Digital Health and Inclusion: A Literature Review of Migrant and Refugee Women's Access to Health Information in Australia

MULTICULTURAL
CENTRE FOR
WOMEN'S HEALTH

Acknowledgement of Country

This report was written on the land of the Wurundjeri people of the Kulin Nation, who have never ceded sovereignty. Migrant and refugee women's digital health equity is inextricably connected to, and cannot precede, First Nations Peoples' digital health equity and digital health sovereignty. The report authors pay our respect to First Nations Elders and health advocates past and present. We hope our report contributes to understanding digital heath equity for all.

About this Report

Building on the findings of the *Australian Digital Inclusion Index* (ADII), this report was commissioned by the Multicultural Centre for Women's Health (MCWH) in 2024 to review and synthesise current evidence on how migrant and refugee women use digital technologies to access health information in Australia, and to identify key barriers to their digital inclusion.

The report presents a desktop literature review of peer-reviewed and grey literature published between 2014 and 2024, drawing together national and international evidence on digital health access, literacy, and equity.

While grounded in academic research, the report aims to be accessible to the public and to practitioners across the health, digital inclusion, and community sectors. It highlights how digital inequities intersect with gender, language, migration experience, and socioeconomic status to shape migrant and refugee women's digital participation and health outcomes and offers practical insights to guide more inclusive digital health strategies.

A note on language used in the report

MCWH and this report aims to promote the health and wellbeing of all people who are impacted by the intersections of racial discrimination, gender inequality and the migration system in Australia, including migrant and refugee non-binary, gender diverse and trans people.

The research cited in this report often rests on an assumption that women are cisgendered. Consequently, the literature review on which this report is based predominantly reflects the experiences of cis migrant and refugee women. It does not reflect the specific experiences or barriers for non-binary, gender diverse and trans migrant and refugee people living in Australia.

The term 'migrant and refugee' is used throughout the report to describe people living in Australia who were born overseas or whose parent(s) or grandparent(s) were born overseas in a predominantly non-English speaking or non-Western country.

Original report prepared by Dr Jasmin Chen for MCWH in March 2025. With thanks to Delaram Ansari, Catalina Labra Odde, Dr Maria Hach and Dr Adele Murdolo for their review and feedback.

Recommended citation: Chen, J. (2026). Digital Health and Inclusion: A Literature Review of Migrant and Refugee Women's Access to Health Information in Australia. Multicultural Centre for Women's Health.

Summary of Key Barriers to Digital Inclusion for Migrant Women

Digital Access Barriers – Affordability and Availability

- **Affordability:** Migrant women experiencing financial hardship or instability may find the costs of digital access unaffordable. Costs can include purchasing, repairing and updating digital devices, and maintaining phone plans or internet connections.
- **Living in regional or remote areas:** Women living in regional or remote areas have fewer opportunities to access stable internet, affordable devices, and develop digital health skills.
- **Access to internet connection:** Women dependent on public Wi-Fi, mobile-only data, or unreliable internet connections experience restricted access, reduced privacy, and higher costs. It is currently optional for aged care providers to supply internet access to residents.
- **Access to digital devices:** Women who rely on mobile phones or public computers to access health information and services face significant privacy, security, and accessibility challenges.

Barriers related to languages and learning – Multiple literacies to consider

- **Health literacy:**
  Women who are new to the Australian health system, unfamiliar with medical terminology, or who have had limited education about human health and wellbeing face challenges in seeking, understanding, and acting on health information.
- **Digital literacy:**
  Women with limited exposure to digital devices or few opportunities for hands-on learning often lack the confidence or experience needed to navigate digital systems. Digital literacy is strongly influenced by education level, age, and generational experience.
- **Language literacy:**
  Women who do not read or write in their main spoken language face considerable barriers when searching for or interpreting health information online. This is particularly common among older women and those who have experienced disrupted education due to displacement or humanitarian migration.
- **English literacy:**
  Women with limited or no ability to read or write in English encounter significant obstacles to digital participation. Access to English language education and ESL classes varies widely and is shaped by visa status, income, caring responsibilities, and location.

Other social and systemic barriers

- **Trust and safety concerns:** Concerns about privacy, data security, and online safety influence women's willingness to use digital technologies, shaping how and whether they engage with online health resources.
- **Health and disability:** Physical or mental health conditions and disability can limit digital engagement, particularly when online content or interfaces are inaccessibly designed.
- **Age and generation:** Age strongly predicts digital literacy. Older women are more likely to experience exclusion from digital technologies, though many are highly motivated to learn. Younger people tend to be more digitally confident and are often expected to support older family or community members in using technology.

- **Gendered norms and migration experiences:** Narrowly defined gender roles and expectations, caregiving responsibilities, and the long-term impact of migration or displacement can restrict women's opportunities to access, learn, and use digital technologies, contributing to gendered patterns of exclusion.

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Purpose

The purpose of this report is to review current literature and synthesise existing evidence about migrant and refugee women's use of digital technologies to access health information, addressing three questions:

1. How do migrant and refugee women use digital technologies to access health information?
2. How does digital health literacy vary based on factors such as age, country of birth, languages spoken, time in Australia, and visa or citizenship status?
3. What are the key barriers to digital health access and equity for these women?

The review of literature focused primarily on Australian studies but includes relevant international literature that sheds light on comparable experiences in other high-income, multicultural contexts. Articles on health literacy and digital literacy were considered if they addressed digital health access or health-seeking behaviour, and some studies on equity issues were included even if they did not explicitly reference migrant and refugee women. Both academic and grey literature were included, recognising the key role of community organisations, digital inclusion advocates, and public agencies in shaping digital health research and practice.

Background

Why digital health equity matters

Digital technologies have become integral to how Australians access, manage, and understand their health. From booking a GP appointment to managing prescriptions or seeking trusted health information online, digital tools now shape almost every aspect of our health and wellbeing.

However, not everyone benefits equally from this digital transformation. The COVID-19 pandemic and other recent events have foregrounded the deep inequities in access to digital health information and services, particularly for older people, people living in regional and remote areas, with limited access to devices or internet, low digital confidence or limited English or health literacy (Altun et al., 2025; ADHA, 2023; Thomas et al., 2023; MCWH & GENVIC, 2021; Good Things Foundation Australia, 2021). For migrant and refugee women, these barriers are often compounded by gendered norms, social isolation and systemic barriers within both the migration and health systems.

Digital inclusion—the ability to access and use digital technologies effectively—is increasingly recognised as a social determinant of health. The *National Digital Health Strategy 2023–2028* warns that gaps in digital access 'can exacerbate gaps in health outcomes and further entrench disadvantage' (Australian Digital Health Agency, 2023). Similarly, the *National Preventive Health Strategy 2021-2030*, stresses that it is 'essential that digital inclusion is equally distributed across all social and economic groups to ensure that advances in digital health technology do not exacerbate the equity divide' (Australian Department of Health, 2021).

The World Health Organization's *Global Strategy on Digital Health 2020-2025* also identifies digital health as 'an essential enabling factor in reaching its Sustainable Development Goals' (WHO, 2021). Yet stark globally inequalities persist. Only 27 percent of people use the internet

in low income countries compared with 93 percent in high income countries (International Telecommunication Union, 2023), and gendered inequality in access to and use of digital tools remains widespread (Gender Digital Divide Index Report, 2022).

