# END ALL BIAS

## Migrant and Refugee Women's Experiences of the Australian Health System

MULTICULTURAL
CENTRE FOR
WOMEN'S HEALTH

## A note on content

This report contains content that may be sensitive or distressing to some readers. Please be advised that the following topics are discussed within this report: birth trauma, mental illness, suicide, and violence.  The following services are available 24/7 to support you:

If you are in a situation that is harmful or life-threatening, contact emergency services immediately on **Triple Zero (000)**.

For crisis support, contact **Lifeline** on **13 11 14**.

For counselling support, contact **Beyond Blue** on **1300 224 636**.

For domestic, family, and sexual violence counselling, contact **1800RESPECT**.

If you require an interpreter for any of these services, contact the **Translating and Interpreting Service (TIS National)** on **131 450**.

# Acknowledgement of Aboriginal sovereignty

Multicultural Centre for Women's Health (MCWH) acknowledges the many Aboriginal peoples and nations on whose lands this research was undertaken. We recognise that each has their own unique cultures, practices, histories and knowledge systems. Without naming the specific locations to maintain anonymity of participants, we acknowledge the custodianship of these lands, waters, and skies, and pay our respects to their Elders past and present. Aboriginal and Torres Strait Islander sovereignty was never ceded.

As migrants and refugees, we benefit from the colonisation of the land now called Australia and accept a shared responsibility to acknowledge the ongoing harm done to its First Peoples and work towards respect and recognition. Aboriginal and Torres Strait Islander people experience disproportionate health inequity due to the ongoing impact of racism and colonisation, and are leaders in equitable health promotion and advocacy. While this report does not include the experiences of First Nations peoples, we hope our work contributes to health equity for all.

# Research team

This research project and report was conducted and written by Catalina Labra-Odde, Amy Tong, Giang Tran, Arundhathi Lekshmi and Delaram Ansari.

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# Executive Summary

This report details the findings of End All Bias, a one-year research project run by MCWH between 2024 and 2025 to learn more about migrant and refugee women's experiences of bias and discrimination in Australia's healthcare system. The project was funded by the Australian Government Department of Health, Disability and Ageing to supplement the 2023 national #EndGenderBias Survey (Jenkinson et al., 2024).

In-language focus groups were conducted in every state and territory with 139 migrant and refugee women on their experiences of the Australian healthcare system. Through thematic analysis of the data, four key findings emerged:

1. **Migrant and refugee women's reports of gender bias were always interlinked with other forms of bias and discrimination in healthcare.**

   All participants who reported gender bias described it in combination with other forms of discrimination, including racism, ageism, ableism and discrimination on the basis of migration status, sexuality, geographical location and ability to speak English fluently. Furthermore, participants' accounts of bias were frequently tied to institutional and systemic barriers to healthcare services and practices.

2. **Migrant and refugee women encountered institutional, systemic and interpersonal bias and discrimination in healthcare.**

   Participants' experiences of institutional, systemic and interpersonal discrimination and bias were interconnected, and are summarised below.

   1) Institutional discrimination in access to healthcare, which included:
      - ➪ visa discrimination and financial inaccessibility of healthcare,
      - ➪ lack of regional and remote healthcare infrastructure, and
      - ➪ barriers to digital health equity.
   2) Systemic discrimination in healthcare, including:
      - ➪ cultural and linguistic bias in healthcare information,
      - ➪ discrimination related to gaps in service provision,
      - ➪ discrimination related to the availability and use of interpreters, and
      - ➪ cultural and linguistic bias in healthcare provision.
   3) Interpersonal discrimination in healthcare settings, including:
      - ➪ being dismissed and disbelieved,
      - ➪ being disrespected, denied treatment and dehumanised, and
      - ➪ being disempowered and silenced.

3. **Bias and discrimination in healthcare had significant and negative health consequences for migrant and refugee women, their families and communities.**

   The harms of bias and discrimination in healthcare extended beyond participants' individual experiences to impact the wellbeing of their families and communities more broadly.

4. **Migrant and refugee women identified promising practices in healthcare that positively addressed bias and discrimination.**

   Many participants shared positive experiences of the Australian healthcare system, and the types of care that made them feel included and respected, including culturally and linguistically responsive practices, non-judgemental approaches, treating patients like capable individuals, respecting migrant and refugee women's agency and anticipating potential access barriers.

