Australian Women's Health Alliance

Policy Paper
Shining a light on reproductive violence: The Australian context

Purpose of this paper

Australian Women's Health Alliance works to articulate the policies and actions necessary to improve health outcomes for women. The purpose of this brief is to gain an understanding of the United Nations Population Fund (UNFPA) 2026 technical paper Shining a Light on Reproductive Violence: A contribution to understanding all forms of gender-based violence against women and girls,[1] and apply it in the Australian context, including the National Women's Health Strategy [2] with a focus on Indigenous and culturally and linguistically diverse women and gender diverse people.

Why the global concept matters for Australia

UNFPA, the UN sexual and reproductive health agency, has recently published a technical paper titled 'Shining a light on reproductive violence: A contribution to understanding all forms of gender-based violence against women and girls'. UNFPA's framework defines reproductive violence as a distinct form of gender-based violence: acts and omissions — physical, sexual, emotional/psychological, economic, and normative/symbolic that compromise a person's ability to decide whether, when, how and under what conditions to become pregnant, give birth and raise children.[3] Crucially, the framework insists this violence is not only interpersonal; it is enabled and perpetrated across relationships, communities, institutions, and societal laws and policies. In it they highlight CEDAW's Recommendation 35 which states that:

'Violations of women's sexual and reproductive health and rights, such as forced sterilizations, forced abortion, forced pregnancy, criminalization of abortion, denial or delay of safe abortion and post abortion care, forced continuation of pregnancy, abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment.'[4]

Applied to Australia, this framing does important work. It draws a direct line between historical and ongoing practices including around coercive population control, forced sterilisation, forced child removal, and the erosion of birthing services on Country. Further, it recognises them as a connected

[1] UNFPA and MSI (2026), *Shining a Light on Reproductive Violence: A contribution to understanding all forms of gender-based violence against women and girls*, United Nations Population Fund. https://www.unfpa.org/publications/shining-light-reproductive-violence-contribution-understanding-all-forms-gender-based

[2] Department of Health (2018), *National Women's Health Strategy 2020–2030*, Commonwealth of Australia. https://www.health.gov.au/resources/publications/national-womens-health-strategy-2020-2030

[3] UNFPA and MSI (2026).

[4] Committee on the Elimination of Discrimination against Women (2017), *General Recommendation No. 35 on gender-based violence against women, updating General Recommendation No. 19*, UN Doc CEDAW/C/GC/35, para 18.

pattern of reproductive violence, rather than isolated historical wrongs, health system failures, or unrelated child-protection statistics. For First Nations people, reproductive violence is inseparable from the broader structure of colonisation, and any Australian application of this framework must centre that reality rather than treat colonisation as background context. An understanding and application of CEDAW's Recommendation 39 on the rights of Indigenous women and girls is imperative here:

'Indigenous women frequently experience difficulties in securing access to sexual and reproductive health information and education, including about family planning methods, contraception and access to safe and legal abortion. They are often victims of gender-based violence in the health system, including obstetrics violence; coercive practices, such as involuntary sterilizations or forced contraception; and barriers to their ability to decide on the number and spacing of their children. Indigenous midwives and birth attendants are often criminalized, and technical knowledge is undervalued by non-Indigenous health systems.'[5]

This document also extends the framework to women from culturally and linguistically diverse (CALD) backgrounds, including migrant, refugee and temporary-visa-holder communities. This is a distinct population with a distinct relationship to reproductive violence, shaped less by colonisation of a homeland than by migration status, language access, and the way Australian systems handle or fail to handle culturally and faith-specific forms of coercion. These two populations should not be conflated or treated as a single "diversity" category; each requires its own analysis, even where the underlying framework and some structural drivers including institutional gatekeeping, language and access barriers, and distrust of authorities overlap.