For migrant and refugee women in Australia today, these global patterns of inequity set the context within which local and social factors—such as education, age, income, places of residence, migration experiences, employment and overseas connections—shape their access to and experience of digital health.

Digital health literacy—defined broadly as 'how people understand, access, and use health information to promote and maintain good health online' (MCWH, 2022)—is critical to digital health access and equity. However, it is rarely acknowledged that digital health literacy comprises multiple, distinct yet overlapping forms of literacy: digital literacy, health literacy, English language literacy, and, in many cases, literacy in one's language spoken at home. These forms of knowledge are often treated as interchangeable and are rarely differentiated, despite each playing a distinct role in shaping how individuals access, navigate, and interpret online health information.

A more nuanced understanding of digital health literacy, access and equity is needed. These inequities are shaped not only by differences in access and literacy, but increasingly by the digital platforms and infrastructure through which health information is mediated and delivered. While it is beyond the scope of this report, an expanded understanding of digital health equity would need to examine global markets, corporate ownership and distribution of technologies, data sovereignty and the environmental and social impacts of digital technologies on health.

Australia's digital health landscape

'Digital health' describes 'the development and use of digital health technologies to improve health' (WHO, 2021, p.11) including:

- mHealth (mobile apps, SMS reminders)
- wearable devices (fitness trackers, glucose monitors) and other 'smart objects' (which make up a network of connected devices described as 'the Internet of Things.'
- telehealth and telemedicine
- personalised medicine (genetic-based treatments)
- robotics and artificial intelligence
- electronic health records
- big data analytics
- information and communication technologies used for health research and education

(AIHW, 2024; WHO , 2021)

The extent to which digital technologies are now integrated in every aspect of our health, is evident in Australia's *Digital Health Blueprint 2023-2033*, which defines digital health simply as 'health and wellbeing in an increasingly digital world' (DOH, 2023).[1] However, the focus of national strategies is more often technological innovation than health equity. The *National*

[1] See Rowlands' white paper, *What is digital health and why does it matter?* (2019), which argues that 'digital health' is not interchangeable with previous terms like 'health IT' or 'eHealth' but is a new and evolutionary step in thinking about health.

Digital Health Strategy 2023–2028 says little about the role digital technologies play in preventative health, health literacy or health system navigation, and makes limited reference to how the government plans to address inequity in digital health access.[2] While the *National Preventative Health Strategy* makes explicit the extent to which digital inclusion is a determinant of health (See DOH, 2021, p. 20), it offers little detail on strategies to improve digital health literacy and access for priority populations, such as migrant and refugee women.

None of these national strategies mention the corporate ownership of, or interests driving the technologies, platforms and digital tools that have become so essential to our health and wellbeing.

Migrant and refugee women's digital inclusion in Australia

Digital inclusion—the ability to access, afford, and confidently use digital technologies—is fundamental to digital health literacy and, by extension, equitable access to healthcare. For migrant and refugee women, digital inclusion is both a prerequisite for participating in digital health and a reflection of broader social inequalities.

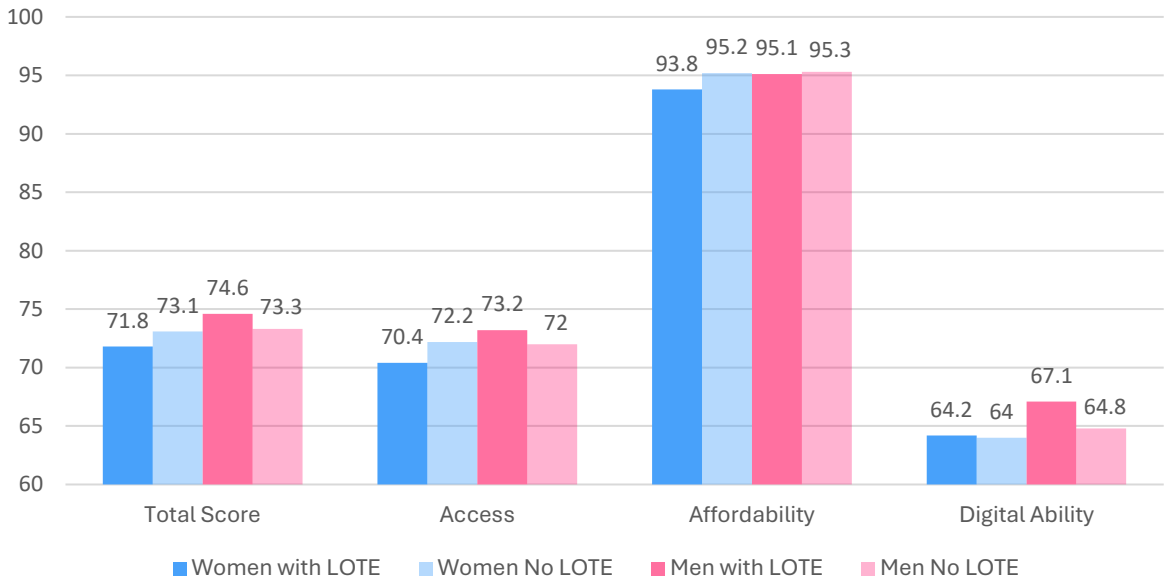
According to the *Australian Digital Inclusion Index* (ADII), in 2022, women in Australia who spoke a language other than English were 'digitally included', despite scoring 1.4 points below the national average (ADII Data Dashboard, 2023). However, many other groups were identified as 'digitally excluded', including people over 75 (24.6 points below the national average), low-income earners (18.4 points below the national average), and those with lower education levels, disabilities, or living in public housing (ADII, 2023). ADII data does not currently allow analysis across multiple categories, limiting insights into how migrant women are represented within these highly excluded groups. However, across Australia, women who spoke a language other than English at home consistently recorded lower digital access, affordability and ability than both 'only English' speaking women and men who spoke a language other than English, who were the most digitally included group (see Fig 1).

While valuable, ADII data is limited for understanding migrant and refugee women's digital access. The survey does not collect information on country of birth, length of stay in Australia, or visa status, and is conducted in English, which excludes many migrants and refugees with limited English proficiency (Wilson, Thomas, & Barraket; The Social Research Centre, 2023). A supplementary ADII survey of recently arrived migrants in Shepparton was conducted in 2019 and provides a more complex picture of digital inclusion. It found respondents had above-average digital access and ability scores but below-average affordability—spending 3.83 percent of household income on internet access compared to the national average of 1.18 percent. The same survey found that 39 percent of respondents had limited or no English literacy, and 27 percent could not read in any language (Thomas, et al., 2019).

Baganz et al. (2023) also found consistently high levels of internet access across surveyed refugee households during the COVID-19 pandemic (95% in 2020 and 98% in 2021), but noted gender and age differences in knowing how to access essential welfare and social services online—over 50 percent of women over 55 stated 'that they would not know how to find help online' for government services like MyGov, Medicare or TAFE (p.13).