# Introduction

The End All Bias research project, conducted from June 2024-June 2025, builds on the important findings of the National Women's Health Advisory Council's #EndGenderBias survey (Jenkinson et al., 2024), which notes the underrepresentation of migrant women's voices in the survey itself and in research more generally (Jenkinson et al., 2024). The project aimed to learn more about migrant and refugee women's experiences of gender bias and discrimination in healthcare, and how they intersect with other forms of bias and discrimination.

A total of 139 migrant and refugee women, reporting 22 countries of birth, were recruited to participate in focus group discussions which were held in each state and territory of Australia. Discussions were facilitated in participants' preferred languages by research-trained Bilingual Health Educators, with strong connections to their communities and shared experiences of migration.

# Method and approach

## Approach

The End All Bias project follows an intersectional feminist approach to research that analyses how power structures can produce or reinforce gender, racial and social inequity. Taking the theories of Moreton Robinson (2009) and Watego et al. (2021) as a conceptual foundation for understanding how discrimination and bias has developed in healthcare, specifically in an Australian context, the project approaches discrimination as a continuous historic process, that not only occurs in interpersonal interactions, but is first and foremost embedded in systems and institutions, policies and infrastructure, namely the health system itself.

In addition, the project centres co-design and community-based participatory approaches, to combat what Fricker (2017) terms 'epistemic injustice', where people from systemically disadvantaged groups are excluded from research and knowledge creation and 'are denied opportunities to create knowledge and derive meaning from their experiences' (Okoroji et al. 2023, p.1). Our research approach is described in detail in Appendix 1.

## Methods

End All Bias used qualitative research methods to investigate migrant and refugee women's experiences of bias and discrimination in Australia's healthcare system. The project consisted of three distinct phases: research co-design and capacity building workshops with Bilingual Health Educators, data collection through in-language focus groups, and thematic data analysis. In addition, a literature review was undertaken to orient the project and interpret findings (see Appendix 2).

To ensure national reach and relevance, the research team engaged a pre-existing national network of partner organisations and Bilingual Health Educators, established though MCWH's Health in My Language program. Bilingual Health Educators across the country played a central role as co-researchers in the collection and evaluation of data and were vital to the research process given their health expertise, training in research and facilitation, and in-depth knowledge of their communities. Their strong connections within migrant and refugee communities and their lived experiences uniquely position them to facilitate and engage women in open, non-judgemental and culturally safe dialogues on health and wellbeing.

## Research co-design and capacity building

In line with the project's community-led and participatory approach, Bilingual Health Educators in every state and territory were engaged to co-design focus group discussion questions (see Appendix 3). Between August and October 2024, MCWH delivered four tailored workshops for 12 Bilingual Health Educators, on qualitative research methods and focus group facilitation.

## Data collection

The project's primary data collection method involved conducting focus groups with migrant and refugee women across Australia aged 18 years and over. Bilingual Health Educators were responsible for recruiting participants, translating questions for the focus groups and facilitating discussions. Bilingual Health Educators conducted 13 focus groups in Victoria, New South Wales, Northern Territory, Queensland, Western Australia, South Australia, Australian Capital Territory and Tasmania, and reached a total of 139 participants. Focus groups were conducted by Bilingual Health Educators in participants' preferred languages and locations. Languages included Arabic, Dari, English, Farsi, Greek, Hakha Chin, Mandarin, Nepalese, and Vietnamese.

All focus group discussions were audio recorded and transcribed and translated by a certified National Accreditation Authority for Translators and Interpreters (NAATI) organisation. Bilingual Health Educators vetted the quality of transcripts and checked them for accuracy.

## Thematic data analysis

The research team conducted data analysis and triangulation using a thematic analysis, guided by an intersectional framework. Thematic analysis involves rigorous and systematic steps to identify repeated patterns of meaning in qualitative data (Braun & Clarke, 2006). Using the qualitative and mixed-methods software Dedoose, the team generated codes and organised the data into initial themes. These codes were then refined and mapped into themes and sub-themes through a triangulation process. The final stage of data analysis involved review and contextualisation of the themes within the current literature and policy environment.

For more detail on the project research methodology, see Appendix 4.

