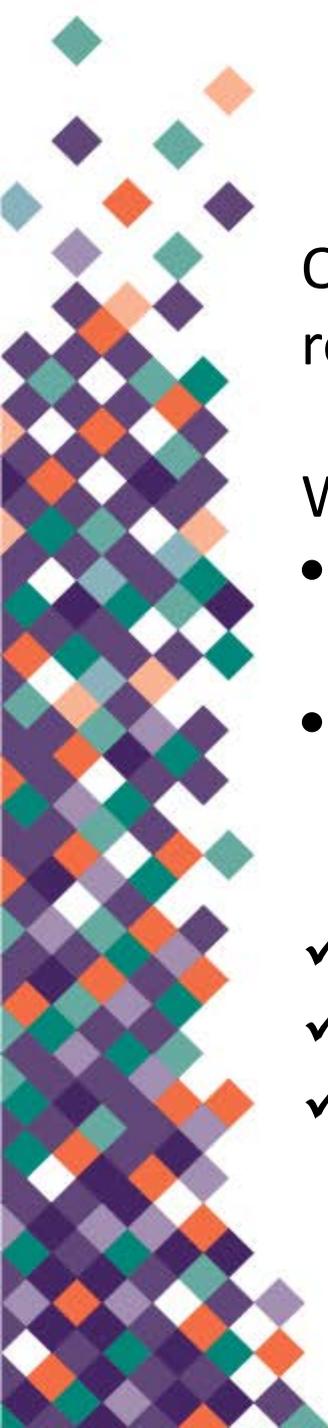




# **“Screening to Safety”**

**a Children by Choice initiative responding to  
the intersection of domestic violence,  
reproductive coercion, unplanned pregnancy  
and abortion**

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



# Children by Choice

Our vision is that all women can freely make their own reproductive and sexual health choices.

We offer:

- Prochoice counselling, information, and referral service on all options with an unplanned pregnancy.
- Sexuality Education, Professional Development and Advocacy.

✓ Mon-Friday: 9-5pm

✓ Locally for callers from Brisbane region: 3357 5377

✓ Free-call state-wide outside Brisbane: 1800 177 725



## Aims of the “Screening to Safety” Project

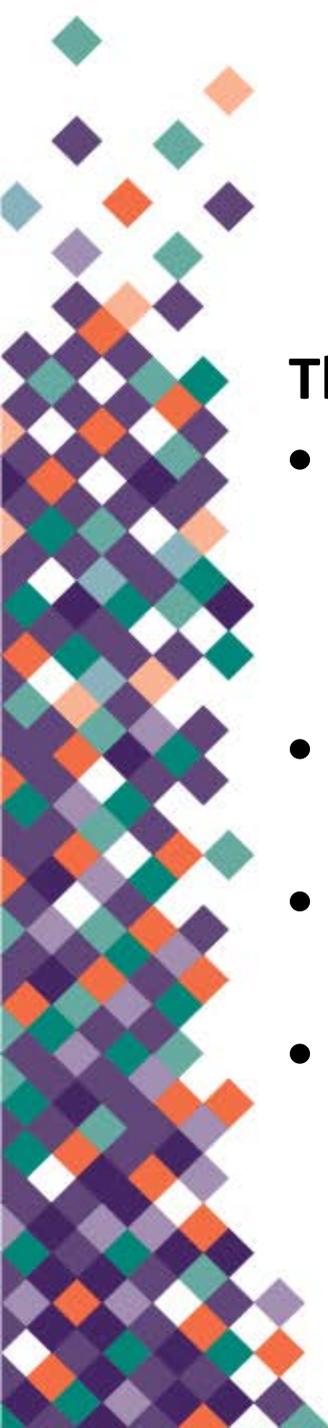
Build the capacity of:

- Abortion providers in Queensland to identify and respond to domestic violence with a particular focus on reproductive coercion.
- Service providers in Queensland to identify and respond to reproductive coercion and unplanned pregnancy risk.