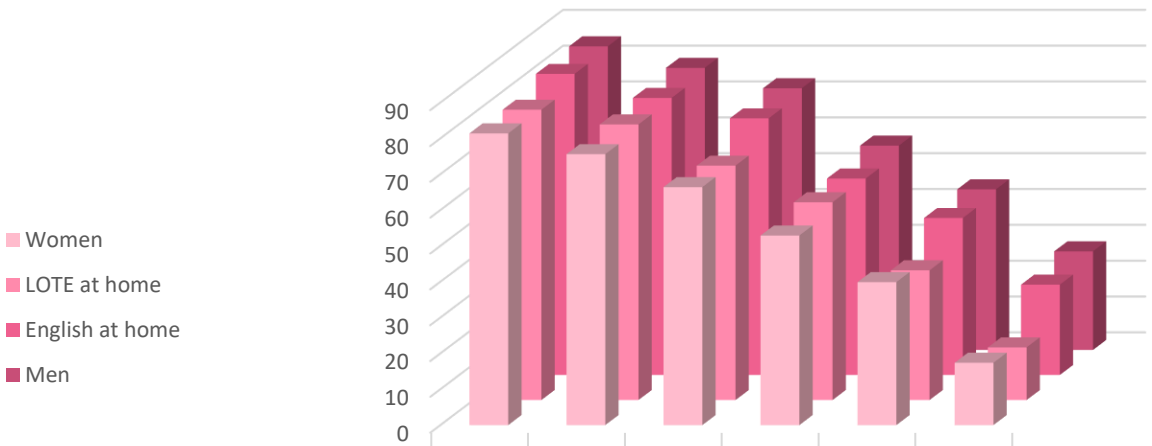
[2] The *Digital Health Blueprint* says it aims to 'support a wide range of research, including into improving health literacy, particularly for socioeconomically and culturally diverse communities' (DOH, 2023).

Fig 1 Comparison of 2023 ADII digital inclusion scores between women and men who spoke a language other than English (LOTE) at home or not



Note: A score of between 61 and below 80 is considered digitally included.

Fig 2 Comparison of Australian Digital Inclusion Index (ADII) scores for reported digital ability by age group in 2022



	18-34	35-44	45-54	55-64	65-74	75+
Women	81.4	75.6	66.4	52.9	39.9	17.4
LOTE at home	81	76.9	65.4	55.2	36.2	14.7
English at home	84	77.3	71.6	54.8	43.8	25.2
Men	84.7	78.7	73	57	44.8	27.5

Age and generational differences [3]

Age is one of the most significant determinants of digital literacy more broadly, with pronounced generational differences. Data from the ADII show that in 2022, people who spoke a language other than English at home aged between 18-44 years ranked 16.2 points above the national average for digital ability, while those aged 65-74 years ranked 28.7 points below (ADII, 2023).

These age-related patterns of disadvantage persist across all ADII population sub-groups and are strongly gendered (see Fig 2). While young women (18-34) and young people who speak a language other than English at home have similarly high digital ability, they are comparatively lower than young men and young people who speak English at home, respectively. By contrast, women over 75 have a digital ability score of 17.4, compared to a national average of 64.9, and people over 75 who speak a language other than English at home score even lower, at 14.7 (ADII, 2023).

This digital ability divide may reflect multiple factors, including the rapid rise of digital technology, gendered stereotypes and opportunities for digital training and education (Ortiz Cobo & Jeri Levano, 2023). Evidence suggests that family support can help bridge the knowledge gap (Baldassar et al., 2023). According to ADII data, households with children are the most digitally included household type, whereas those living alone are comparatively much less digitally included (ADII, 2023).

Worrell (2021) observes that, because of their familiarity with digital technology, younger migrants are often positioned as 'digital brokers', who are responsible for helping older generations to navigate digital spaces. Similarly, an MCWH study found that during the COVID-19 pandemic, older adult migrant women reported that they relied on their adult children for access to health information (MCWH 2024a). These intergenerational relationships of dependence have important implications for privacy, consent, and recognising young migrants' often unseen digital labour and leadership in families and communities (MCWH, 2024a).

Taken together, these studies highlight the need for more nuanced, intersectional analyses of migrant and refugee women's digital inclusion, and for improved national data collection methods that capture the specific barriers and enablers shaping their access to health information and services in Australia. Moreover, they point to importance of health programs and services understanding how this inequality impacts public health initiatives and health promotion reach.

Literature review

Methodology

A structured literature search was conducted between June and August 2024 using Google Scholar to identify peer-reviewed and grey literature on migrant and refugee women's digital health access. Keywords included 'migrant women', 'refugee women', 'culturally and linguistically diverse women', 'digital technologies', 'health information', 'online access',

[3] Some commentators and researchers use the analogy of migration to describe the gulf in experience between the generations that grew up with digital technology ('digital natives') and those who did not ('digital immigrants'). Apart from creating unnecessary confusion in the context of this report, these terms are potentially reductive and unhelpful. See, for example, Tsatsou, 2022, p. 1476.

'digital inclusion/exclusion', and 'Australia'. In addition, a specific search for relevant systematic reviews was undertaken to contextualise and cross-reference findings.

Flow:	440 records → 158 duplicates removed → 282 screened → 198 full text reviewed → 98 included (plus 26 grey literature).
Exclusions:	pre-2014, non-English, unrelated to health/digital.
Limitations:	single database, English-only, short timeframe; future work should add terms like eHealth, app names/platforms, and include multi-database searches.

Results

This report identified 13 studies with a specific or substantial focus on the digital health experiences of migrant and refugee women living in Australia (see Appendix 1). Studies varied widely in topic, participant size, participant ethnicities, location and methodology, limiting the ability to draw generalisable conclusions. An additional 28 journal articles included findings that contributed to understanding migrant and refugee women's digital health equity, including 14 systematic reviews or similar (see Appendix 2).

Grey literature from government and community organisations also provided significant insight into digital health barriers and experiences in Australia. Key sources included the *Australian Digital Inclusion Index* (ADII) and reports from both government and non-government organisations, which helped contextualise the challenges that migrant and refugee women face in accessing digital health resources.

Limitations

The findings presented here are limited by the availability and scope of existing research, as well as the limited timeframe in which the review was conducted. Moreover, the review excluded non-English language papers, which may be highly relevant to this research topic.

Despite these limitations, the body of literature analysed provides valuable insights into how digital inequities shape health experiences and outcomes for migrant and refugee women in Australia. Given additional resources, a more comprehensive search across multiple databases, that include additional terms like eHealth, mHealth, Facebook, mobile apps, ICT and WhatsApp could yield further findings.

Findings

How migrant and refugee women use digital technologies to access health information

This review identified several studies examining migrant and refugee women's use of digital technologies to seek health information (Griffin et al., 2022; ADII, 2023; Potocky, 2021; Baganz et al., 2023; Lau, 2024). While topics, methods, and sample sizes varied, research consistently shows that migrant and refugee women access health information in diverse ways, including online searches, social media, forums, YouTube, appointment scheduling, and telehealth (Griffin et al., 2022; ADII, 2023; Gong & Bharj, 2022).

The following sections summarise key themes identified in the literature, including online health information search methods; social media use and transnational influences; participation in online health education; mobile health app use; mental health and social connection, and; other online preferences noted in the literature.

