Update

Unplanned pregnancy counselling and pregnancy termination: are women accessing the services they need?

Pregnancy termination is one of the most common medical procedures an Australian woman will experience in her lifetime, with one in three pregnancies being unintended and 70% of terminations the result of failed contraceptives. Campaigns for easier access to abortion in Australia have largely focused on changes to the law but in a recent speech to Emily’s List the Labor deputy leader, Tanya Plibersek, highlighted another crucial factor: cost.

“For many women abortions are unaffordable and unattainable,” she said. “The legal right to access a termination isn’t much use to a homeless teenager when the upfront cost of an abortion is more than $500.”

Prohibitive expenses (including travelling expenses) interact with legal restrictions to limit access to pregnancy terminations. Abortion costs are substantial, increase at later gestations, and are a financial strain for many women. Poor knowledge, geographical and financial barriers restrict method choice.

The following are some further points the Labor deputy leader made: “Putting RU486 on the PBS undoubtedly made it easier for some women to end an unwanted pregnancy.” But she said the current reality is that for many women who have decided they want an abortion, it’s still unaffordable and unattainable.

“The reality of the situation is that if you’re a middle class woman from a relatively privileged background living in a capital city, maybe you’ll agonise over the decision, there will be barriers and

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stigma around you getting an abortion, but you’ll probably be able to get one if you need to. If you live in a rural or remote area, if you’re experiencing poverty, if you don’t speak much English, if you’re young… it’s going to be a whole lot harder, if it’s possible at all.”

A study examining access and equity to induced abortion services in Australia, published in the Australian and New Zealand Journal of Public Health, recently showed that of 2326 women who presented at 14 Dr Marie Stopes International clinics across Australia, more than a third opted for a medical abortion. More than 1 in 10 stayed overnight. The median Medicare rebated upfront cost of a medical abortion was $560 compared to $470 for a surgical abortion at up to nine weeks. Women who travelled more than four hours, had no prior knowledge of the medical option, had difficulty paying and those identified as Aboriginal or Torres Strait Islander were more likely to present later than nine weeks.

Experts say that along with changes to laws, increasing the number of GP and nurse providers would improve access and reduce costs. But these groups can be reluctant to get involved in abortion, or to publicise their involvement. The significant legal and cultural barriers that discourage doctors and hospitals from providing abortions and push their provision into the private sector are a considerable barrier to women according to Children by Choice.

Geography often compounds existing impediments. Access to any medical service is limited in rural and remote areas. While in WA pregnancy terminations can be legally performed outside a medical facility, a woman still needs to be less than nine weeks pregnant, be within one hour of a medical facility in case of complications, be able to have an ultrasound and be able to cover the cost.

In her speech to Emily’s List, the Labor deputy leader also expressed concerns about “reproductive coercion” – when a partner attempts to control or sabotage a woman’s birth control, make threats or are violent if a woman attempts to use a condom, or even removes a condom without consent. It is a problem that must also be addressed, Plibersek insisted.

She noted the need for a comprehensive approach to improving the use of effective contraceptive, better access to healthcare for vulnerable women, and the need to improve sex education for both genders, particularly around the meaning of consent. “It’s girls who are more likely to be pressured to have sex when they don’t want to, to be publically shamed for sending selfies, to be ostracised for being too frigid or too promiscuous. It is girls who will end up pregnant, who are less likely to receive pleasure, who are more likely to be victims of violence. When our sex education system fails, girls pay a higher price.”

Recent research undertaken by Children by Choice examines the impact of poverty on women’s access to abortion services. In unravelling the cycle of poverty they gained greater insight into its contribution to women’s experience of unplanned pregnancy and choices available to her. Utilising organisational data and case studies collected over the past two years they provided a detailed analysis of the over-representation of women in poverty needing a pregnancy termination. According to Children by Choice data: 45% of contacts were Health Care Card holders and 67% reported abortion cost as a barrier to access. In response to this Children by Choice introduced a financial assistance program.

Their research showed that the main presenting issues for women are: mental health, sole parenting and family and domestic violence. They also found that the abortion experience typically involves:

- Multiple disclosures.
- Judgement from others when asking for money.
- Asking a violent or unsupportive man.
- Gestation advancing while trying to find funds.
- Escalation of mental health issues.
- Increased poverty from raising the money – housing/rent arrears, not paying bills, etc.

Through this research, we see traumatic life circumstances ∙ violence, benefit dependency, single parenting ∙ surrounding and exacerbating the abortion experience.

