



# Act Now

**to advance health equity for migrant and refugee women's sexual and reproductive health**

## Introduction

Act Now is a summary and set of actions based on MCWH's Data Report (2021) which brings together data and evidence, to describe the state of migrant and refugee women's sexual and reproductive health (SRH) in Australia. It also draws on discussions and actions arising from our two-day conference held in February 2020. The conference, *Advancing the Evidence: Migrant Women's Sexual and Reproductive Health*, brought together over 160 delegates to identify key issues for migrant and refugee women's SRH and the way forward.<sup>1</sup>

Eleven years after the release of our first Sexual and Reproductive Health Data Report in 2010, it is unacceptable that

migrant and refugee women continue to experience poor SRH outcomes, including adverse maternal and child health outcomes. For example, rates of dangerous pregnancy-related health conditions such as pre-eclampsia and gestational diabetes are higher than the general population, and migrant women are over-represented in the numbers of women who have a stillborn baby.

Sexual and reproductive health is a human right, and an essential element to achieving health, gender and social equity. However, in many countries including Australia, significant health disparities exist among different population groups.

**Despite the lack of data on migrant and refugee women's SRH, the available evidence shows that compared to Australian-born, non-Indigenous women, migrant and refugee women are:**



at greater risk of suffering poorer maternal and child health outcomes;

---



at greater risk of contracting a sexually transmitted condition such as HIV and hepatitis B;

---



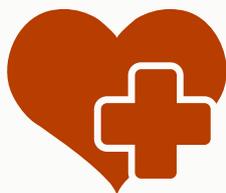
at greater risk of experiencing family violence and are more likely to face barriers to obtaining support;

---



less likely to have access to evidence-based, in-language and culturally appropriate information which will enable them to manage their own fertility, contraceptive choices, and menstrual health;

---



more likely to experience barriers to sexual and reproductive health care, including abortion care and support services.



# Why we need to Act Now

**The evidence is clear. Migrant and refugee women continue to have lower access to sexual and reproductive health services and poorer health outcomes in a range of areas. This is what we know:**

**Migrant and refugee women are more likely to be impacted by barriers to accessing contraception.**

While migrant and refugee women report the lowest rates of contraceptive use (when compared with those born in Australia and those born in other mostly English-speaking countries)<sup>2</sup> they are generally open to learning about different contraceptive options. However, because migrant and refugee women are less likely to have access to in-language and culturally appropriate information, they

may find it difficult to make an informed choice about what form of contraception is best for them.

Barriers to accessing contraception are structural and can include: insufficient use of trained interpreters; lack of multilingual information; cost; the dynamics of decision-making in interpersonal relationships; lack of continuity of care in the healthcare setting; and lack of clear guidelines regarding culturally responsive practice. For example, cultural stereotyping may result in a reluctance on the part of health providers to offer all contraceptive options to women from particular cultural communities.

## Migration related processes can **increase** migrant and refugee women's vulnerability to family violence, including reproductive coercion.

Family violence can lead to poor sexual and reproductive health outcomes. Intimate partner violence is associated with unintended pregnancy, abortion, unsafe abortion, and pregnancy complications. For example, those who are exposed to intimate partner violence during pregnancy are more likely to have a low birth weight and preterm babies.<sup>3</sup>

Migrant and refugee women are at risk of family violence, including reproductive coercion.<sup>4</sup> Reproductive coercion can occur at an interpersonal and structural level.<sup>5</sup> For migrant and refugee women, family violence and reproductive coercion intersect with migration related inequity and discrimination. The dynamics of power and control in intimate and interpersonal relationships can be directly shaped by government policies related to migration and healthcare.



The violence that migrant and refugee women endure may be more severe and prolonged and they often experience structural barriers to accessing support services.<sup>6</sup> Visa restrictions may prevent migrant and refugee women from accessing government support services such as contraception, or maternal and abortion services. For women on visas, the out of pocket costs can be prohibitive.

## Migrant and refugee women experience **higher rates** of perinatal mental health issues.

Women from migrant and refugee communities have greater rates of perinatal mental health issues. Migrants from non-English speaking backgrounds and migrants who have lived in Australia for a shorter length of time, are particularly

at risk of experiencing perinatal depression and anxiety.<sup>7</sup> In 2015-2017, suicide was one of the leading causes of maternal deaths in Australia.<sup>8</sup>

Risk factors for perinatal mental health conditions for migrant and refugee women include social isolation and socioeconomic or financial insecurity, which can be compounded by migration related stressors, such as immigration status and family separation. Family violence and trauma are also associated with perinatal mental health among migrant and refugee women.