Online health information search methods

Literature consistently found that migrant and refugee women frequently rely on search engines, particularly Google, to find health information for themselves and their families (Jawad et al. 2023; Jawad, 2024; Perrenoud et al., 2023; Lang et al., 2020). In a survey of parents of young children and pregnant women living in Australia, Jawad et al. (2023) found those who were born in a non-English speaking country or spoke a language other than English at home were more likely to use search engines to find health information "very frequently" than those from an English-speaking background (39.3 % vs 24.1%). They were also more likely to search websites using keywords (63.1% vs 50.4%). However, the literature provided very little detail on the specific types of websites that migrant women were accessing for health information. Moreover, as the authors noted, all survey participants were required to read and write English and have access to the internet to participate.

A 2017 report from the Centre for Multicultural Youth found that young migrant women were slightly more likely (69%) than young men (61%) to regularly search for health information online, with longer residence in Australia positively influencing internet use (Edmee, 2017). However, the type of health information they were seeking online was more likely to be advice from friends and acquaintances, than from services or formal online health resources.

Social media use and content preferences

Many studies reported that some migrant and refugee women use social media platforms as a source of health information including WeChat (known as Weixin in China), Facebook, WhatsApp, Instagram, Twitter, TikTok and YouTube. However, data on how, why, or when they use these platforms is both extremely limited and highly varied (Lang et al., 2020; Goldsmith et al., 2022; Jawad et al., 2023; Perrenoud et al., 2023; Cheong, 2024; Jawad, 2024).

Social and transnational influences

Digital health information-seeking behaviours can be shaped by localised social and linguistic contexts, but generalisations across communities are difficult. Some studies highlight that transnational ties and pre-migration experiences using technology and healthcare systems can

shape how migrant and refugee women engage with digital tools in Australia (Georgeou et al., 2023, Zysset et al., 2023). For example, WeChat is a widely used social media platform in China, used by many Chinese migrants to share and access information in Chinese, including recommendations for local Chinese doctors (Zysset et al., 2023). Marketing of specific digital technologies towards ethno-specific audiences and levels of access to digital technologies in countries of origin are also likely to influence women and gender diverse people's digital health engagement, yet few studies address this in detail. However, even within language groups or specific digital communities, how individuals seek health information is deeply interwoven with their education, age, and many other factors which also require further research.

Online health education

Two studies that specifically explored migrant and refugee women's engagement with online health education programs suggest they can increase health literacy (Power et al. 2022; Cheong et al. 2024). However, online health promotion sessions were found to have both advantages and disadvantages in comparison with in-person education. Positive aspects for participants included ease of use, women being able to access information from their own home, and online education mirroring a face-to-face experience. Negative aspects included the online experience lacking emotion (Power et al. 2022).

Mobile health app use

Although a few studies examined the use of mobile phone applications or 'mHealth' among migrant and refugee women (Bartlett et al., 2022; Buchanan et al, 2021; Hughson et al., 2018), the extent to which migrant and refugee women use, or benefit from them remains uncertain. Bartlett et al. (2022) found that, although many women own smartphones, barriers around affordability and digital literacy persist. These factors may explain the finding that women with lower incomes and from non-English-speaking backgrounds have lower usage rates for pregnancy apps (Buchanan et al., 2021; Hughson et al., 2018).

Mental health

A number of studies explored the potential of digital technology to improve access to mental health information and services (Tran et al., 2023; Baker et al., 2016; Sullivan et al., 2020; Liem, 2021; Ayobi et al., Kayrouz et al., 2020; 2022; Potocky, 2021), but this review found very little information about migrant and refugee women's experiences. In one study, migrant women reported using overseas counselling services online and found it complex to search online for mental health information (Tran et al., 2023).

Social connection

Many studies mention potential health benefits for migrants and refugees using technology, particularly social media, as an inexpensive and reliable form of social connection, especially older individuals who are more likely to experience social isolation (Georgeou et al., 2023; Millard et al., 2018; Panagiotopoulos et al., 2013; Walker et al., 2013; Wilding et al., 2020; Ayobi et al., 2022).

Research suggests that digital literacy can play a critical role in reducing loneliness, depression, and dependence on family (Caidi et al., 2020; Millard et al., 2018; Wilding et al., 2020). However, excessive use of social media can sometimes heighten feelings of

homesickness and social isolation (Caidi et al., 2020). Given the growing evidence connecting social inclusion with health, online relationships and support networks may play a role in shaping migrant and refugee women's digital health literacy and are an important consideration for migrant and refugee women's health more generally (Millard et al., 2018; Nguyen et al., 2022).

Other online health information preferences

Migrant and refugee women's preferences for online health information was found to vary based on factors such as education, English language confidence, community size, and age (Jawad, 2024; Perrenoud et al., 2023). Studies highlight significant differences in platform use and content format preferences across linguistic and cultural groups.

Studies on young people's health information-seeking behaviour highlight a strong reliance on digital sources, particularly for sensitive topics. For example, a study on contraception decision-making among CALD youth in Australia found that many relied more on online resources than in-person sources and trusted these more than peer advice (Mpofu et al., 2021). Similarly, a study of 27 migrant and refugee young people in Sydney found that online sources—especially Google, Reddit, YouTube, and private Facebook groups—were the primary means of learning about sex, sexuality, and sexual health (Botfield et al., 2018). Participants valued the anonymity of online platforms but also expressed concerns about the reliability of the information available, indicating a critical awareness of digital content.

The limited available findings also indicate the broad range of variables involved in digital preferences, including:

- **Platform use:** Mongolian-speaking mothers predominantly used Facebook parents' groups, preferring written information, books, or podcasts, whereas Arabic-speaking women were less likely to engage in online forums and preferred visual formats, such as Arabic-language videos created by doctors (Jawad, 2024; Perrenoud et al., 2023). Younger women with less education were more inclined toward YouTube and video content.
- **Content format preferences:** Across groups, many women expressed a preference for short, clear, summarised information (Jawad, 2024).
- **Generational and educational differences:** Wilding et al. (2022) found older, highly educated Sinhalese migrants had strong digital literacy, regularly using Facebook, WhatsApp, Viber, and YouTube. In contrast, older Karen migrants, despite low formal education levels, engaged actively with social media and video content, but relied heavily on younger family members (Wilding et al., 2022).
- **Content delivery:** In a cross-sectional survey of 122 CALD and 399 non-CALD parents and pregnant women, CALD respondents were significantly more likely to favour videos (48.4%) over written attachments (33.3%), whereas non-CALD respondents preferred written materials (Jawad et al., 2023).
- **Search and convenience:** Zysset et al. (2023) found information accessibility and convenience influenced digital health-seeking choices, with searchers selecting sources based on their digital skills and the availability of trusted personal or online sources.

Summary of findings

The literature suggests that digital health information-seeking behaviours among migrant and refugee women can vary widely based on health topic, education level and access to devices. Taken together, these findings point to the need for diverse, culturally tailored digital health resources, ensuring information is available in multiple formats that align with different educational, linguistic, and generational preferences.