First Nations women, migrant and refugee women and women with disability may experience additional and intersecting forms of reproductive violence, shaped by ableism alongside other forms of discrimination. These can range from assumptions that women with disability should not parent or reproduce, to barriers to contraception and other reproductive healthcare, and reproductive control by partners, families, carers or institutions.[6]

This understanding is reinforced by General Comment No. 3 under the Convention on the Rights of Persons with Disabilities, which identifies barriers to reproductive healthcare including women being refused access to health services, physical barriers to gynaecological and obstetric care, and attitudinal barriers to fertility treatment, alongside forced or involuntary reproductive interventions without free and informed consent.[7]

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[5] Committee on the Elimination of Discrimination against Women (2022), *General Recommendation No. 39 on the rights of Indigenous women and girls*, UN Doc CEDAW/C/GC/39, para 52.

[6] Women With Disabilities Australia (2022), *Towards Reproductive Justice for Young Women, Girls, Feminine Identifying, and Non-Binary People with Disability (YWGwD): Report from the YWGwD National Survey*, WWDA; Steele L (2024), *Redressing Reproductive Violence Against Women with Disability: Justice Beyond the Royal Commission*, WWDA.

[7] Committee on the Rights of Persons with Disabilities (2016), *General Comment No. 3 on women and girls with disabilities*, UN Doc CRPD/C/GC/3, paras 32, 43 and 57.

Reproductive violence at the societal level: Laws, policy and colonisation

Historical foundations

From the 1920s–30s eugenics era through to the 1960s and 1970s, Australian governments, doctors and policymakers explicitly framed Aboriginal fertility as a problem to be managed. Historians working from government records of that period have found evidence of coercive sterilisation including sterilisation practices, with prominent doctors and even a future federal health minister publicly describing First Nations pregnancy rates as "excessive" and calling for free access to sterilisation and intrauterine devices (IUDs) as a "solution".[8] In response, Aboriginal women organised through the late twentieth century specifically to keep the state out of their personal reproductive decisions, campaigning against forced sterilisation and the use of long-acting contraceptives (LARC) administered without informed consent.[9] First Nations scholars including Larissa Behrendt, Jackie Huggins and Aileen Moreton-Robinson have argued that where the mainstream feminist movement saw contraception and abortion access as liberation, family-planning technologies functioned in Aboriginal communities as instruments of state control.[10]

In recent years, Australia's healthcare practitioners have recognised reproductive violence and made various commitments to prevention in practice. In 2022, nursing and midwifery education leaders formally apologised for the professions' role in racist policies and practices that harmed AbFirst Nations peoples, including acting as agents of government in the removal of children and racial segregation in health services.[11] The same year, MSI Australia issued a public apology to First Nations peoples for forced contraception, abortion and sterilisation connected to institutional and systemic racism since colonisation, specifically naming the compounded harm experienced by Aboriginal and Torres Strait Islander people with disability and LGBTQIA+ people.[12]

Contemporary policy

Reproductive violence at the societal level in Australia is not confined to history. Contemporary policies and practices still inflict harm on women across groups. Below are some examples:

- **Clinical decision-making procedures fail to prevent interpersonal and institutional harms.** Despite the Disability Royal Commission's final report (2023) affirming the right of women

[8] Hurst J, Rademaker L and Troy J (2024), 'Friday essay: "too many Aboriginal babies" – Australia's secret history of Aboriginal population control in the 1960s', *The Conversation*, April. https://theconversation.com/friday-essay-too-many-aboriginal-babies-australias-secret-history-of-aboriginal-population-control-in-the-1960s-189249; Rademaker L (2024), 'Being Counted: Family Planning and Aboriginal Population, 1967–75', *Australian Historical Studies*, 55(3):506–524. https://doi.org/10.1080/1031461X.2023.2297964

[9] Byrnes C (2018), 'Reproduction regulation, abortion and Indigenous women since the 1970s', *Australian Women's History Network*, 25 February. https://www.auswhn.com.au/blog/abortion-indigenous-women/

[10] Rademaker (2024).