## Migrant and refugee women experience poorer maternal and child health outcomes than the general population.

Migrant and refugee women tend to access antenatal care later. Mothers who are born in mainly non-English speaking countries are less likely to attend antenatal care in the first trimester, compared with those born in Australia and other mainly English-speaking countries.<sup>9</sup>

The changes associated with the perinatal period can be particularly challenging for migrant and refugee women. However, there are relatively few studies that focus on the perinatal support needs of migrant and refugee women and their preferred support interventions. The available evidence shows that maternal country of birth is a factor that can contribute to adverse perinatal health outcomes.

Migrant and refugee women are at higher risk of pregnancy related conditions such as preeclampsia and gestational diabetes mellitus (GDM) which can lead to serious complications including preterm birth. For example, in 2016-2017, women born in Southern and central Asia were more than twice as likely to be diagnosed with GDM, compared with Australian-born, non-Indigenous women (28% and 13% respectively).<sup>10</sup>

Mothers who were born overseas are more likely to have an instrumental vaginal birth or a caesarean section, compared with Australian-born women. Expectant mothers with gestational diabetes are more likely than those with no diabetes to experience caesarean section.<sup>11</sup>

Australian research and data indicate that there are higher rates of stillbirth among migrant and refugee communities in Australia. According to the Australian Institute of Health Welfare, in 2018, the rate of stillbirths was 6.7 deaths per 1,000 births for mothers born in Australia and 7.3 deaths per 1,000 births for mothers born overseas.<sup>12</sup> In 2013-2014, 1,531 of the 4,419 stillbirths (34.6%) that occurred in Australia were born to women born in countries other than Australia.<sup>13</sup>

**The health system is inequitable and migrant and refugee women continue to face barriers to access.**

People who speak a language other than English at home participate less in health services than those who speak English at home.<sup>14</sup> For example, migrant and refugee women have lower screening rates in BreastScreen Australia and Cervical Screening compared with women who speak only English at home.<sup>15</sup> Barriers to seeking assistance include difficulty navigating the health system, limited transport options, and lack of culturally relevant or appropriate services.

The cost of sexual and reproductive health services is a significant structural barrier that limits migrant women's ability to exercise sexual and reproductive autonomy. For example, international students are not entitled to Medicare, and must have Overseas Student Health Cover (OSHC) for the duration of their stay in Australia. OSHC does not cover pregnancy related conditions in the first 12 months of arrival in Australia, unless the pregnancy is linked to an emergency situation. This means that if an international student, or the partner of an international student experiences an unintended pregnancy within the first 12 months of arrival in Australia, they may be faced with limited reproductive choices while simultaneously experiencing financial and settlement difficulties.



# Equity in action and the way forward

For over 40 years, MCWH has worked with migrant and refugee women, health services, community organisations, and research groups to build knowledge on migrant and refugee women's sexual and reproductive health and their experiences of accessing services. Our actions below are based on this ongoing work.

**Everyone has a role to play.** Whether you are a health provider, researcher or policy maker, there are actions you can take to improve migrant and refugee women's health and advance health equity in Australia.

**The time to act is now.**



## 1. Research



**Develop** a national framework for collecting sexual and reproductive health data.



**Ensure** comprehensive and cohesive coordination and analysis of collected data.



**Provide** more accessible data.



**Form** equitable research partnerships focusing on migrant and refugee women's sexual and reproductive health. Research is led by migrant and refugee women, and funding is allocated for the leadership and participation of migrant and refugee women.



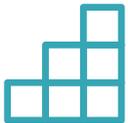
**Disaggregate** data by gender, sex, ability, ethnicity, disability, place of birth and visa status.

## 2. Policy



**Conduct** health policy analysis and development that is intersectional and addresses the specific issues faced by migrant and refugee women. Policies should aim to eliminate structural barriers to access such as cost, migration status and visa category.

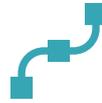
Health policy development and reform is guided by the lived experience of migrant and refugee women.



**Develop** a national information infrastructure to deliver community led, in-language preventative women's sexual and reproductive education and support programs across Australia, including in rural, regional and remote areas.



**Evaluate** new initiatives and publish evidence on best practice care for migrant and refugee women, for example antenatal care.



**Develop** a comprehensive, intersectional and evidence-based national sexual and reproductive health strategy.



**Allocate** specific and sustainable funding for migrant and refugee women's health programs, including healthcare provision and access.



**Invest** in innovative, tailored education and interventions run by migrant women's organisations and delivered to migrant women by trained bilingual workers, in partnership with clinical care providers.



### 3. Practice



**Collaborate** with migrant women's organisations to develop best practice guidelines for culturally responsive service delivery. This includes the employment and engagement of bilingual and bicultural staff. Guidelines should improve cultural responsiveness and remove barriers to access.