However, the small sample sizes and specificity of many of these studies limits the extent to which these insights can be generalised for specific communities or for migrant and refugee women in Australia more broadly. Most studies provide limited detail on the specific technologies, languages and apps being used, and rarely evaluate the quality of the health information that women access (Radu et al., 2023). The findings that are available are further constrained by the rapid evolution and diversification of online platforms and modes of delivery.

Notably, this report found limited discussion of the predominantly corporate ownership of online platforms, or the influence of market forces on users' health information-seeking practices. While the literature highlighted migrant and refugee women's resourcefulness and criticality in seeking information, the potential for profit-driven platforms to influence the content that all users find was entirely unexplored and has wide ranging implications, not only for online preferences, but for migrant and refugee women's privacy and security.

Barriers to digital health access and equity

The ADII identifies key factors contributing to digital exclusion, including reliance on mobile-only internet, financial stress, regional or remote location, lack of broadband infrastructure, low literacy, and lower education levels (ADII, 2024b). Additional research highlights affordability, access to devices, digital literacy and health literacy, as well as barriers related to culturally and linguistically appropriate language and content design, physical and mental health, and trust and security concerns (Altun et al., 2025; SCA & Good Things Foundation, 2020; Whitehead et al., 2023).

Cost and financial stress

Cost is a significant barrier for many migrants and refugees, particularly young people and older adults, despite relatively high ADII national affordability rankings for people who speak a language other than English at home (ADII, 2024; Thomas, et al., 2019; Tran et al., 2023; Harris et al., 2023; SCA, 2020; Edmee, 2017). Financial hardship, precarious employment, and reliance on low-paid work contribute to digital unaffordability (Tran et al., 2023). Expenses extend beyond devices and internet plans to include repairs, software and app subscriptions, mobile-data, data storage and electricity. People who speak a language other than English at home who are over the age of 65 also face financial challenges.

Limited access to devices and infrastructure

Affordability constraints and uneven infrastructure shape how migrant and refugee communities connect. Several studies show that young migrants and refugees, especially young women, are reliant on predominantly mobile-only internet access, depend on shared and/or public devices, and have limited access to desktops or laptops (Harris et al., 2023; SCA,

2020; Edmee, 2017). In addition to sharing devices with family members, young people also reported a lack of private study or browsing spaces (Harris et al., 2023).

Mobile-only internet access is linked to lower digital inclusion in Australia, due to higher data costs, limited functionality for complex tasks, and unreliable networks (ADII 2022). According to ADII data, the proportion of Australians with predominantly mobile-only connection rose in 2022 and is higher in in remote areas (32.6%), and among First Nations people (21.3%) and low-income households (20.7%). Household composition was also seen to play a role, with those living alone or in share-housing being significantly more likely to be mobile-only (ADII, 2022).

Baldassar et al. (2023) highlight that Wi-Fi access is an optional extra in residential aged care under current government standards, underscoring the need for improved access and digital literacy support for older migrants and refugees, particularly those who live alone or in aged care (Baldassar et al., 2023; OMI, 2020).

Regional and remote inequity

It is well established that people living in regional and remote regions, including migrant and refugee women, face unequal access to health services and digital inclusion. This inequity is attributed to multiple and overlapping factors, including the cost and lack of infrastructure across dispersed and remote areas, lower socio-economic status of regional residents, 'lower educational levels, higher median ages, higher indigenous population, higher unemployment rate, and proportionately larger primary industry sectors' (Park, 2017, p. 404; Cheng et al., 2021). Park (2017) also notes that because of the social network effects of many sharing platforms, the lower uptake of digital services in these areas can reinforce digital exclusion.

English language proficiency

The literature consistently identifies limited English proficiency as a significant barrier to digital literacy, and digital health access (Stanzel et al., 2020; Griffin et al., 2022; Shaw et al., 2018; Zhang et al., 2023). For example, a 2023 study of a major health service in Queensland found that people requiring interpreters were 66 percent less likely to use telehealth services (Gallegos-Rejas, et al., 2023). Other studies have found English language proficiency to be a predictor of digital health literacy (Zhang et al., 2023). Language has been identified as a significant barrier for many older migrants and refugees, who consequently struggle to navigate online services (Georgeou et al., 2023; MCWH, 2024), and in some cases may have limited literacy in any language (Karidakis et al., 2022).

Lack of culturally and linguistically appropriate content and design

Although language is consistently identified as a barrier to digital health access (Bartlett et al., 2020; Gong & Bharj, 2022; Lau et al., 2024; Zhang et al., 2023; Stanzel et al., 2020; Griffin et al., 2022; Shaw et al., 2018), few studies examined migrant and refugee women's specific language preferences when searching for health information online. Lau et al. (2024) found that women commonly search in their first language. Gong & Bharj (2022) similarly reported that women rely on first-language resources unless they are confident English users.

More broadly, research on the accessibility of Australian health websites shows that health information remains difficult to find, search, read, and use for migrant and refugee women and those with low health literacy (Bandyopadhyay et al., 2022). This reinforces the importance of

in-language functionality—including search, navigation, and browsing options—in addition to in-language health resources themselves.

In addition to health information, Tran et al. (2023) caution that digital health infrastructure—such as online booking systems and patient portals—may inadvertently increase barriers and undermine agency for women with limited digital literacy or English proficiency if not designed with accessibility in mind. If these systems are not inclusive, they can deepen inequities in access to preventative and early-intervention care (Tran et al., 2023). For example, a 2023 study found that individuals requiring interpreter services were 66 percent less likely to use telehealth compared to English speakers, and preferred telephone consultations over videoconferencing (Gallegos-Rejas et al., 2023).

Disability and health

This review did not find research specific to migrant and refugee women with disabilities in Australia, which indicates a significant evidence gap that needs to be urgently addressed.

The review indicated that poor physical or mental health can further limit digital engagement. In their study of Chinese migrants in Sydney, Zhang et al. (2023) noted a correlation between poorer self-reported health status and digital health literacy. This finding is supported by a study of older Russian-speaking migrants in Finland that found depressive symptoms and poor health were linked to lower use of digital technologies, including smartphones and social media (Kouvonen et al., 2021).

Education

Several studies observe differences in the digital health literacy and preferences based on levels of education. Lower education levels are strongly associated with lower digital literacy and digital health access (Stanzel et al., 2020; Griffin et al., 2022; Shaw et al., 2018; Zhang et al., 2023). Moreover, some studies identified differences in health seeking behaviours based on level of education.

Impacts of migration and displacement

Migration experiences, particularly for people who experience forced migration, can significantly and negatively impact their digital health literacy and access. Refugee communities face multiple barriers to becoming digitally literate, including having a disrupted or low level of education, lack of access to digital devices, low English language proficiency for those from non-English speaking backgrounds, and for some, being illiterate in their country of origin, especially for older migrants (Healey, et al., 2022; Motevali et al., 2024). Healey et al. (2022) note that the cognitive and mental impacts of forced migration hinder many refugees' ability to process, learn or retain new information, including digital literacy skills. They also identify trust as a key theme in accessing digital information (Healey, et al., 2022).