## Setting the scene

- The intersection of domestic violence and abortion
- Abortion and the Not Now, Not Ever recommendations
- The legal status of abortion in Queensland
- The context for abortion provision in Queensland
- Reproductive coercion as a perpetrator practice



## Setting the scene

### **The intersection of domestic violence and abortion**

- Women who experience domestic violence are two to three times more likely to face an unplanned pregnancy and to have an abortion than women who do not experience violence. (On et al 2016)
- Women name violence in their decision making (Chibber et al 2013; Bacchus, Mezey & Bewley, 2006).
- Women who access abortion experience lower levels of violence than those denied abortion. (Roberts, 2014)
- Children by Choice data: of the 4591 contacts during 2015-16, 34% of related to women experiencing DV



## Setting the scene

**Abortion and the Not Now Not Ever  
recommendations**

**The legal status of abortion in Queensland**

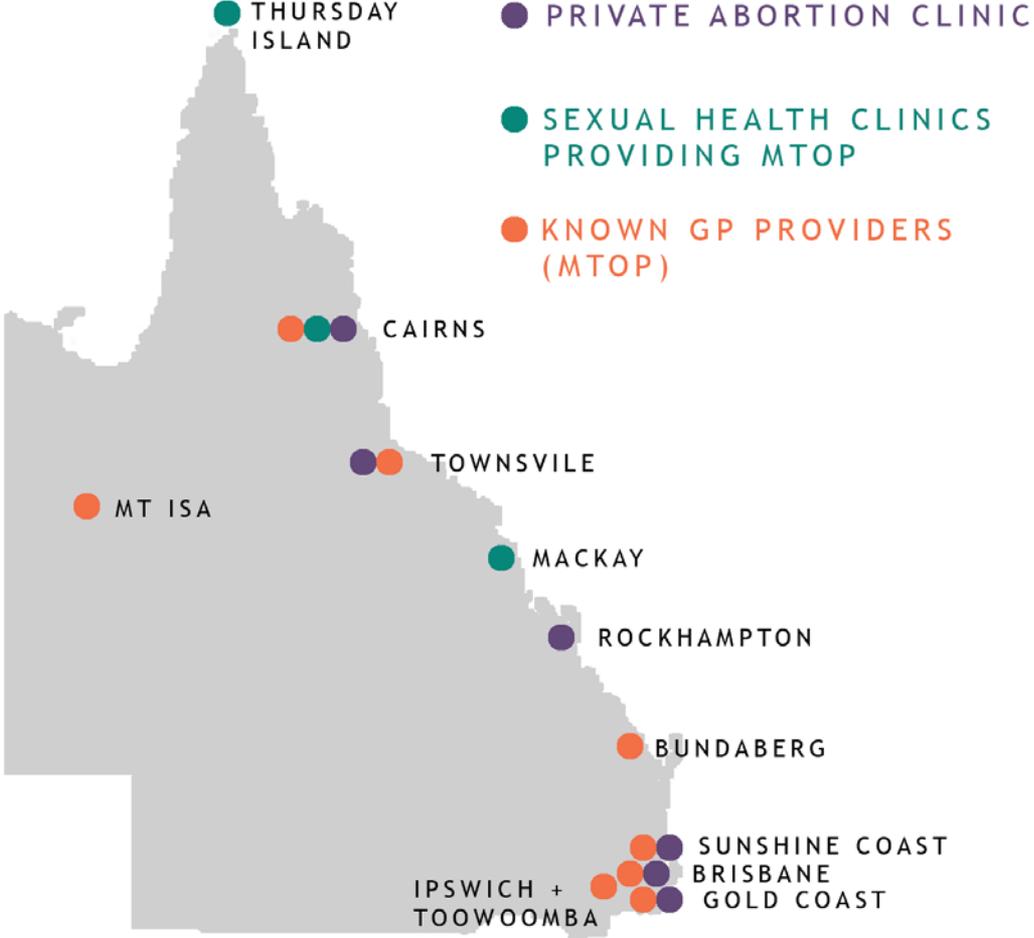


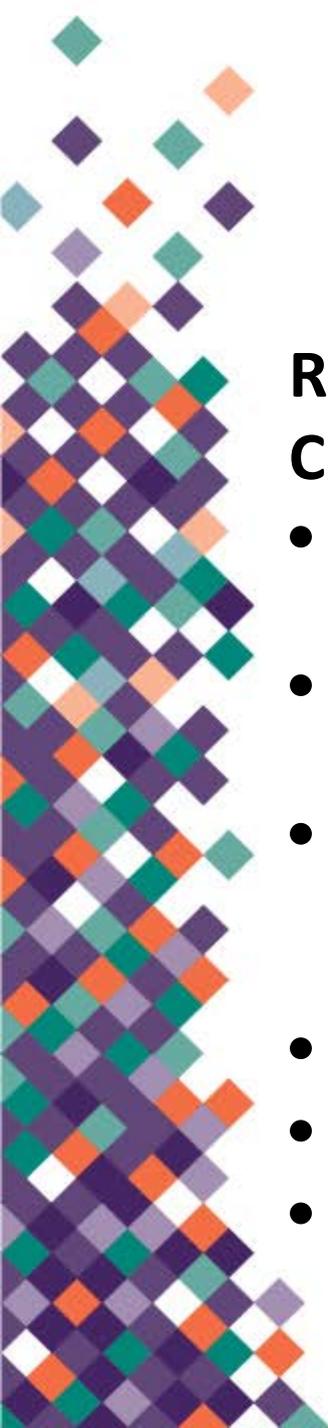
## Setting the scene

### **The context for abortion provision in Queensland**

- 98-99% of Qld's TOPs are done by private providers
- 30 different private providers, comprising 5 different setting types
- 10,000-15,000 abortions done in Qld each year
- Children by Choice data: women experiencing DV require more contacts and more \$ to resolve their issues and abortion access

# Location of abortion providers in Queensland





## Setting the scene

### **Reproductive coercion as a perpetrator practice**

#### **Children by Choice data:**

- 12.4% of all contacts with our service reported reproductive coercion
- 1:3 women reporting DV also reported experiencing reproductive coercion
- Approx 24% of contacts reporting reproductive coercion did so as the only form of violence at that time
- Higher gestations at time of request for support
- CALD and ATIS women are over-represented
- Young women (>20) are under-represented



## Setting the scene

### **Reproductive coercion as a perpetrator practice: implications for the project**

- HCP are in a unique position to intervene in reproductive coercion (O'Doherty, 2014)
- Trials show a reduction in reproductive coercion when screening, educating, responding and referring happens (Miller et al 2016)
- The prevalence of reproductive coercion in populations of women seeking TOP in contact with CbyC compels us to do something different. (CbyC, 2015)
- The Project has specific funds for LARC provision for women experiencing DV and RC at time of