## Strengths and limitations

Published studies that apply an intersectional lens to the exploration of migrant and refugee women's experiences of the healthcare system have been limited in number and scope. As such, a key strength of this study lies in its community-based, participatory research approach. As qualitative research, which prioritises migrant and refugee women's voices, this study helps to further explain and interpret the #EndGenderBias survey findings and improves our understanding of the specific ways in which migrant and refugee women experience gender bias in relationship with other forms of bias.

A key limitation of this study is that it underrepresents the experience of LGBTQIA+ identifying migrants and refugees, and does not fully capture the distinct and intersecting forms of bias and discrimination that LGBTQIA+ communities experience when accessing healthcare (Cochrane, 2023; Haire et al., 2021; Hill et al., 2020) Also see Appendix 5 for a note on language used in this report. Another limitation of this study is that it does not explicitly capture the experiences of migrant and refugee women with a disability, which is an important future line of inquiry.

# Participant demographics

Almost all participants identified as ‘women’.  Around six percent identified as being from LGBTQIA+ communities. Participants spanned a wide range of age groups, from youth (18-24 years of age) to older adults (65+ years of age). However, in comparison to the age distribution of overseas-born women in Australia as reported in the 2021 Census, our research had a stronger representation of middle-aged and older women (58%).

Participants reported 22 different countries of birth, with larger cohorts from Afghanistan, China, Myanmar and Vietnam. Participants also represented a wide range of settlement backgrounds, from newly arrived migrants who had been in Australia for six months to long-term residents who had lived in the country for up to 45 years. At the time of participating, around half of all participants had Australian citizenship (52%). However in focus group discussions, many participants shared pre-citizenship experiences when they were on visas. Participants represented a wide range of visa categories, including those on permanent visas, which includes humanitarian and spousal visas, and temporary visas, which includes bridging and student visas, as well as a range of working visas.

In line with the Australian Statistical Geography Standard Remoteness Structure, this study included participants across four of the five remoteness classes, namely Major Cities, Inner Regional, Outer Regional and Remote. Overall, approximately 17 percent of participants came from regional Australia, and 83 percent were based in major cities.