Counselling can be an integral part of the abortion process and may or may not include support in decision-making. Counselling should be available to women if they want it either before or after a termination. Not all women experiencing an unintended pregnancy wish to speak to a pregnancy
Most women believe that it is important that a pregnancy counsellor refer for all three options: abortion, adoption and parenting. The more difficulty women have in making their decision when faced with an unintended pregnancy, the more important they felt it is to have a counsellor who will refer for all three options.

There are some serious concerns about the accuracy of information provided by some pregnancy counselling services (and their appearance high up in a google search). Some services are run by anti-choice organisations but use misleading advertising that implies that women are offered non-directive pregnancy advice. The omission of key information can result in women not being fully informed on all the options for dealing with an unplanned pregnancy and not feeling fully supported to arrive at an independent decision. The limited timeframe available to make a decision about whether or not to continue with an unplanned pregnancy increases the importance of access to complete, accurate and unbiased information.

A government-run/funded telephone counselling service that provides non-directive counselling on pregnancy options, including contact information for termination clinics, would ensure that women in WA had access to appropriate information and the options available to them.

Western Australian women would also benefit from a well-planned response to the difficulties rural, remote and disadvantaged women are experiencing in accessing pregnancy terminations.

Contesting family-based violence: sole parenting possibilities and alternatives

In a recent paper published in the Journal of Family Studies, Genine Hook argues that the intersection of masculine entitlement and compulsory heteronormativity combines with gendered norms and social constructions of deficit for sole parent families to limit and problematise the capacity for women to build lives with their children that are free from violence. The author is careful not to minimise the risks, as heightened threats and violence are common within the separation process, nor does she downplay the structural impediments to separation such as financial, housing and childcare limitations. Rather, she seeks ‘to examine the overlapping social systems that operate to perpetuate family-based violence including the deficit discourse of sole parenting which tends to minimise this as an option.’

The researcher argues that when we fail to recognise sole parent families as possibilities for and constituting a ‘liveable life’ then an erasure of choice and diversity within family form occurs. She concludes that negative and deficit constructions of sole parent families contributes to ‘creating conditions that can create and maintain family-based violence’.

Access the article here.

The health of Australia’s females

Females are a diverse population, with differing health behaviours, conditions and health service use across a range of characteristics. Australia’s 12 million females (in 2016) experience varying health outcomes across population characteristics like Indigenous status, remoteness, socioeconomic disadvantage and age. Females also experience different health outcomes than males. A new report from the Australian Institute of Health and Welfare covers the following topics:

- Who are Australia’s females?
- Lifestyle and risk factors of Australia’s females
- How healthy are Australia’s females?
- How do Australia’s females access health care?

Read the report.

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3 Ibid.
4 Ibid.
Mental health, sexual identity, and interpersonal violence: Findings from the Australian longitudinal Women’s health study

Researchers examined the relationships among experiences of interpersonal violence, mental health, and sexual identity in a national sample of young adult women in Australia. The study found that experiences of interpersonal violence varied significantly by sexual identity. Controlling for demographic characteristics, compared to exclusively heterosexual women, mainly heterosexual and bisexual women were significantly more likely to report physical, sexual, and emotional abuse. Mainly heterosexual and lesbian women were more likely to report severe physical abuse. Mainly heterosexual women were more than three times as likely to have been in a violent relationship in the past three years, and all three sexual minority subgroups were two to three times as likely to have experienced harassment. Bisexual women reported significantly higher levels of depression than any of the other sexual identity groups and scored lower on mental health than did exclusively heterosexual women. In linear regression models, interpersonal violence strongly predicted poorer mental health for lesbian and bisexual women.

Notably, mental health indicators were similar for exclusively heterosexual and sexual minority women who did not report interpersonal violence. Experiencing multiple types of interpersonal violence was the strongest predictor of stress, anxiety and depression.

The researchers concluded that more research is needed that examines within-group differences to determine which subgroups are at greatest risk for various types of interpersonal violence. Such information is critical to the development of effective prevention and intervention strategies.

Access the article [here](#)

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Supporting and enabling women beyond five-year post-settlement

This report presents findings from the Empowering Migrant and Refugee Women study, undertaken by the Australian Institute of Family Studies. This research report has focused on two specific cohorts of particularly vulnerable migrant women:

- former humanitarian entrants (including Woman at Risk visa holders) who have completed their involvement with Settlement Services and have been in Australia for more than five years; and
- former family stream migrants who have completed their involvement with Settlement Services and have been in Australia for more than five years.