## Literature underpinnings to screening in TOP settings and how we are responding to that in our project

### Establishing an environment that supports disclosure

- Practical provision of signs and posters to TOP providers
- Inclusion in the screening tool and implementation (asking alone, how to introduce the screening)

(Chamberlain and Levenson; RACGP; Baillie & Mulligan)

### Boundaries to confidentiality

- Script incorporated in the tool

(Chamberlain and Levenson; Deshpande and O'Connor; Aston & Bewley; Taft; WHO).

### Know where to refer women for support have protocols set up, resources to support the process

- Aim for tailored local pathways of referral for each TOP provider involved in the project

(O'Doherty; On; Nyame)



## Literature underpinnings to screening in TOP settings and how we are responding to that in our project

Knowledge of contraception options less vulnerable to detection and sabotage and resources to support this process

- Development of two resources to support this now in final draft, one is a small, discreet pamphlet aimed at women that helps them to evaluate their circumstances for signs of RC, the other is a practitioner resource including contraceptive options, and information about all contraceptive methods and their features as they relate to detectability and tamper-ability, as well as practitioner advice on how to explore the safety of these options with the woman, based on her unique circumstances.
- Inclusion of this issue in implementation training with abortion providers who opt to incorporate screening
- Commencement of the S2S LARC fund which has commenced providing LARC to women at time of TOP who identify DV and RC

(Chamberlain and Levenson; O'Doherty)



# Literature underpinnings to screening in TOP settings and how we are responding to that in our project

## Written protocols

- Supporting providers to document their processes around this issue also as a tool for other providers considering implementation  
(Chamberlain and Levenson)

## Health practitioners need the skills to screen and respond in relation to domestic violence

- Specific training on asking about DV and responding to disclosures  
(Renker; Taft; On; DeBoer; Baird, Price & Salmon 2004; Natan; Nyame 2013)

## Staff self-care and support

- Raising this issue for consideration throughout the consultation process with providers. A duality of themes emerge here with providers expressing concern about the impact on staff of receiving and responding to disclosures, but also a recognition that there are times when they suspect DV but do not know how or of to ask about it – and the stress of that.  
(Goldblatt, 2009)