## Total focus group participants

**139**

### Gender

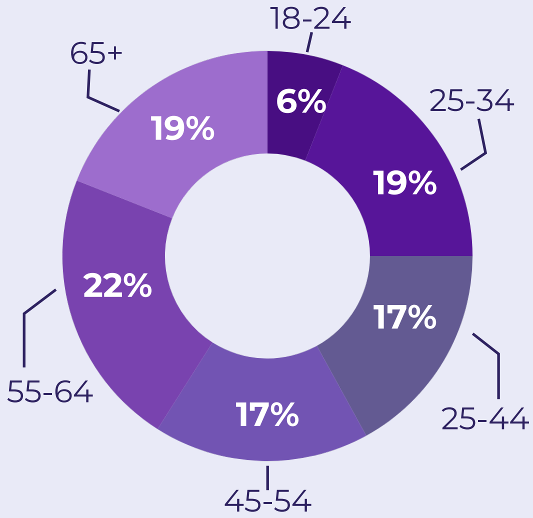
**99% Women**

**1% not stated**

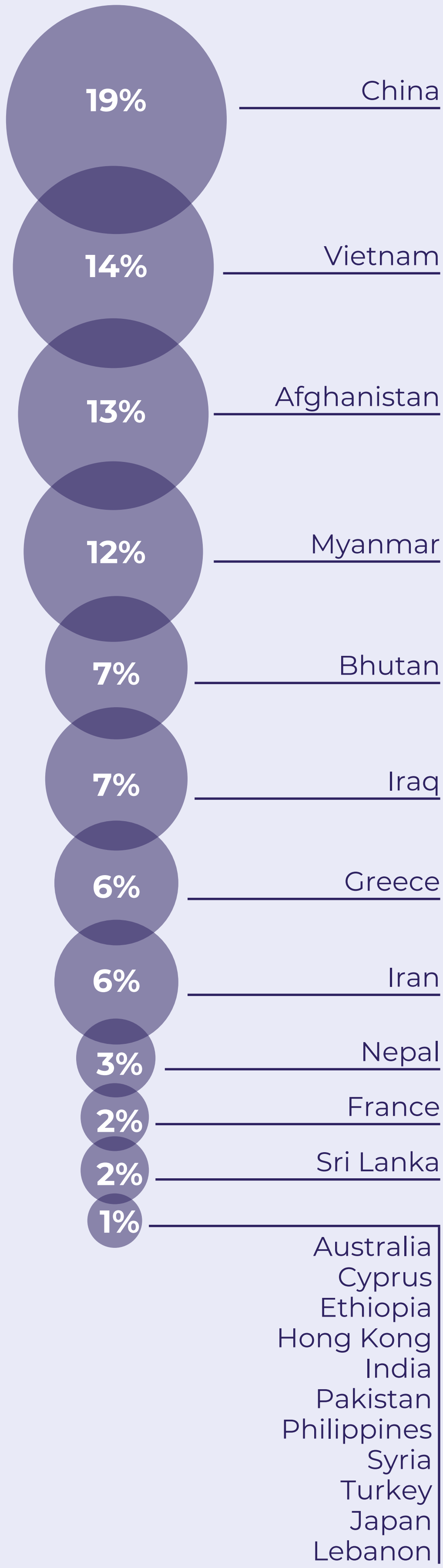
### Residency status

**52%** Australian citizen
**36%** Permanent resident
**12%** Temporary visa
**1%** Not stated

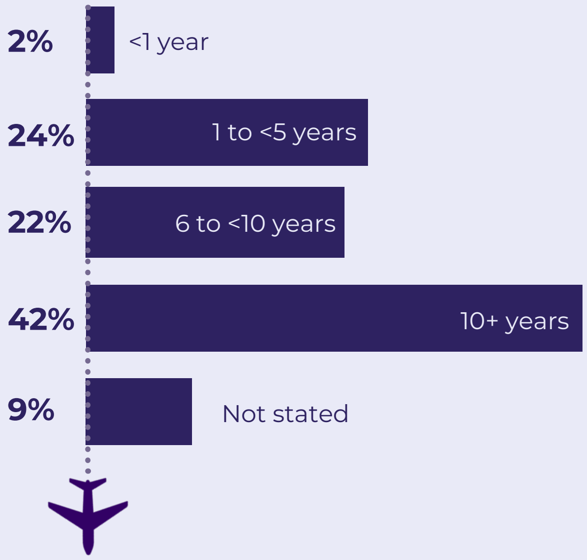
### Age



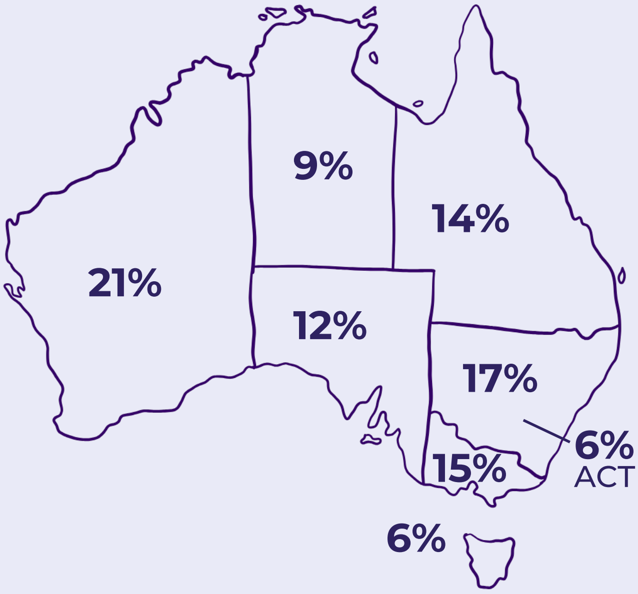
## Country of birth



## Length of time in Australia



## Jurisdiction



## Geographical location

**83%** Major city

**17%** Regional

**1%** Remote

# Key findings

## 1

### Experiences of gender bias were inseparable from other forms of bias and discrimination.

Across all focus groups, migrant and refugee women shared experiences of gender bias and discrimination that were enmeshed with other forms of structural, systemic and interpersonal discrimination, including racism, ageism, ableism and discrimination on the basis of migration status, sexuality, geographical location and ability to speak English fluently. Many of these experiences of discrimination occurred in the context of accessing typically gendered forms of healthcare such as sexual and reproductive health. Participants' experiences of bias and discrimination in healthcare were embedded in the systemic and structural barriers to safe and culturally responsive services and practices, which ultimately limited their agency.

