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Reproductive Coercion

Understanding the implications for migrant and refugee communities

What is **reproductive coercion?**

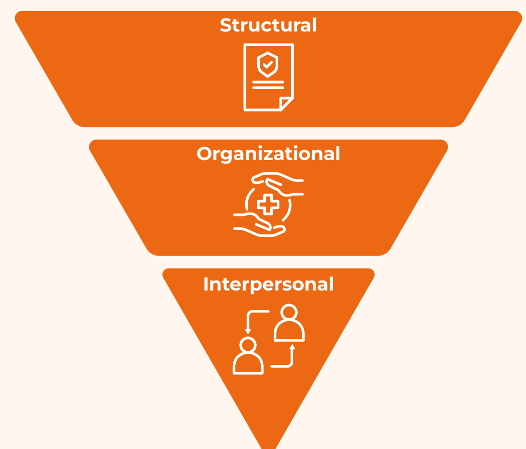
Reproductive coercion refers to actions and behaviours that interfere with a person's reproductive autonomy and decision-making. Reproductive coercion can be enabled at multiple levels, including by state policies and institutional actors. At the interpersonal level, it can be perpetrated by individual partners or multiple family members, and may occur alongside other forms of violence, most often intimate partner violence and family violence. Reproductive coercion is associated with a range of negative outcomes, including poor mental health, unintended pregnancy or abortion, and sexually transmitted infection.

Implications for **migrant and refugee communities**

Emerging evidence indicates that migrant and refugee women and non-binary and gender diverse people are more likely to have their reproductive autonomy and decision-making curtailed by factors such as the reluctance of healthcare providers to engage interpreters, visa conditions which limit sexual and reproductive healthcare rights, and gendered and racial discrimination which limit access to timely health information and care. We need more research and evidence on migrant and refugee people's experiences of reproductive coercion, and how they intersect with racial, gender, socioeconomic and visa inequality.

Reproductive coercion is enabled at three levels

At a **structural level**, reproductive coercion is enabled by factors such as gender and racial inequality, migration policy, visa restrictions, insecure working conditions for the healthcare and interpreting workforce, and monolingual service delivery (Kevin and Agutter 2018). For instance, Australian research shows that perpetrators can exploit the threat of deportation and visa restrictions to stop women accessing contraception, maternal, and abortion services (Marie Stopes 2020). Currently, national policy allows health insurance companies to reject claims made for pregnancy and abortion care during international students' first 12 months in Australia. While women can obtain healthcare on paper, the costs can be prohibitive in practice. This policy disproportionately impacts women and their ability to make sexual and reproductive healthcare decisions, amounting to a form of state-enabled reproductive coercion.



Healthcare providers requiring interpreting services are often constrained by the casualisation of the interpreting workforce, which leaves them unable to find a suitable interpreter when most needed. These systemic constraints restrict patients' access to timely abortion and pregnancy care, and can enable coercive perpetrators.

At an **organisational level**, reproductive coercion is enabled when healthcare providers do not provide adequate care, for instance by not properly consulting patients or not questioning when perpetrators make decisions for them. Research has found that when perpetrators accompany victims/patients and claim the patient does not speak English, providers often fail to question this or are reluctant to engage a qualified interpreter. This reluctance risks facilitating abuse, since it centres perpetrators' voices, and gives them ultimate control over reproductive decisions (Sheerin et. al. 2022 and Suha et. al. 2022).

On the **interpersonal level**, reproductive coercion can encompass threats or coercion to force a person to become or remain pregnant; force a person to have an abortion; or interfere with a person's decision-making about fertility, family planning and contraceptive use. It also encompasses actions which sabotage a person's contraceptive use; and the use of violence with the intent to cause miscarriage.

The role of service providers in **promoting reproductive justice**

Emerging evidence indicates that women experiencing reproductive coercion are more likely to seek reproductive health care than women who do not (Block et. al. 2021), meaning healthcare providers play an important role across the spectrum of prevention, early intervention and response.

- → It is important that healthcare providers address patients directly, do not rely on the accompanying person/s to interpret or make decisions, and do not assume that the instructions of the accompanying person/s reflect those of the patient.
- → When family members offer to interpret, always explain the need for an independent interpreter, and organise an interpreter. For immediate telephone interpreting services, please call the National Translation and Interpreting Service on **131 450**
- → When it is unclear whether the patient's decisions are being communicated, offer the patient a solo appointment.
- → If reproductive coercion is disclosed or identified, it is important to follow organisational policies related to family violence, and to offer relevant sexual and reproductive health information and services.

Key **Recommendations**

- **Removing visa restrictions** Ensuring support services are available regardless of visa status, avoiding a multi-tiered discriminatory system.
- **Promoting secure work** Providing ongoing, secure employment for the healthcare and interpreting workforce, improving access to interpreters, and ensuring adequate appointment times.
- **Developing a national sexual and reproductive health strategy** Ensuring a comprehensive, intersectional and evidence- based strategy which accounts for the structural inequities created by the immigration system, and addresses the healthcare needs of migrant and refugee women and non-binary and gender diverse people.
- **Promoting evidence-based best practice** Resourcing healthcare providers to ensure continuity-of-care, and to provide culturally responsive and trauma-informed care.
- Implementing all **36 recommendations** of the Senate Inquiry into Universal Access to Reproductive Healthcare, in particular:
  - → **Recommendation 25:** that the Australian Government consider options and incentives to expand the culturally and linguistically diverse (CALD) sexual and reproductive health workforce including leveraging the success of the 'Health in My Language' program.
  - → **Recommendation 30:** that the Australian Government, in consultation with state and territory governments, consider options for ensuring the provision of reproductive health and pregnancy care services to all people living in Australia, irrespective of their visa status.

Sources

Block, K., Hourani, J., Sullivan, C., & Vaughan, C. (2022). "It's about building a network of support": Australian service provider experiences supporting refugee survivors of sexual and gender-based violence. Journal of Immigrant & Refugee Studies, 20(3), 383-397.

Community Affairs Reference Committee. (2023) Ending the postcode lottery: Addressing barriers to sexual, maternity and reproductive healthcare in Australia (Report of the Senate Inquiry into Universal Access to Reproductive Healthcare). Accessed from https://parlinfo.aph.gov.au/parlInfo/download/committees/reportsen/RB000075/toc_pdf/EndingthepostcodelotteryAddressingbarrierstosexual,maternityandreproductivehealthcareinAustralia.pdf

Children by Choice (2019) Reproductive Coercion. Accessed online at: https://www.childrenbychoice.org.au/factsandfigures/reproductivecoercion

Kevin, C. & Agutter, K. (2018). Failing 'Abyan', 'Golestan' and 'the Estonian Mother': Refugee Women, Reproductive Coercion and the Australian State. Immigrants & Minorities 36(2), 87-104.

Marie Stopes Australia (2020). Hidden forces: a white paper on reproductive coercion in contexts of family and domestic violence, Second edition. Melbourne: Marie Stopes Australia.

Sheeran, N., Tarzia, L., & Douglas, H. (2022). Communicating reproductive coercion in the context of domestic and family violence: perspectives of service providers supporting migrant and refugee women. Journal of Family Violence, 1-11.

Suha, M., Murray, L., Warr, D., Chen, J., Block, K., Murdolo, A., & Vaughan, C. (2022). Reproductive coercion as a form of family violence against immigrant and refugee women in Australia. Plos one, 17(11), e0275809

Tarzia, L., & Hegarty, K. (2021). A conceptual re-evaluation of reproductive coercion: centring intent, fear and control. Reproductive health, 18(1), 1-10.