This study was commissioned by the Department of Social Services (DSS) to build evidence on practical strategies that could empower migrant and refugee women in the areas of women’s safety; economic and social participation; leadership opportunities; and to foster their role in promoting community cohesion. This report explores various aspects of service delivery to migrant women who have been living in Australia for at least five years. It documents the nature and types of service available, and identifies best practice principles and key service gaps in service delivery for migrant and refugee women.

The report also outlines key priorities for addressing these service gaps. Principles that were identified as being important in supporting migrant women and enhancing service delivery to this cohort:

- Delivering services in a gender responsive and culturally appropriate manner
- Culturally competent delivery was identified as being critical for both engaging clients and maintaining ongoing relationships with the client base.
- A culturally diverse and bilingual workforce (including the employment of migrant and refugee women themselves) is a key component in the delivery of good practice services and programs.
- Collaborative practices with other settlement and mainstream service providers are an important best practice principle and can play a significant role when refugee and migrant women’s services do not have specific expertise in a particular area. Forming such collaborations can assist with empowering and supporting migrant women, by offering referral opportunities that would not be possible otherwise.
- Consultation and collaboration with migrant and refugee community groups and community leaders were identified as an important best practice principle. Fostering these collaborative relationships
was an effective mechanism for services to better understand the needs of their clients. It also served an important role in promoting service visibility.

- A strengths-based approach to service delivery was acknowledged as an important best practice principle.

**Key service gaps and priorities for filling these gaps**
1. Delivery of services in a gender responsive way.
2. Cultural competency and mainstream service delivery— (training and other supports to build culturally and linguistically appropriate mainstream service delivery).
3. Greater visibility and promotion of service accessibility—
4. Transition to mainstream services and the move towards service delivery in large hubs had the potential to dilute the cultural and linguistic capacity of staff and the flexibility required to provide services and support the needs of migrant and refugee women.
5. Funding for post-settlement services and reporting requirements—a lack of dedicated funding for supporting migrant and refugee women in the post-settlement period was identified as a service gap.

Access the report [here](#).

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**Seeking help for domestic and family violence in regional, rural, and remote areas**

Recent research by ANROWS explores regional, rural, and remote women’s coping experiences and help seeking. The research contributes to the limited evidence on how geographical and social isolation shapes women’s coping with, and decisions to seek assistance for, domestic and family violence, and their efforts to live safely.

**Key findings:**
- Most women explained they were not negatively affected by geographical isolation: that is, they did not see physical distance as a barrier to accessing services.
- Geographical isolation was only a factor for women who lived on isolated properties outside the regional centre.
- Geographical isolation was a key issue for managers and practitioners, as it significantly shaped specialist domestic and family violence agency responses and work contexts.
- There is little or no help for men who use violence in regional, rural, and remote places outside a police or court response.
- All sites reported that, because crisis response and risk management dominated the work, “the hub” often lacked the staff, time, and resources to do outreach work, making it much harder to provide services and support to smaller townships and properties across large geographical distances.

**Implications for policy and practice:**
Services embedded in their local community contexts are more likely to be successful, with services operating with the hub-and-spoke model being effective in assisting women living in isolated places. Specialist domestic and family violence agencies based on this model require the following to increase their success:
- adequate levels of staffing and funding to enable the hub to reach across large distances and into local communities, and to invest in a range of responses to domestic and family violence that move beyond crisis response and accommodation: and
- time and opportunity to reach beyond the hub to engage with regional, rural, and remote women’s individual and diverse needs, and to lead local initiatives, coordination, and community development.

A number of findings from this project are relevant to clinical practice. These include women’s common experiences of:
- extended periods of coping with violence through various active strategies such as placating and trying to help their partner prior to their own help-seeking:
• shame and embarrassment over being a victim of abuse or a partner of someone engaging in illegal activities, delaying help-seeking;
• Aboriginal women’s dignity and pride being associated with being able to keep their children safe and rely on families;
• Aboriginal women using temporary stays at refuges as a way of staying safe; and
• significant social isolation, which affected help-seeking more than physical distance from local communities.

Compass (research to policy and practice) Key findings and future directions paper
Horizons (research report) In-depth research report

Whatever it takes: Access for women with disabilities to domestic and family violence services
In the Third Action Plan of the National Plan to Reduce Violence Against Women and Children responding to and preventing violence against women with disabilities is a key priority. To date there has been limited organised and funded activity in this area. This new ANROWS research report aims to help tertiary response services to respond effectively to the needs of women with disabilities. It draws on the experiences of women with disabilities who have experienced violence and abuse and have used tertiary response services.