# 2

# Migrant and refugee women encountered institutional, systemic and individual or interpersonal bias and discrimination in healthcare.

While participants shared both positive and negative experiences of accessing and receiving healthcare in Australia, experiences of bias and discrimination were prevalent. Thematic analysis of the data revealed that migrant and refugee women encountered institutional, systemic and interpersonal discrimination and bias, which often intersected with or compounded one another, and are summarised below:

1) **Institutional discrimination in access to healthcare**

   Participants identified policies and practices in which the healthcare system operates that discriminated against and/or denied them equitable health access and outcomes. This can be described as institutional discrimination and includes:

   a. visa discrimination and financial inaccessibility of healthcare
   b. lack of regional and remote healthcare infrastructure, and
   c. barriers to digital health equity

2) **Systemic discrimination in healthcare**

   Participants reported experiencing discrimination and/or inequitable treatment in the healthcare system. This can be described as systemic discrimination and includes:

   a. cultural and linguistic bias in healthcare information
   b. discrimination related to gaps in service provision
   c. discrimination related to the availability and use of interpreters, and
   d. cultural and linguistic bias in the health system, including lack of representation in healthcare

3) **Interpersonal bias and discrimination in healthcare settings**

   Participants reported facing direct discrimination in healthcare settings, specifically against migrant and refugee women's agency and bodily autonomy. Rather than indicating a few bad actors, these experiences were often normalised and deeply interconnected with and enabled by institutional and systemic forms of discrimination. These experiences included:

   a. being dismissed and disbelieved,
   b. being disrespected, denied treatment and dehumanised, including experiences of birth trauma, and
   c. being disempowered and silenced

# 3

# Bias and discrimination in healthcare had significant and negative health consequences for migrant and refugee women, their families and communities.

The harms of bias and discrimination in healthcare extended beyond participants' individual experiences to impact the wellbeing of their families and communities more broadly.

# 4

# Migrant and refugee women identified promising practices in healthcare that positively addressed bias and discrimination.

Many participants shared positive experiences of the Australian healthcare system, and the types of care that made them feel included and respected, including culturally and linguistically responsive practices, non-judgemental approaches, treating patients like capable individuals, respecting migrant and refugee women's agency and anticipating potential access barriers.

Overall, findings indicate a pressing need for reforms to eliminate all forms of bias and discrimination and to ensure Australia's healthcare system is equitable, safe and responsive to the lived experiences and needs of migrant and refugee women.

# Institutional discrimination in access to healthcare

Focus group participants reported experiencing several forms of bias and discrimination that are external to the healthcare system but significantly impact migrant and refugee women's experience of healthcare. This includes visa discrimination, financial inaccessibility, lack of adequate healthcare infrastructure and barriers to digital health. In this report, we use the term 'institutional discrimination' to refer to policies and practices outside the healthcare system that discriminate against and/or deny equitable health access and outcomes to migrant and refugee women.

# Visa discrimination in healthcare access

## Findings

In almost one third of the focus group discussions, visa discrimination and the financial inaccessibility of healthcare was raised. Some women observed that Australia's multi-tiered visa system discriminates against certain groups by restricting access to subsidised services like Medicare and the Pharmaceutical Benefits Scheme because of their visa status. As one participant described:

> ***The problem is the Medicare, we are all come here for different visas, like mine is spouse visa … my husband is Australian, then I can get Medicare right … in Australia we cannot get right away the healthcare card because of our visas when we come here … It's bad for the health when we already have some sickness, when we have lump on breast … you just wait that's all, just waiting.***

Visa discrimination was also raised as a key structural barrier for international students who must purchase Overseas Student Health Cover (OSHC) as a condition of their visa. Despite this, one participant reported hesitating to seek healthcare because of the high cost.

> ***I was on an overseas visa health cover. So when we usually go to a GP it doesn't really cover the GP cost. So it's $70 or something and I have to pay by my pocket. It's a big amount. Yeah so … So I have to think twice before I go.***

Another international student shared her dehumanising experience of being denied treatment and feeling reduced to her ability to pay in an emergency situation.