[11] Council of Deans of Nursing and Midwifery (Australia and New Zealand), Strickland K, Deravin L et al. (2023), 'An apology to Aboriginal and Torres Islander people: A moment of truth for the nursing and midwifery professions', *Collegian*, 30(2):207–209. https://doi.org/10.1016/j.colegn.2023.03.011

[12] MSI Australia (2022), 'Apology for forced medical procedures linked to colonisation and racism in Australia', *MSI Australia*, 3 August. https://www.msiaustralia.org.au/apology-for-forced-medical-procedures-linked-to-colonisation-and-racism-in-australia/

and girls to control decisions about their own bodies,[13] involuntary sterilisation including hysterectomy or long-acting contraception imposed to prevent menstruation or pregnancy of reproductive violence. remains permitted in Australia. UN human rights bodies have described forced sterilisation as a form of torture and structural violence.[14] This risk falls disproportionately on First Nations women and girls with disability, sitting at exactly the intersection of racial and disability discrimination the UNFPA framework identifies as a risk factor that ma?

- **Maternal healthcare clinic closures function as institutional and societal-level harms.** Successive government policy decisions have driven the closure of maternity units across regional and remote Australia, forcing many women to relocate for centralised, tertiary-based care, a pattern that disproportionately affects First Nations families.[15] This is a clear example of the framework's "societal laws and policies" layer producing downstream harm at the interpersonal and community levels.
- **Child protection and removal systems function as institutional and societal-level harms.** Read through a reproductive-violence lens, Australia's child-protection system functions as an ongoing, state-level intervention into First Nations parenting and reproductive autonomy. National data for 2025 show First Nations children are around six to almost ten times more likely to be in out-of-home care than non-Indigenous children (estimates vary by data source and year) and make up roughly 45 per cent of all children in out-of-home care nationally, despite being a small fraction of the child population. First Nations infants are removed at an even higher relative rate than the wider First Nations child population, and reunification rates with family remain far lower than for non-Indigenous children.[16] Set against the history of the Stolen Generations, First Nations organisations and communities widely understand this pattern not as a series of unrelated child-safety decisions but as continuity of state control over who is permitted to parent.

Reproductive violence at the institutional level

Obstetric and maternity care

The UN framework's concept of reproductive violence, including disrespectful, neglectful or abusive care during pregnancy, birth and postpartum maps closely onto documented experiences of First

[13] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (2023), *Final Report*, Commonwealth of Australia. https://disability.royalcommission.gov.au/publications/final-report

[14] Woods C (2025), '"State-sanctioned torture": women with disability continue to suffer forced sterilisation', *Law Society Journal*, 21 January. https://lsj.com.au/articles/state-sanctioned-torture-omen-with-disability-continue-to-suffer-forced-sterilisation/

[15] Ireland S, Roe Y, Moore S et al. (2022), 'Birthing on Country for the best start in life: returning childbirth services to Yolŋu mothers, babies and communities in North East Arnhem, Northern Territory', *Medical Journal of Australia*, 217(1):5–8. https://doi.org/10.5694/mja2.51586

[16] SNAICC – National Voice for our Children (2025), *Family Matters Report 2025*, SNAICC. https://www.snaicc.org.au/resources/family-matters-report-2025/; Productivity Commission (n.d.), *Closing the Gap Information Repository: Dashboard*, Socio-economic Outcome Area 12. https://www.pc.gov.au/closing-the-gap-data/dashboard

Nations women in mainstream Australian maternity systems, compounded by routine "evacuation" practices in remote areas.