Structural constraints within settlement systems can exacerbate these barriers. For example, the Settlement Council of Australia criticised the provision of 'one mobile phone for a family and no other devices such as laptops or computers' in the Basic Household Goods Package, provided as part of Australia's current Humanitarian Settlement Program (SCA & Good Things Foundation, 2020), noting that this can lead to women being dependent on their partner and lacking independent means to communicate, which is 'particularly problematic in abusive relationships' (p. 18). However, Motevali et al. (2024) found that refugee women 'who own

digital devices, such as smartphones, often still depend on their husbands or children to assist them with various tasks, including understanding English text messages' (Motevali et al., 2024, p. 116). Their study suggests that the lack of personal devices are not the only factor to consider, and that gender also plays a role. Berardi et al. (2022) also note that subsidised telehealth services remain unavailable to temporary visa holders due to Medicare restrictions.

Age

Research on older migrants' digital health literacy rarely explores gender directly. However, there is broad agreement that digital technology is increasingly vital for older migrants' access to healthcare (Georgeou et al., 2023; MCWH, 2024b; Ekoh et al., 2023; Millard et al., 2018; Baldassar et al., 2023; Nguyen et al., 2022). Studies suggest that older migrant and refugees use digital tools for a wide range of health-related and health supporting functions but face obstacles such as limited digital literacy, language barriers, access issues, health issues, and limited support (Georgeou et al., 2023; MCWH, 2024b; Ekoh et al., 2023; Millard et al., 2018; Baldassar et al., 2023; Nguyen et al., 2022, Buchert et al., 2023).

Despite these challenges, studies suggest that older migrants are often more motivated to build digital skills than their non-migrant peers (Nguyen et al., 2022; Wilding et al., 2022), often driven by the desire to stay connected to family transnationally (ADII, 2021). These findings challenge dominant narratives of older migrants as lacking agency or interest in using digital technologies (Nguyen et al., 2022; Wilding et al., 2022; Baldassar et al., 2023; Gamage, 2023).

Gendered norms and expectations

Gender plays a significant role in digital inclusion globally, particularly in low-income countries (ITU, 2024)[4]. Yet few studies identify differences in digital skills among migrant men and women (Zhang et al., 2023).

In Australia, women from CALD backgrounds report lower digital skills than men and reduced ability to connect with family and access news (Baganz et al., 2023). Some studies suggest women's digital participation may be impacted by the need to prioritise domestic duties over personal development and encountering barriers such as lack of safe public internet spaces which can lead to a cumulative disadvantage, limiting opportunities to build digital literacy and confidence (Goodman et al., 2020; Singh, 2017, Edmee, 2017). Conversely, other research suggests that digital responsibilities often fall on women, reinforcing traditional gendered caregiving roles (Wilding et al., 2022, Ortiz Cobo & Jeri Levano, 2023). Caluya, Bororica & Yue (2018) found that young men were often seen as the digital expert within households and were more likely to look online for help in using digital technology, while young women were more likely to seek support to use digital technology from parents, family members, or teachers.

This report found very little research on gender-diverse migrant and refugee communities, though some studies suggest digital health tools may provide LGBTQI+ migrants greater privacy and protection from discrimination (Yarwood, 2022; McCulloch et al., 2023).

[4] For more on digital gender disparity globally, refer to the International Telecommunication Union (ITU), the UN agency for digital technologies, and the Gender Divide Digital Index.

Trust, privacy and safety concerns

Discussions of trust in the literature are multifaceted and include migrant and refugee women's confidence in digital technologies, platforms, information sources, as well as trust in their personal or community networks and in their privacy and online safety (Hwahng et al., 2021; Ayobi et al., 2022). Karidakis et al. (2021) also identify a distinction between interpersonal trust (e.g., family, friends) and institutional trust (e.g., governments, health systems).

The literature found that concerns about the reliability of online health information were common, especially among refugees (Alencar, 2020), young people (Harris et al., 2023; Botfield et al., 2018), and on social media (Heaperman & Andrews, 2020; Liem et al., 2021; Perrenoud et al., 2023; Edmee, 2017; Jawad, 2023). For example, Heaperman & Andrews (2020) found that conflicting advice and fear of judgment in online parent groups reduced trust in both content and platforms.

Beyond health information sourced through group chats, Zhang et al. (2023) note that the quality of online health information in general is largely unregulated. Hughson et al. (2018) further note that the commercial interests of many app developers and lack of regulation makes it very difficult for users to assess the reliability of app content.

To manage these concerns, women often cross-checked information and consulted trusted networks (Felton, 2015; Moran, 2023). Lang et al. (2020) noted that women sought to verify online content through credible sources like health professionals. Some studies suggest digital sources are preferred for sensitive topics (e.g., sexual, reproductive, and mental health) due to privacy and anonymity, but strong data protection and encryption are critical for maintaining trust (Mpofu et al., 2021; Liem et al., 2021).

Misinformation

Misinformation poses a major public health risk, fuelling fear and mistrust (Coulibaly, 2023; Moran, 2023). Participants in several studies raised concerns about unreliable health information online (Perrenoud et al., 2023; Edmee, 2017; Jawad, 2023), though little is known about how or why misinformation spreads (Coulibaly, 2023), and no research identified gendered patterns. Community leaders were seen as key to moderating and countering misinformation on social media (Goldsmith et al., 2022; Coulibaly, 2023).

Technology-Facilitated Abuse

Digital technologies can also enable abuse and violence, particularly in the context of family and intimate partner violence. Migrant and refugee women face a range of online risks, including scams, phishing, harassment, image-based abuse, identity theft, and cybercrime—each with serious implications for wellbeing. Experiences of judgment, stigma, or feeling unsafe online can further limit women's engagement with digital spaces (Vasil & Seagrave, 2024; Tran et al., 2024; Henry et al., 2021; Louie, 2021).

Summary of findings

Across the literature, digital health access for migrant and refugee women is shaped by intersecting structural, socio-economic, linguistic, geographic, and gendered factors. Cost and financial stress significantly influence whether women can afford devices, data, repairs, and reliable broadband, while uneven infrastructure and mobile-only connectivity limit functionality

and privacy. Migration and displacement—particularly forced migration—compound these barriers through disrupted education, trauma, low English proficiency, and gendered patterns of dependence within households. Regional and remote contexts introduce additional layers of inequity due to limited infrastructure, social network effects, and broader socio-economic disadvantage. A consistent barrier across studies is the lack of culturally and linguistically appropriate information and design, which affects navigation, comprehension, and the usability of telehealth and health websites. Trust and safety concerns—including privacy, misinformation, and technology-facilitated abuse—further shape how women assess the reliability of online information and whether they feel safe engaging in digital spaces. Age, education, poor physical and mental health can also reduce digital engagement, and significant evidence gaps remain, particularly concerning migrant and refugee women with disabilities. Together, these findings demonstrate that digital exclusion is not a single issue but an accumulation of structural and social constraints that shape women's access to, confidence in, and benefit from digital health.

Enablers of digital health access and equity

In response to these barriers, the literature identifies a range of approaches to improving digital health equity for migrant and refugee women. Across studies, three interrelated themes emerge:

1. Culturally responsive and accessible design,
2. Participatory and community-led development, and
3. Supportive learning environments and digital facilitation.