> ***You get to the hospital and they ask for your credit card before they even take you … I had this thing I thought was appendicitis so it was very, very painful and they were like, 'Oh we need your credit card or we can't do anything for you.' My boyfriend had to go home, get the card, and they would just leave you there. It was just terrible. Because you are international and because they know you don't have Medicare, so if you leave the country then they don't get any money back.***

Numerous participants reported that without Medicare, they were faced with limited choices and were put in financial positions where they had to delay care until they became permanent residents. Participants in more than one focus group shared the sentiment that equitable healthcare should be a human right, citing the need to remove visa discrimination as a fundamental first step. They said:

> ***This is a right for every human being living here, so that basic you know kind of assistance should be provided everywhere to everyone, to every visa holder, to every migrant, to everyone, obviously the categories should be different or have rule, but the basic need should be provided to everyone.***
>
> ***The basic healthcare system should be accessible to everyone, every migrant, either it's a student, either it's a skilled migrant, either it's a student visa.***

## Discussion

Participants' discussion showed that the migration system significantly impacts many migrant and refugee women's access to healthcare. Australia's migration system is structured through a complex matrix of visas, in which a person's entitlement to ‘rights, state-sponsored services, and freedom of movement, among other things, is determined by the visa they hold (or do not hold)’ creating “hierarchies of (non) citizenship” with different levels of access to social support (Azeredo, 2025). Due to lack of Medicare access, migrant and refugee women face limited choices and are forced to “just wait”, delaying treatment and leading to poorer health outcomes. These findings support similar results in other recent studies (Gatwiri et al., 2021; Khatri & Assefa, 2022; Radhamony et al., 2023).

Participants’ comments highlight the large number of different visa categories and conditions, leading to a complex and confusing system to understand or navigate, as well as creating specific vulnerabilities, such as women with a spousal visa being forced to rely on their partners for access to rebated healthcare.

Gender bias and discrimination intersect with visa discrimination to disproportionately impact the sexual and reproductive health outcomes of international students and their dependents (MCWH, 2013). For example, pregnant international students are forced to pay significant out of-pocket costs for abortion care or antenatal care, limiting their reproductive autonomy and treatment choices (Vazquez Corona et al., 2025). Despite promising amendments in 2025, the OSHC Deed exemplifies how gender bias intersects with visa discrimination in Australia’s healthcare system to financially and disproportionately impact the sexual and reproductive health and wellbeing of migrant and refugee women.

> **“This is a right for every human being living here, so that basic you know kind of assistance should be provided everywhere to everyone, to every visa holder, to every migrant, to everyone...”**

# Impacts of visa on healthcare affordability

## Findings

In a number of focus groups, participants connected their ability to equally access healthcare to their limited opportunities for employment, limited earning capacity and restricted work rights. For example, one woman explained that international students face the double burden of having restricted work rights and no access to Medicare:

> ***There are also many international students. When they have health problems, they have to pay a lot of money. They are not able to work as much as they want. Students also have no income. That is why it is becoming difficult to get medical treatment access.***

Participants often situated concerns about the cost of healthcare within the broader cost-of-living crisis, emphasising how income, housing affordability and employment opportunities influenced their access to healthcare and health outcomes. As one woman shared:

> ***Life is tough, costs are high, life is expensive, and doctors are exploiting us. I mean, we do receive an income, we don't deny that, but the income barely covers anything. The income isn't enough for doctor expenses, treatment expenses, rent, and electricity, especially for those who are ill.***

Several participants also raised the impact of the migration and settlement process on access to healthcare for newly arrived migrants. As one woman explained:

> ***The basic Medicare should be covered, I think, under all of the visas, because obviously a migrant whenever they come they are not in a position, we are jobless, we were, me and my husband we were both searching, so we cannot go for the option to get a private health insurance.***

While discussing the cost of accessing healthcare, one participant reported that she was forced to take on work that was deeply detrimental to her health by JobSeeker, despite living with a serious health condition:

> ***I've been suffering from allergies and shortness of breath and my oxygen levels drop. I was taken by an ambulance three times. Every time I go to a doctor, they tell me, 'Your condition is terminal, you're going to die during your sleep.' But when I give them [Centrelink] the report, they say, 'Half of Australia's population suffers from allergies.' They kept insisting and refused the report … JobSeeker pressured me into taking on a job at a food factory. I worked for two months, but during this time, I experienced severe allergies and shortness of breath, leading to oxygen deficiency and my body turning blue.***

As this participant's experience starkly illustrates, limited opportunities for secure employment can mean that migrant and refugee women's health is deprioritised or undermined, in order to meet basic needs.