- Researchers studying Indigenous birthing experiences deliberately use the term "evacuation" rather than "referral" or "transfer" for the relocation of women for birth, because these moves are frequently imposed with little or no input from the women themselves, often under urgent circumstances.[17]
- First Nations women are around fourteen times more likely than non-First Nations women to live remotely, and roughly a fifth of all Indigenous birthing women live more than an hour's drive from the nearest birthing facility. Cultural birthing practices and traditional midwives are rarely accommodated in hospital birthing rooms, and many women report the care they receive as culturally unsafe.[18]
- The coercive character of this system is visible in women's own responses to it: in several of the largest remote communities routinely subject to evacuation in order to influence off-Country birthing, between five and twenty-two per cent of women bypassed the system each year between 2003 and 2008. Some women were deliberately discreet about their pregnancies or returned home shortly after scheduled transfer specifically to avoid mandatory relocation for birth.[19] This illustrates the framework's point that reproductive violence causes harm regardless of whether it is "pregnancy promoting" or "pregnancy preventing": a system built around safety instead drives women away from antenatal care altogether.
- Enforced evacuation to distant hospitals breaks women's connection to Country, prevents family presence at birth, and disrupts the integration of traditional birth attendants and practices, a pattern of imposed cultural disconnection.[20] This echoes the "normative and symbolic" form of violence in the UN figure, where formal systems override or fail to accommodate culturally grounded understandings of birth and kinship.
- The health consequences are severe: national data show maternal death is around 3.7 times higher for First Nations mothers than for other Australian women, perinatal death is roughly

[17] Sivertsen N, Johnson T, Mehus G et al. (2025), 'What is known about Indigenous women's dissatisfaction of birthing experiences in mainstream maternity hospitals in Australia, Aotearoa, Canada, US, Kalaallit Nunaat and Sápmi? A systematic scoping review', *Frontiers in Public Health*, 13:1495197. https://doi.org/10.3389/fpubh.2025.1495197

[18] Kildea S, Hickey S, Barclay L et al. (2019), 'Implementing Birthing on Country services for Aboriginal and Torres Strait Islander families: RISE Framework', *Women and Birth*, 32(5):466–475. https://doi.org/10.1016/j.wombi.2019.06.013

[19] Kildea S, Kruske S, Barclay L and Tracy S (2010), '"Closing the Gap": How maternity services can contribute to reducing poor maternal infant health outcomes for Aboriginal and Torres Strait Islander women', *Rural and Remote Health*, 10:1383. https://www.rrh.org.au/journal/article/1383

[20] Kildea S and Van Wagner V (2012), *'Birthing on Country' maternity service delivery models: a rapid review*, Sax Institute for the Maternity Services Inter-Jurisdictional Committee. https://www.saxinstitute.org.au/wp-content/uploads/Birthing-on-Country1.pdf

twice as high, and preterm birth is about 1.7 times more common for First Nations babies nationally, rising to nearly one in five births in remote parts of the Northern Territory.[21]

Disability and reproductive coercion in institutional settings

The First Peoples Disability Network representatives have described how First Nations women and girls with disability can be coerced into sterilisation by carers, partners, or the medical and guardianship systems responsible for their care,[22] an institutional-level harm compounded by the same broader system's disproportionate removal of First Nations children from their families.

Reproductive violence at the community level

UN's framework notes that community-level reproductive violence includes both active interference in reproductive decisions and the withdrawal of material and informational support that communities would otherwise provide. In the Australian context, decades of policy-driven distrust, a direct legacy of the sterilisation and child-removal history above, has shaped how First Nations communities relate to mainstream reproductive health services. The growing Birthing on Country movement should be read as a community-level resistance strategy to institutional and societal reproductive violence, not simply a cultural preference: it is an international movement to return maternity care to First Nations communities and community control, in pursuit of improved health and wellbeing outcomes.[23]

Reproductive violence at the interpersonal level

UN's framework stresses that interpersonal reproductive coercion which can be defined as control by partners or family members over contraception, pregnancy or parenting decisions, is shaped and legitimised by the societal and institutional layers surrounding it. In Australia, this dynamic is sharpened by intergenerational trauma: family and community understandings of pregnancy surveillance, "unborn" reports to child-protection authorities before a baby is even born, and fear of removal all shape how First Nations women engage even with trusted intimate and family relationships around pregnancy. This is a dynamic not well captured in mainstream reproductive-coercion research, which is drawn largely from non-Indigenous, global-north samples, and is an area the framework itself flags as needing dedicated, community-led research.