Additionally, the limited literature in this area highlights the need for continued research to better understand migrant and refugee women's digital literacy and inform effective policy and program design.

Culturally responsive and accessible digital design

Studies consistently emphasise that digital health information must be linguistically accessible, culturally relevant, and tailored to community contexts (Zhang et al., 2023; Jawad et al., 2023). Yet diverse literacy levels, technology use, and communication practices across migrant and refugee communities create tensions between designing broadly accessible resources and developing highly specific, culturally nuanced materials.

Many studies recommend disseminating information through multiple modes, including audio, video, social media, community media, and print, while noting that media preferences vary both within and between communities (Pourmarzi, Yuen & Lambert, 2023; Raymundo et al., 2021; Power et al., 2022; MCWH, 2024). This suggests that dissemination strategies must be responsive to local contexts rather than standardised.

Findings suggest that effective digital health initiatives are those that are tailored to the communication practices, preferences, and everyday digital environments of specific communities, and that decisions about format, platform, and style are likely to be more effective when they are community-led.

Participatory and community-led development

Across the literature, participatory and community-led approaches are frequently identified as critical for developing effective digital health initiatives for migrant and refugee communities. Studies suggest that involving intended users in the design and development process helps ensure that tools reflect relevant lived experiences, communication norms, and cultural values (Ding, 2020; Goodman et al., 2020; Bartlett & Boyle, 2022; Gray et al., 2024).

Specific participatory strategies described in the literature include the use of peer researchers or Community Health Workers to help bridge cultural and linguistic divides (Stanzel et al., 2020; Cheng et al., 2021; Cardona et al., 2023); co-design (Bartlett et al., 2022) and pretesting resources to ensure cultural and linguistic effectiveness (Gray et al., 2024).

More broadly, studies highlight the involvement of migrant and refugee communities in the development of health resources to support their cultural appropriateness (Zhang et al., 2023; Jawad et al., 2023; Goodman et al., 2020; Bartlett & Boyle, 2022).

Supportive learning environments and digital facilitation

Several studies highlight the importance of providing structured support for migrants and refugees who may be at greater risk of digital exclusion, including older adults, women with lower education or poorer health, and those with limited experience using digital technologies. Recommended strategies include promoting access to credible information sources (Zhang et al., 2023; Jawad et al., 2023), building digital facilitation skills among health workers to support online engagement (Power et al., 2022), and embedding support roles such as Community Health Workers and peer facilitators to assist with navigating digital platforms (Liem et al., 2021).

In general, while online sessions were acceptable, face-to-face delivery was considered more engaging overall, allowed for more personal connection with participants and allowed facilitators more flexibility to be responsive to participants, change communication style and body language (Gagliardi et al., 2022).

Power et al. (2022) note that online health engagement requires distinct facilitation skills and recommend specific training for health workers to support participants online. Their findings also indicate that Community Health Workers can play a valuable role in providing practical and technical assistance, such as downloading videoconferencing software, locating session links, and troubleshooting connectivity issues.

Continued research into migrant and refugee women's digital literacy

A key finding of this report is the limited availability of research that specifically examines digital health access among migrant and refugee women. Despite the rapid expansion of digital health research, studies that address the intersection of gender, migration, cultural diversity, and health literacy remain scarce (Husain et al., 2022). For example, a scoping review of Australia's digital health ecosystem identified only nine out of 98 relevant articles that considered culturally and linguistically diverse backgrounds in the design or use of digital health technologies (Alvandi et al., 2021). Internationally, a scoping review of 2,248 studies on digital health interventions identified only 57 that focused on migrants, refugees, or ethnic minorities, and just nine that addressed women specifically (Radu et al., 2023). Similarly, Whitehead et al.'s (2023) qualitative systematic review of digital health among CALD populations identified gender-related barriers in only two of 34 studies.

Studies identified significant gaps in relation to specific communities and contexts, including limited focus on access to services (Raymundo et al., 2021) and a lack of research on populations including asylum seekers and undocumented migrants, humanitarian and environmental migrants, migrants living in regional and remote areas, unaccompanied minors, LGBTQI+ communities, and migrants and refugees with disabilities (Alencar, 2020; McCulloch et al., 2023). Zhang et al. (2023) highlight the need for future studies to distinguish whether participants are seeking health information in English or their primary language, an important aspect that is rarely addressed in the literature.

Several studies highlighted the value of collaborative and participatory research approaches to address these gaps. Approaches included engaging community members as co-researchers to enhance relevance, cultural fit, and trust (Jawad, 2024); using creative and participatory

methods to support inclusion (De Souza et al., 2021); and involving peer researchers to ensure that digital health interventions reflect real-world experiences (Goodman et al., 2020).

Conclusion

This review found limited evidence on how migrant and refugee women specifically use digital technologies to access health information. Available studies show that age, level of education, English proficiency, and access to devices shape women's digital health literacy, while cost and financial stress, geographic location, and the absence of culturally and linguistically appropriate information and design remain major barriers. Structural barriers and policies also limit digital inclusion, such as the optional provision of Wi-Fi in aged care centres and the provision of a single device to people arriving in Australia through the humanitarian migration stream. To respond to these challenges, the research offers implementable solutions: culturally responsive and accessible digital design, participatory and community-led research and development, and supportive learning environments can help enable more equitable digital health access and contribute to the creation of effective, inclusive digital health tools.

Despite these findings, there remain many unanswered questions about migrant and refugee women's use of digital technologies in relation to health, including mental health. More nuanced and community-engaged research into how migrant and refugee women use digital technologies and how their experiences of digital technologies shape their experiences of health and healthcare is urgently needed. Without this, there is a real risk that digital health systems will deepen existing inequities rather than support migrant and refugee communities to benefit fully from Australia's digital health transformation.

In addition, a critical examination of the corporate ownership of digital health tools, platforms and infrastructure is needed. Most digital platforms are owned by multinational companies, driven by profit rather than public health, which has significant implications for ethics, accountability, privacy, security and data tracking. When health systems direct health consumers—especially those communities who have been made marginalised —to use these tools, they effectively endorse the corporate practices embedded within them.

Digital spaces are not inherently equitable. Achieving digital health equity requires addressing the structural inequalities that limit migrant and refugee women's health access, and centring the knowledge, leadership, and lived experience of communities.