Women with disabilities who have experienced violence seek help and support from tertiary services for similar reasons that other women do, including family and intimate partner abuse, sexual harassment and assault, coercive control, and stalking. However, women with disabilities also experience abuse related to their disability, including institutional violence and denial of provision of essential care. The key findings of the research include:

• Accessibility requires more than physically modified accommodation or providing interpreters for people with sensory impairments. Women with disabilities who participated in the research provided insights drawn from their experiences that suggest a need to extend the definition of “access” to include appropriateness, approachability, and acceptability as core components.
• By addressing broader issues of access in addition to disability-specific needs (such as the way information is provided to meet broad information access needs), the interface between what services offer and what women with disabilities need can be better aligned.
• Tertiary response services are not experts in disability and meeting some women’s specific access needs can be challenging. A “clash of cultures” between tertiary response services and other services that support women with disabilities was identified that hampered collaboration.
• At times, agencies providing services to women with disabilities who have experienced violence tended to act in ways that sought to “protect them” from being traumatised further, which led to less rather than more access to supports and services.
• Rather than simply referring women with disabilities to disability services for support, a process for DFV services to collaborate and engage with disability services (rather than handing over to them) was developed.

From these findings, the research recommends:

• Promoting access and accessibility: Services should review their understanding of “disability” and “access” and ensure that they provide services that are approachable; acceptable and appropriate; and affordable and available.
• Building cross-sector collaboration: In order to support initiatives for cross-sector collaboration, the emerging models of promising practice identified in this research should be further developed and informed using a facilitated process of reflection, consultation and engagement with other tertiary response services.
• Involving women with disabilities: Women with disabilities should be consulted about their experiences using tertiary response services and their advice incorporated into planning and practice development.
• High-quality data collection: DFV services should collect data on the disability experiences of clients. Qualitative and quantitative data measures across all programs offered in DFV
services should be developed and implemented, and tied to the same measurement and reporting metrics for other demographic characteristics (e.g. age, Indigenous status, and so on).

Access the report [here](#).

**The post-separation journey of women who have experienced intimate partner violence**

This thesis by Sarah Jayne Parkin explores the experiences of both women who have experienced IPV, and formal support workers in order to generate a theory that explains the post-separation journey of women after leaving an IPV relationship. The findings of the study highlighted that although the post-separation journey is unique for each woman, there were common individual processes that influence long-term wellbeing. The findings support and add to prior research which concludes that the approach of formal supports can serve to either help or hinder women’s wellbeing post-separation. The individual journey of women post separation was found to occur as the result of interactions between a woman, other people, situation, services, community and cultural context. In order to highlight all the external influences identified by participants the individual post-separation journey of women was positioned within context using an ecological perspective.

According to the researcher, although IPV research has begun to conceptualise the causes and consequences of IPV as a complex interaction of numerous individual, relational, situational and socio-cultural factors, the participants in the current study identified there continues to be somewhat “simplistic” perceptions of IPV in friends, family, colleagues and some formal supports. This lack of understanding contributed to women experiencing stigma, fear of disclosing IPV, a lack of support, and pressure to end the relationship despite the individual circumstances of the relationship. This finding, the researcher says, suggests the importance of continuing to actively involve women in informing research, policy, and practice. It also suggests a greater need for new knowledge to be incorporated and represented in our communities; including in current practices within service provision, policy development and community intervention.

The study’s findings are consistent with research conducted by Pennington-Zoellner (2009) who emphasised that a ‘community response’ to IPV needs to involve informal support networks, individual support services, therapeutic services for women, children and perpetrators, legal services, child protection departments, criminal and family law departments, religious and spiritual supports, employers as well as community services such as schools, General Practitioners, child care services, and other community groups. The researcher writes: “a collaborative community approach will better support women, men and children who have been involved in IPV relationships, and is more likely to lead to a change in community attitudes. Therefore, continued reflection on current practices within services and possible areas of improvement should endure.”

Importantly, the researcher notes that: “As each woman’s journey will differ it is important to acknowledge that not all women will choose to leave an IPV relationship. Some women will choose to remain in an IPV relationship based on positive feelings towards their partner, increased ability to satisfy basic needs when with the partner (e.g., housing, food), risk of escalated abuse if the woman leaves and perceived better ability to manage the IPV while remaining in the relationship.” The researcher further states that:” Leaving an IPV relationship is not consistently linked with better outcomes for women and children as abuse or risk may increase after separation or living conditions may decline. Consequently, for some women the decision to stay in the relationship is the safest option at that time.” Some women in the study expressed feeling pressure by informal and formal supports to end the relationship even if this was not their goal. For some women this led to them seeking support without disclosing IPV e.g., seeing a counsellor to reflect on themselves in an attempt to improve the relationship. Such findings emphasise the importance of considering the individual characteristics of a relationship in shaping the support provided.