Reproductive violence against culturally and linguistically diverse women

Applying UN's framework to CALD communities in Australia surfaces a different but equally structured pattern of harm, again spanning all four social levels discussed above.

Societal level: Legal frameworks as a structural driver

Australian legal frameworks themselves create conditions in which reproductive coercion can flourish and, in the case of migration law, arguably reward it. The partner visa system requires applicants to prove a "genuine and continuing relationship" across four evidentiary categories, and Australian immigration law practitioners note that pregnancy and childbirth are treated by the Department of

[21] Ireland et al. (2022).

[22] Woods (2025).

[23] Kildea et al. (2019).

Home Affairs as compelling evidence reinforcing that claim.[24] This creates a documented incentive structure in which a sponsoring partner can pressure a visa-dependent partner into pregnancy specifically to strengthen an immigration case, a form of forced pregnancy that is reproductive violence in the UNFPA sense, produced by the ordinary operation of migration law rather than by any individual perpetrator's intent alone.

These dynamics compound in the context of pregnancy. Research on reproductive coercion among immigrant and refugee women in Australia has documented contraceptive sabotage, restricted movement, and violence used specifically to force a pregnancy, and researchers note that when children result from this coercion, it may lead women to feel obliged to stay with their intimate partner.[25]

For a woman on a temporary visa, that obligation is compounded: leaving the relationship risks not only her own visa pathway but also a contest over custody of an Australian-born child, and fear of this combined loss is a documented reason women remain in coercive relationships. The same legal architecture that can pressure a woman into pregnancy also constrains her decisions once pregnant, since a visa-dependent woman may fear that seeking contraception independently, or ending a pregnancy, could be read as evidence against the "genuine and continuing" relationship her visa depends on.

The Victorian Royal Commission into Family Violence (2016) found more broadly that people from CALD backgrounds without permanent residency can feel unable to leave an abusive relationship because doing so risks deportation, loss of custody of their children, or the withdrawal of a partner's sponsorship of their residency application,[26]a power imbalance that applies with particular force to decisions about whether to continue a pregnancy, access contraception, or leave a relationship once a child is born. Temporary partner and prospective marriage visa holders can continue a permanent visa application after a violent relationship ends, but many women remain unaware of this pathway, and fear of deportation remains a primary reason women stay in coercive relationships.[27] This is a societal-level structural harm in the UN sense: a formal legal system that, through its ordinary operation, hands one partner leverage over another's most fundamental reproductive decisions, whether to become pregnant, whether to continue a pregnancy, and whether she can safely leave once a child exists.

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[24] Agape Henry Crux (2025), 'Pregnancy, childbirth or shared children and partner visa', *Agape Henry Crux*, 20 November. https://www.ahclawyers.com/news-articles/25/11/20/pregnancy-childbirth-shared-children-affect-partner-visa

[25] Suha M, Murray L, Warr D et al. (2022), 'Reproductive coercion as a form of family violence against immigrant and refugee women in Australia', *PLOS ONE*, 17(11):e0275809. https://doi.org/10.1371/journal.pone.0275809

[26] State of Victoria (2016), *Royal Commission into Family Violence: Report and Recommendations*, Parl Paper No 132 (2014–16); discussed in Segrave M (2019), 'Australia's migration system fails victims of gendered violence', *Monash Lens*, 11 November. https://lens.monash.edu/how-australias-migration-system-is-failing-victims-of-gendered-violence/

[27] Wang AC and Kainth S (2022), 'Visa and cultural barriers trapping migrant women in abusive relationships', *SBS English*, updated 12 August. https://www.sbs.com.au/language/english/en/article/visa-and-cultural-barriers-trapping-migrant-women-in-abusive-relationships/4felfcwsl