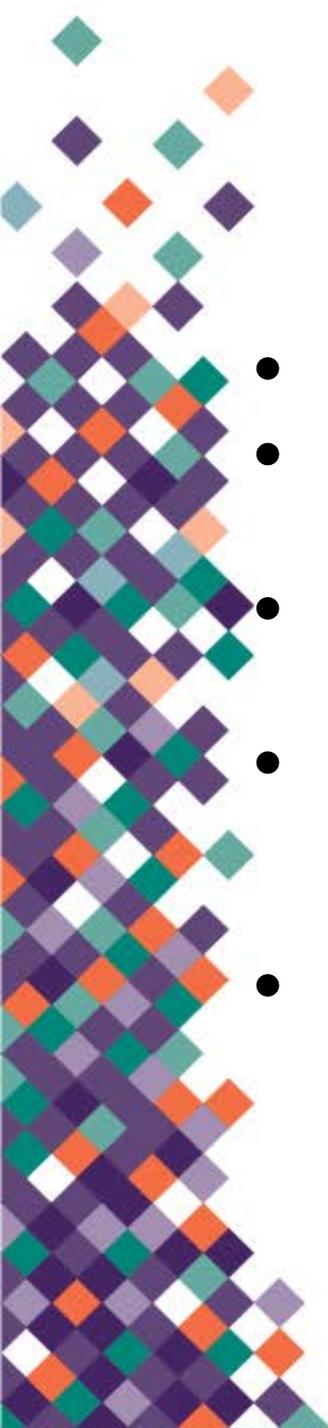


## Literature underpinnings to screening in TOP settings and how we are responding to that in our project

A review of the current literature reveals that women who are currently or have experienced DV presenting for termination of pregnancy are more likely to:

- Have had a previous termination of pregnancy
- Present with a more advanced pregnancy than those that are not exposed to violence.
- Under-estimate the gestation of their pregnancy
- Report not being in a relationship at the time of the termination of pregnancy
- State that the man involved in the pregnancy does not know about the termination of pregnancy
- Indicate that she has no financial support to end the pregnancy from the man involved
- Report the pregnancy to have been planned

(References at end)



# Broader recommendations

- Recognition of abortion as a safety upgrade
- Introduction of a Medicare item number for DV screening within HCP settings
- Broader HCP resources and training to include reproductive coercion as a perpetrator practice
- Expanding antenatal screening to include direct questioning about RC particularly in younger women.
- Inclusion of reproductive coercion in broader research agendas.



# Broader recommendations

That reproductive coercion to be specifically included in Section 8(2) of the Domestic and Family Violence Protection Act 2012 (Qld)

That the symposium support the decriminalisation of abortion in Queensland, though public support of the two bills currently before the parliament.



“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.”

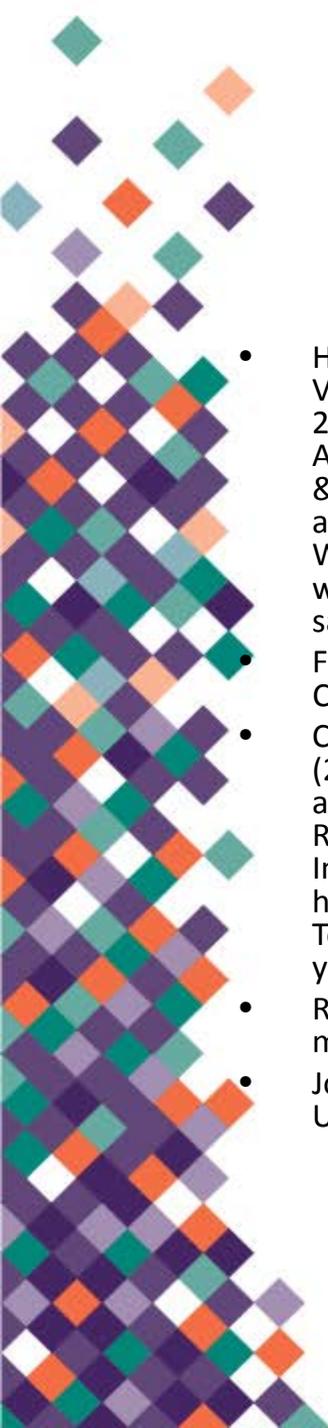
- Jill C. Morrison, National Women’s Law Center, USA.  
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# Thank You

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