Whitebook, 'Abuse and Violence – Working with our patients in general practice' < http://www.racgp.org.au/your-practice/guidelines/whitebook/ >.
6. This model of barriers and enablers was adapted from the Gender at Work Framework < https://genderatwork.org/analytical-framework/ >.

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