Institutional level: Service and language gaps exploited by perpetrators

Immigrant and refugee women face additional structural barriers to reproductive healthcare compared with the general Australian population, including limited access to interpreters and services. Research on reproductive coercion among immigrant and refugee women found that perpetrators actively exploit these service gaps. For example, controlling a woman's access to interpreters or appointments, to undermine her reproductive choices.[28] The same body of research notes that women experiencing reproductive coercion are, somewhat counterintuitively, more likely than other women to seek reproductive healthcare, meaning health services are a critical, but currently under-used, point of contact for identifying and responding to this form of violence. Female genital mutilation/cutting (FGM/C) survivors face a related institutional gap: Australian clinical and policy responses have historically lacked sufficient specialist expertise and culturally safe maternity pathways for women with FGM/C, despite well-documented higher maternal and neonatal complication risks where that expertise is absent.[29]

Community level: Culturally specific forms of coercion

Some forms of reproductive violence experienced by CALD women are not well recognised by mainstream Australian services or law as family violence at all, including forced and early marriage, or dowry-related abuse. Forced marriage is now a specific offence under the Commonwealth Criminal Code, but researchers note there is still limited public understanding of the difference between forced and arranged marriage, and little reliable data on the prevalence or forms forced marriage takes in Australia.[30] Queensland data cited in that reporting found that more than one in five CALD women had experienced reproductive coercion, and three-quarters of those women also reported experiencing broader domestic violence at the same time, underscoring the framework's point that reproductive coercion rarely occurs in isolation from other forms of intimate partner violence.

Interpersonal level: Reproductive coercion by partners and extended family

For many migrant and refugee women, reproductive coercion is perpetrated not only by an intimate partner but by members of the extended family. An Australian study of immigrant and refugee

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[28] Suha et al. (2022); El-Murr A (2018), *Intimate partner violence in Australian refugee communities: Scoping review of issues and service responses*, CFCA Paper No. 50, Australian Institute of Family Studies. https://aifs.gov.au/resources/policy-and-practice-papers/intimate-partner-violence-australian-refugee-communities

[29] Varol N, Hall JJ, Black K, Turkmani S and Dawson A (2017), 'Evidence-based policy responses to strengthen health, community and legislative systems that care for women in Australia with female genital mutilation/cutting', *Reproductive Health*, 14:63. https://doi.org/10.1186/s12978-017-0324-3

[30] *Criminal Code Act 1995* (Cth), s 270.7B; Australasian Institute of Judicial Administration (n.d.), 'Forced marriage', *National Domestic and Family Violence Bench Book*. https://dfvbenchbook.aija.org.au/article/1080125; Australian Government (n.d.), 'Forced marriage', *Modern Slavery in Australia*. https://www.modernslavery.gov.au/about-modern-slavery/types-modern-slavery/forced-marriage; Monash University and inTouch Multicultural Centre Against Family Violence (2022), *Research brief: Forced marriage in Australia*, inTouch. https://intouch.org.au/wp-content/uploads/2022/11/MonashResearchBrief_ForcedMarriageInAustralia.pdf; Safe and Equal (n.d.), 'Forced marriage in the context of family violence', *Safe and Equal*. https://safeandequal.org.au/resources/forced-marriage-in-the-context-of-family-violence/

women who had experienced reproductive coercion documented violence during pregnancy intended to end it, contraceptive sabotage and sexual violence used to force a pregnancy, and forced abortion, with mothers-in-law and sisters-in-law in some cases arranging abortion appointments against a woman's wishes. Perpetrators also reached directly into women's healthcare: family members spoke to health professionals on the woman's behalf and misrepresented her English proficiency, undermining her ability to give or withhold informed consent to procedures.[31]

Practitioners working with South Asian communities identify pressure around gender selection and forced abortion as recurring forms of reproductive control. Because this pressure is often framed as a family, religious or cultural expectation rather than as abuse, it can be harder for both victim-survivors and services to recognise, and practitioners caution that behaviours which do not look "extreme" on their face can be just as corrosive over time.[32] Reproductive coercion also rarely stands alone. A 2022 report by inTouch Multicultural Centre Against Family Violence found that 92 per cent of perpetrators of family violence had used controlling behaviours,[33] and reproductive coercion is best understood as one strand of that wider pattern of coercive control. Responses therefore need to ask about reproductive coercion directly, including the role of in-laws and extended family, rather than assuming it will surface through general questions about partner violence.