**Provide** capacity building and professional development for health professionals and the interpreting workforce in gendered, cross-cultural awareness.



**Contact** your local Member of Parliament to advocate for migrant women on temporary visas' access to sexual and reproductive health services. Contact us for a letter template.



**Learn** about how factors such as visa category can impact on migrant women's ability to access to health services and advocate for structural change. You can learn more here:

<https://www.mcwh.com.au/project/sexual-and-reproductive-health/>



**Commit** to implementing best practice guidelines.

- 
- 1 MCWH - Multicultural Centre for Women's Health (2020) Advancing the evidence: Migrant women's sexual and reproductive health conference, conference report. Melbourne: MCWH.
  - 2 FPNSW - Family Planning NSW (2020) Contraception in Australia 2005-2018. Ashfield, Sydney: FPNSW.
  - 3 WHO - World Health Organisation (2019) Violence against women: evidence brief. Available online at: <https://apps.who.int/iris/bitstream/handle/10665/329889/WHO-RHR-19.16-eng.pdf?ua=1>
  - 4 Children by Choice (2019) Reproductive Coercion. Accessed online at: <https://www.childrenbychoice.org.au/factsandfigures/reproductivecoercion>
  - 5 Marie Stopes Australia (2020) Hidden forces: A white paper on reproductive coercion in the contexts of family and domestic violence, Second edition. Melbourne: Marie Stopes Australia.
  - 6 Vaughan et. al (2016) Promoting community-led responses to violence against immigrant and refugee women in metropolitan and regional Australia: The ASPIRE Project: Key findings and future directions. Sydney: ANROWS.
  - 7 Shafiei T, Flood M & Bee J (2018) Identifying the perinatal mental health needs of immigrant and refugee women, Judith Lumley Centre, La Trobe University & Sullivan C, Vaughan C & Wright J (2020) Migrant and refugee women's mental health in Australia: a literature review. School of Population and Global Health, University of Melbourne.
  - 8 AIHW - Australian Institute of Health and Welfare (2020c) Maternal deaths in Australia. Cat. no. PER 99. Canberra: AIHW.
  - 9 Australian Institute of Health and Welfare (2020) Australia's mothers and babies 2018: in brief. Perinatal statistics series no. 36. Cat. No. PER 108. Canberra: AIHW.
  - 10 Ibid.
  - 11 Australian Institute of Health and Welfare (2019) Incidence of gestational diabetes in Australia. Cat. no. CVD85. Canberra: AIHW.
  - 12 Australian Institute of Health and Welfare (2020) Australia's mothers and babies 2018: in brief. Perinatal statistics series no. 36. Cat. No. PER 108. Canberra: AIHW.
  - 13 Commonwealth of Australia (2018) Select Committee on Stillbirth Research and Education Report. Canberra.
  - 14 ABS (2017) Health service usage and health related actions, Australian, 2014-2015. Cat. 464.0.55.002.
  - 15 Australian Institute of Health and Welfare (2021) Cancer Screening and COVID-19 in Australia. Cat. no. CAN 137. Canberra: AIHW.

## **MCWH / MWA**

This document has been developed by the Multicultural Centre for Women's Health (MCWH) for the Multicultural Women's Health Australia Program (MWA). MWA is made up of a network of services in Australia with a shared commitment to migrant and refugee women's health. For more information about the MWA network, please visit: [www.mcwh.com.au/project/sexual-and-reproductive-health](http://www.mcwh.com.au/project/sexual-and-reproductive-health)

MCWH is a national, community-based organisation led by and for women from migrant and refugee backgrounds. MCWH's mission is to promote the health and wellbeing of migrant and refugee women through advocacy, social action, multilingual education, research and capacity building.

## **Acknowledgement of Country**

MCWH acknowledges and pays respect to the Wurundjeri people of the Kulin nation, on whose land this document was written. Sovereignty was never ceded.

## **Acknowledgement of funding**

MCWH acknowledges the financial support provided by the Commonwealth Department of Health for the implementation of the MWA program.

Suggested Citation: Multicultural Centre for Women's Health (2021), Act Now to advance health equity: migrant and refugee women's sexual and reproductive health. Melbourne.

Photography by Nynno Bel-Air.

Thanks to the MCWH staff featured in the images in this paper.

Suite 207, Level 2, Carringbush Building  
134 Cambridge Street, Collingwood 3066  
Telephone (03) 9418 0999 or  
FREE CALL 1800 656 421  
ABN 48 188 616 970  
[www.mcwh.com.au](http://www.mcwh.com.au)  
[reception@mcwh.com.au](mailto:reception@mcwh.com.au)