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Appendices

Appendix 1: Studies on migrant and refugee women's digital health in Australia

	Title	Authors & Year	Study type	Study participants
1	Barriers and enablers to accessing child health resources and services: Findings from qualitative interviews with Arabic and Mongolian immigrant mothers in Australia	Jawad (2024)	Qualitative study	20 Mongolian-speaking and 20 Arab-speaking mothers living in NSW
2	Co-designed, culturally tailored cervical screening education with migrant and refugee women in Australia: a feasibility study	Power et al. (2022)	Feasibility study	71 CALD women from African or Middle Eastern backgrounds and living in Western Sydney
3	Ezidi voices: The communication of COVID-19 information amongst a refugee community in rural Australia-a qualitative study	Healey et al. (2022)	Qualitative (focus groups and semi-structured interviews)	10 Ezidi women aged 20-50 years old, newly settled in Armadale
4	Online health information-seeking behaviours and eHealth Literacy among first-generation Chinese immigrants	Zhang et al. (2023)	Quantitative (paper-based survey using linear regression)	356 Mandarin speaking immigrants, born in Mainland China, Hong Kong, Taiwan, or Macao and living in Sydney, aged mean 59.3 years, female (68.3%),
5	Lifecourse transitions: How ICTS support older migrants' adaptation to transnational lives	Nguyen, Baldassar & Wilding (2022)	Investigates the role of ICTs in supporting older Vietnamese migrants' adaptation to transnational lives in Australia.	12 women and 10 men Vietnamese migrant grandparents in Perth Melbourne and Sydney
6	Seeking health information: a qualitative study of the experiences of women of refugee background from Myanmar in Perth, Western Australia	Griffin et al. (2022)	Qualitative study (semi-structured interviews)	14 refugee background women from Myanmar living in Western Australia
7	What do women want? Migrant and refugee women's preferences for the delivery of sexual and reproductive healthcare and information	Hawkey, Ussher & Perz (2021)	Qualitative (interviews and focus groups)	169 migrant and refugee women from Afghanistan, India (Punjab), Iraq, Somalia, South Sudan, Sri-Lanka (Tamil), Sudan and various South American (Latina) backgrounds living in Australia or Canada
8	'Not everybody is an internet person': Barriers for menopause-related health literacy among immigrant women from the Horn of Africa nations	Stanzel, Hammarberg & Fisher (2020)	Qualitative	11 women born in Horn-of-Africa nations living in Melbourne

	Title	Authors & Year	Study type	Study participants
9	Sources of information and the use of mobile applications for health and parenting information during pregnancy: Implications for health promotion	Buchanan et al. (2021)	Randomised Control Trial telephone survey with multiple logistic regression	1155 women 63% born outside Australia and (54%) spoke English as their primary language at home
10	Empathy and journey mapping the healthcare experience: a community-based participatory approach to exploring women's access to primary health services within Melbourne's Arabic-speaking refugee communities	Bartlett et al. (2022)	Community-based participatory qualitative study	28 refugee background women from Iraq, Syria, Egypt and Ethiopia living in Melbourne
11	*Resources used and trusted regarding child health information by culturally and linguistically diverse communities in Australia: An online cross-sectional survey*	Jawad et al. (2023)	*Cross-sectional survey*	*122 CALD and 399 non-CALD (parents and pregnant women) living in Australia*
12	Practices of 'Digital homing' and gendered Reproduction among Older Sinhalese and Karen Migrants in Australia.	Wilding et al. (2022)	Ethnographic interviews	25 older Sinhalese adults (9 men and 16 women) aged 65+, who migrated from Sri Lanka to Australia in the 1980s and 1990s; and 19 older Karen humanitarian migrants (8 men and 11 women) living in Australia.
13	Improving access to health information for older migrants by using grounded theory and social network analysis to understand their information behaviour and digital technology use	Goodall, Newman, & Ward (2014)	*Qualitative study using constructivist grounded theory and social network analysis*	*54 Australian migrants (14 men and 40 women) aged 63–94, born in Italy or Greece*

Appendix 2: Table of relevant literature reviews

	Title	Author	Journal	Year	Review Type	Studies	Key findings
1	How marginalized young people access, engage with, and navigate health-care systems in the digital age: systematic review	Robards et al.	J of Adolescent Health	2018	Systematic review	Of 1,796 identified, 68 included	Found 11 studies included young refugees, 11 gender and/or sexuality diverse, 44 qualitative, 16 quantitative, and 8 mixed method. 'Technology opportunities' identified as one of 8 themes.
2	The opportunities and risks of mobile phones for refugees' experience: A scoping review	Mancini et al.	PloS ONE	2019	Scoping review	Of 64 identified, 43 studies included	Health and education identified as one of five themes for refugee mobile usage
3	Promoting the health of mothers of young children in Australia: A review of face-to-face and online support	Heaperman & Andrews	Health Promotion J of Australia	2020	Systematic review	15 studies included	Both face-to-face and online support provided benefits to mothers (no specific focus on migrants)
4	Desperately seeking intersectionality in digital health disparity research: narrative review to inform a richer theorization of multiple disadvantage	Husain et al.	J of Medical Internet Res	2022	Narrative review	Of 663 identified, 27 studies included	Found limited research, substantial disparity for low household income, older age and ethnic minority background especially limited-English speakers.
5	Culturally adapting internet-and mobile-based health promotion interventions might not be worth the effort: a systematic review and meta-analysis	Balci et al.	NPJ Digital Medicine	2022	Systematic review & meta-analysis	Of 9438 identified, 13 studies included	Found limited benefit in culturally adapting health promotion internet or mobile based interventions based on 13 randomised control trials.
6	The design and impact of culturally-safe community-based physical activity promotion for immigrant women: Descriptive review	Gagliardi et al.	BMC Public Health	2022	Descriptive review	13 studies included	Found physical activity promotion is likely best offered in-person rather than online.
7	Use of social media platforms by migrant and ethnic minority populations during the COVID-19 pandemic: a systematic review	Goldsmith et al.	BMJ Open	2022	Systematic review	Of 1849 identified, 21 articles included	Found social media platforms are an important source of information about COVID-19 for some migrant and ethnic minority populations.

	Title	Author	Journal	Year	Review Type	Studies	Key findings
8	LGBTQI+ migrants: a systematic review and conceptual framework of health, safety and wellbeing during migration	Yarwood et al.	Int J Environ Res Public Health	2022	Systematic review	Of 785 identified, 20 articles included	Suggested that digital options maybe particularly important for this cohort because of its protective factors.
9	Barriers to and facilitators of digital health among culturally and linguistically diverse populations: qualitative systematic review	Whitehead et al.	J of Medical Internet Res	2023	Qualitative systematic review	Of 1418 identified, 34 articles included	Found 18 descriptive themes describing barriers and facilitators, two of them gendered.
10	Understanding the impact of digital technology on the well-being of older immigrants and refugees: A scoping review.	Ekoh et al.	Digital Health	2023	Scoping review	15 studies included	Found digital technology is essential to the quality of life of older immigrants and refugees, but poor utilisation of digital technologies suggesting barriers to access.
11	Seeking Health in a Digital World: Exploring Immigrant Parents' Quest for Child Health Information—A Scoping Review	Zysset, Schwärzler & Dratva	Int J Environ Res Public Health	2023	Scoping review	Of 625 identified, 12 studies included	Found that studies varied in topics and methodologies, making it challenging to draw general conclusions. Most immigrant parents relied on digital information on child health but preferred human sources such as family, friends, or healthcare providers.
12	Digital Health for Migrants, Ethnic and Cultural Minorities and the Role of Participatory Development: A Scoping Review	Radu et al.	Int. J. Environ. Res. Public Health	2023			Found 57 studies highlighting the importance of the use of participatory methods to develop digital health interventions for migrant populations.
13	The rise of pregnancy apps and the implications for culturally and linguistically diverse women	Hughson et al.	JMIR Mhealth Uhealth	2018	Narrative review	38 studies included	More research is needed to understand the extent to which CALD populations benefit from pregnancy-related apps.