Access the thesis [here](#).
Elder abuse report ignores impact on people’s health

The long awaited Australian Law Reform Commission (ALRC) report into elder abuse is a substantial step forward in addressing physical, sexual, psychological, emotional and financial abuse of the elderly. An article published in The Conversation welcomes the report, but highlights some of the more hidden aspects of abuse and neglect such as sexual assault. Sexual assault, the authors argue, is the least acknowledged, detected, and reported type, especially in people living in residential aged care. They believe it deserves far more attention. This is especially important considering the role of the health sector and health professionals who should be working to improve identifying, reporting, managing and responding to sexual assaults. Currently, care staff and health professionals are poorly equipped to appropriately identify and respond to sexual assault. This situation is not helped by the lack of supporting policies in aged care facilities to investigate and support victims.

The authors write: “These situations persist because of community inaction. We are reluctant to accept the possibility of these incidents because they are too horrific to contemplate. We reassure and rationalise our inaction by saying the perpetrators are a very small minority of criminally minded individuals, which is not the reality. In fact the perpetrators are more often a person who is in a position of trust such as a family member or carer.”

According to the authors, “the greatest challenge in preventing elder abuse is equipping the law, health and aged care sectors to be better at screening, identifying and intervening to protect the rights of the elderly. Incredible sensitivity is also required as the vast majority of children, partners and care staff are fabulous advocates and supporters of older people.” They go on to say that: ‘More research is also needed to inform decisions about social policy, aged care practice and resource allocation. This requires a dedicated, co-ordinated, multidisciplinary approach and the necessary technical expertise in aged care, law, health care, public health, injury prevention and public policy.’

Read more here
See also: Understanding elder abuse: A scoping study.

Serving Up Inequality: how sex and gender impact women’s relationship with food: Issues Paper

This latest Issues Paper from Women’s Health Victoria explores various aspects of women’s health relating to food. These include the impacts of nutritional deficiency, the links between nutrition and chronic disease, and women’s food-related behaviours. Gender is a key structural determinant of women’s health and inequality, playing out in women’s roles in relation to food, in psychosocial health and the socioeconomic factors that impact on access to nutritious food.

Controversy exists in public health and health promotion about the approach and key messages that should be adopted in relation to food-related behaviours and body size to promote ‘health’ and prevent illness for women. This paper outlines various perspectives in this discourse and highlights principles and recommendations for designing health promotion programs and managing the risks of public health messages.

Access the Full issues paper, fact sheet and infographics

Violence Against Young Women in Non-urban Areas of Australia: A Scoping Review

Young women (18 – 24 years) experience significantly higher rates of physical and sexual violence than women in older age groups. The aim of this review was to map the breadth and nature of the “violence against women” literature particular to young non-urban Australian women and identify research gaps to inform future research with young people. Themes identified include prevalence and type of abuse, experiences and response to violence, and the consequences of abuse. There is limited research on violence against young women living in non-urban areas of Australia. Evidence to date consists of predominantly quantitative data generated from general population surveys.

There is a lack of qualitative research on this topic, and the authors argue that more is needed to gain a better understanding of the violence that young women experience. Recommendations from the review include the need for improved service access, improved data collection on the prevalence of violence, and a focus on more research with young women in non-urban areas.

Access the article [here](#).

**New research highlights high rates of self-harm among Australian teenagers**

One in 10 teenagers surveyed as part of a national study said they had self-harmed and one in 20 reported having attempted suicide.

According to data released from The Longitudinal Study of Australian Children, rates of self-harm and suicidal behaviour are high among Australian teens. Among 14-15 year olds, one in ten reported that they had self-harmed in the previous 12 months, and 5% reported they had attempted suicide.

Girls appeared to be at greater risk than boys of both self-harm and suicidal behaviour. One in four girls had had thoughts about self-harming, and 15% had engaged in some form of self-harm. When it came to suicide, 12% of girls had thought about suicide in the past year, with 6% actually attempting suicide.

Among boys, 8% had thought about self-harm, and 4% had done it. With suicide, 6% of boys had thought about it, and 4% had made a suicide attempt. Boys were, however, much more likely to act impulsively and make an unplanned suicide attempt.