Researchers working directly with refugee and migrant women caution against treating "culturally and linguistically diverse" as a single, homogenous category. Interviews with frontline workers found that domestic and family violence in these communities is often racialised and reflexively attributed to "culture" in ways that are not applied to Anglo-Australian women's experiences of the same behaviours, and that the CALD label itself can obscure real differences in ethnicity, faith, visa pathway, and migration history that shape both risk and the right response.[34] Any Australian reproductive violence framework should avoid replicating this flattening: forced marriage risk, FGM/C-related care needs, temporary-visa vulnerability, and English-language access are distinct issues requiring distinct, community-specific responses, even though they can be usefully grouped under the same conceptual framework.

Intersectionality: The compounding effect in Australia

The UN framework's intersectionality lens applies directly to Australia, where reproductive violence risk compounds across several axes:

- **Race and colonisation:** the fundamental structural driver for First Nations peoples, as discussed above.

[31] Suha et al. (2022).

[32] Wang and Kainth (2022).

[33] inTouch Multicultural Centre Against Family Violence (2022), as cited in Wang and Kainth (2022).

[34] Maturi J and Munro J (2022), 'Refugee and migrant women are often excluded from mainstream domestic violence services and policy', *The Conversation*, July. https://theconversation.com/refugee-and-migrant-women-are-often-excluded-from-mainstream-domestic-violence-services-and-policy-187164

- **Migration and visa status:** for CALD women, temporary or precarious visa status can be directly weaponised to control reproductive and family decisions in a way permanent residents and citizens do not face.
- **Disability:** First Nations women and girls with disability face the highest documented risk of coerced sterilisation; CALD women with disability face compounding language and cultural barriers on top of this.
- **Diverse gender and sexuality:** ART/IVF access is still limited.
- **Intersex women:** Forced medical procedures still occur to children.
- **Remoteness and geographic isolation:** for First Nations women, this converts routine maternity care into forced relocation; for some CALD women, particularly recently arrived refugees settled outside major cities, it compounds already-limited access to interpreters and culturally safe services.
- **Poverty and socioeconomic status:** underfunding of Aboriginal community-controlled family support services is a direct driver of child removal; economic dependence on a partner is a recurring driver of reproductive coercion among CALD women, especially where visa status limits independent work rights.
- **Age:** First Nations infants are removed at higher relative rates than the wider First Nations child population; forced marriage disproportionately affects younger women and girls in some CALD communities.
- **Language:** a distinct barrier for CALD women that has no direct equivalent in the First Nations context (though English-language health literacy and communication style mismatches affect some First Nations communities too), but which materially affects a woman's ability to disclose coercion, understand her rights, or access an interpreter independent of her partner or family.

These populations should not be merged into a single "vulnerable groups" category in policy or research design: the structural drivers, service history, and appropriate community partners differ substantially between First Nations communities and CALD communities, even where the reproductive-violence framework usefully applies to both.

The National Women's Health Strategy 2020–2030 provides a useful anchor for this approach. Most of the axes above correspond directly to its priority population groups, including First Nations women and girls; culturally and linguistically diverse women and girls; women and girls living with disability; members of LBTI communities; women and girls from rural and remote areas; women and girls from low socioeconomic backgrounds; pregnant women; and women and girls who experience violence or abuse. The Strategy also recognises that many women belong to more than one of these groups, with a compounding effect on health needs and outcomes, and that sub-groups within each priority population are not homogenous.[35] This aligns closely with the intersectional, community-specific approach argued for here. There is, however, a gap: although maternal, sexual and reproductive

[35] Department of Health (2018).

health is the Strategy's first priority area, it does not name reproductive coercion or reproductive violence.[36] Applying the reproductive-violence framework across the Strategy's priority populations would help close that gap, without collapsing those populations into a single category.