Self-harm and suicide do not happen in parallel, and often self-harm can act as a "gateway" to suicide. Of those who had attempted suicide, two thirds had previously self-harmed.

**Some teens are more at risk of self-harm than others**

- Teens who reported that they were same-sex attracted, bisexual, or unsure of their sexuality were at greater risk of self-harm than heterosexual teens.

- Teens with more reactive temperaments; those who had depression, anxiety or general feelings of unhappiness; and those who reported being threatened or feeling victimised by their peers because of their health, skin colour, sexual orientation, language, culture or religion were also at greater risk of self-harm.

- Teens had an elevated risk of suicide if they had self-harmed; were same-sex attracted, bisexual, or unsure of their sexuality; or if they had been involved in so-called "delinquent behaviour" such as crime or property offences.

**The risk factors for suicide are similar, with sexual identity again featuring strongly in these dynamics**

Overall, the findings highlight that preventative strategies should be directed towards young people, in order to increase their awareness of risk factors for themselves and also their peers, as well as increase awareness of the support services and other resources available. Programs to assist teachers and parents to appropriately assess the signs of self-harm and suicidal intent also could be of considerable benefit of reducing the overall disability burden of self-destructive behaviour in young people.

Access the full chapter [here](#).

**ABS ‘victims of crime’ figures**

The ABS recently released its 2016 ‘victims of crime’ figures, showing WA with 5 years of continuous increase in the number of sexual assault victims, and 3 years of continuous increase in

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6 Thank you to Janelle Veitch for providing this information.
the rate of victimisation. The release also lists a 5 year continuous increase in sexual assault numbers nationally, to reach the highest level in 7 years (there is an interactive slider you can drag to see the change each year on the web page here).

The release includes information on FDV-related crimes, with FDV-related assault showing a 12% rise in the rate of victimisation in WA – more here. There is also a general WA page here that notes that assault victimisation numbers increased by 10% in 2016, to reach the highest level since recording began in 2010. Three in five victims of assault in WA are female, and the page includes a good chart comparing assault by gender and age to show where need/ risk occurs.

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**Two in five pregnant women don’t receive care in the first trimester**

Around 40% of expectant mothers in New South Wales are delaying important early pregnancy tests and screening, new research has found.

The study was conducted by the Western Sydney Local Health District and published in the *Australian and New Zealand Journal of Public Health*. It found socioeconomically disadvantaged groups were most at risk of missing out on early antenatal care (ANC). Researchers said teenagers, unmarried women, smokers and migrants were among those least likely to receive a comprehensive assessment from a doctor in the first 14 weeks of their pregnancy.

Antenatal care involves regular monitoring of a pregnant mother by health professionals. This can include physical tests, blood tests and ultrasounds. Tests provided during antenatal care can detect whether the woman is at risk of preterm birth. They also examine the health of the fetus and check for congenital defects such as heart defects and Down Syndrome. The first antenatal visit should occur around the ten-week mark. At the first antenatal check, a health care provider will interview the woman and discuss any issues of concern. The check-up also provides a woman with useful health advice, education and screening tests.

According to the researchers, fewer antenatal visits, and delayed entry to ANC in particular, hinders timely and important health advice and education and benefit from screening tests. The study said strategies encouraging women to seek antenatal care early in their pregnancy needed to be promoted, especially those targeting women who fall into higher-risk groups such as smokers and migrants.

In an article published in *The Conversation*, Professor Baum argues it’s the health services themselves that need to be improved to become more accessible for pregnant women. She said a young pregnant woman who smokes, for example, will likely avoid visiting a health clinic for fear of reprimand. “Rather than targeting the women,” Professor Baum said, “you ask the question: ‘How do we make these services welcoming to migrant women, young women, to people who don’t have much money, to people who smoke?’

"They’re saying they can’t get the women, which implies those women are hard to reach. I think the way I would look at it is that the services are hard for those people to reach, so I think it’s the services that need to change.” Read the article

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**The Community, Respect & Equality (CRE) Project**

The Community, Respect & Equality (CRE) Project aims to inspire, innovate and connect community leaders, sector and service organisations, and government to work together on creative and sustainable strategies for the primary prevention of family violence in Geraldton. It provides a sound, evidence based foundation from which the community can start a unified journey to challenging and saying no to violence within a regional context. The project has created and launched a 2017 Strategic Action Plan for Family Violence Prevention in Geraldton. Visit the [CRE website](#)