Intersectionality: The compounding effect in Australia

Below are some recommendations on adapting UN's 7 recommendations, with parallel actions for both populations:

1. **Adopt and refine the framework, relevant to and led by communities:** For First Nations peoples, this means leadership by Aboriginal and Torres Strait Islander women's health organisations, disability advocates (e.g. First Peoples Disability Network) and community-controlled health services. For CALD communities, this means multicultural women's health organisations (e.g. Multicultural Centre for Women's Health, inTouch Multicultural Centre Against Family Violence) and community-specific, faith-literate services, not a single generic "diversity" consultation covering both.
2. **Keep it contextualised:** One universal concept or definition across Australia will not be possible, because the definition needs to be contextually relevant. Reproductive violence in remote, rural and urban First Nations communities takes different forms from one another; equally, reproductive violence experienced by a recently arrived refugee on a temporary visa differs materially from that experienced by a longer-settled migrant with permanent residency. Enabling communities to adapt it to their contexts will make the concept and related prevention mechanisms more likely to be timely, effective, and sustainable.
3. **Build an Australian-specific baseline, and indicators of change:** Build on the National Women's Health Strategy's existing measures of success, which already include increased early access to antenatal services by First Nations women (Priority Area 1) and, in the Strategy's monitoring and reporting framework, a reduction in the rate of reproductive coercion (Priority Area 5). However, the framework's 2024 baseline report found insufficient data to measure reproductive coercion at all, and very limited disaggregation of women's health data by priority group status, including First Nations, CALD and disability status. New reproductive-violence indicators should be reported by priority population. This should include rates of coerced or unconsented sterilisation by Indigenous status and disability status; rates of birth "evacuation" and associated antenatal-care avoidance; prenatal and infant child-protection notifications and removals by Indigenous status; access to Birthing on Country and community-controlled maternity models; rates of reproductive coercion and forced marriage among CALD women by visa category; and interpreter access rates in sexual and reproductive health consultations.
4. **Evaluate what works for health:** Investing in Birthing on Country models for First Nations communities, and in specialist multicultural family violence and reproductive health services

[36] Department of Health (2018).

(including FGM/C-specialist maternity pathways) for CALD communities. Celebrate best practice models, share clinical guidelines and reproductive health literacy materials.

5. **Reform health law:** Including closing the legal gap that prevents voluntary sterilisation in disability contexts. Ensure any references to reproductive health are removed from State/Territory Criminal Codes.

6. **Reform health policy and regulations:** Reviewing and re-opening remote and rural maternity services, enabling universal access to reproductive healthcare for women in institutional care, including prisons and detention.

7. **Integrate services and care pathways:** Connecting maternal and reproductive healthcare with family-support and child-protection prevention services for First Nations families and ensuring independent (non-partner-arranged) interpreter access is standard practice in reproductive health settings for CALD women.

8. **Integrate GBV and SRH responses:** Position Aboriginal community-controlled health organisations and multicultural specialist services as first responders and system navigators for their respective communities, given the distinct trust. Remove out-of-pocket costs for all essential maternal healthcare. Ensure that all options for pelvic pain management, contraception and abortion care is available to metropolitan, regional and remote Australia.

9. **Addressing reproductive health inequities:** Requires removing legislative, regulatory, quality, cost and movement barriers to access reproductive healthcare. The National Women's Health Strategy 2020-2030 is positioned to do so, yet this needs to be actioned and measured in ways that can track and scale community-led models for reproductive violence prevention and response.

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About us

Australian Women's Health Alliance provides a national voice on women's health. We highlight how gender shapes experiences of health and health care, recognising that women's health is determined by social, cultural, environmental, and political factors.

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Suggested citation

Australian Women's Health Alliance, Shining a Light on Reproductive Violence: The Australian Context, Australian Women's Health Alliance 2026.

We acknowledge the Traditional Custodians of the lands and waters on which we live and work. We pay our respect to Elders past and present. Sovereignty has never been ceded.