Older participants also spoke about how visa discrimination within Australia's social security system impacted their financial ability to seek healthcare and support, thus undermining their opportunities for healthy ageing. For example, one participant spoke about the impact that the lack of a pension had on her access to healthcare:

> ***I couldn't afford a private hospital. We elderly people haven't received the pension here yet. We have no income here. The registration fee was so expensive, and I didn't know how much the examination would cost.***

Numerous participants who had the benefit of Medicare access still described significant out-of-pocket expenses, that made them consider delaying seeking healthcare. In particular, the lack of coverage for dental care, specialist appointments, and ambulances was raised. For example, when asked about changes they would like to see in healthcare, one participant said:

> ***I have a suggestion regarding ambulances. Unfortunately, here they charge for it, and many families don't know. It's really expensive. If ambulances were free, it would prevent many … If there is an emergency, they may hesitate to call because of the cost. A thousand dollars is too much. Ambulances are really important, and I think they should be free in this country.***

A number of other participants offered suggestions for discounted healthcare commensurate with income, age, and health conditions.

> ***Mainly, as people age, they tend to have more health problems. If the financial burden becomes too heavy, it would be great if adjustments could be made based on the severity of the illness. For example, for those who have a critical need for certain medications, adjustments should be made accordingly.***

> ***The government could issue a medical card to each person, with money directly deposited onto the card based on one's health condition and the estimated cost of treatment.***

> ***You would use this card to purchase medication. How about this idea? Based on one's health status, which is determined through regular check-ups, the government would deposit the estimated treatment costs onto the card. Then, you could use this card to buy medication without having to pay out of pocket.***

## Discussion

Literature suggests that financial barriers are often gendered and have a compounding impact on migrant and refugee women, who are more likely to be in insecure or low-paid work, carry significant caregiving responsibilities, and face visa-related restrictions (Hach & Aryal-Lees, 2019). This includes facing gender-specific barriers to workforce participation, education, secure housing and reduced opportunities for wealth and superannuation accumulation (Hach & Aryal-Lees, 2019; Arashiro, 2021, Tran et al., 2023; Ziersch, Loehr et al., 2024). Gender bias in the labour market intersects with racism and the migration system in ways that limit migrant and refugee women's economic capacity and rights, forcing them into financially vulnerable positions. For example, temporary visa holders are not eligible for government-paid parental leave and childcare rebates meaning that gender-responsive policies remain inequitable.

The limited earning capacity migrant and refugee women face – shaped by factors such as insecure employment, unpaid care work, and structural discrimination – directly undermines their ability to afford essential healthcare. For those without access to Medicare and for whom private health insurance is financially unviable, the stressors of resettlement can also contribute to poorer physical and mental health outcomes.

Older migrants and refugees too, face considerable barriers to economic security, which can impact their access to healthcare. Migrants must reside in Australia for at least 10 years to qualify for the Age Pension, where five of those years must be of continuous residence in Australia and time spent on a temporary visa does not go towards eligibility for the Age Pension. This is an example of how ageism intersects with economic inequity to limit choice and ultimately prevent older migrant and refugee women from accessing responsive healthcare. Without adequate financial supports in place, they are forced to rely upon limited personal savings, family members, or limited social services to meet basic needs.

The high costs of ambulances and other health services like dental care are prohibitive, nationally inconsistent and disproportionately impact families and individuals who have low income or live in remote or regional areas. While some states offer waivers for concession card holders, it was not clear from the focus groups if they were known about or accessible to migrant and refugee populations.

From unequal access to Medicare to gender and racial inequality in employment, both formal and informal structural inequities in Australia ultimately determine who can access care, when, and on what terms. When service delivery failures and barriers to accessing healthcare become normalised and remain unchallenged, this is a form of institutional discrimination (Watego et al., 2021).

# Lack of regional and remote healthcare infrastructure

## Findings

Focus group participants living in rural and regional areas reported the lack of healthcare infrastructure as a significant barrier to accessing health services, which constitutes a form of discrimination against people living outside metropolitan areas. As one migrant woman living in a regional area shared:

> ***Even when I went to the medical centre in my area, they told me there was no doctor available in our region. When I went there, they again told me that they only had doctors for emergencies, and my case wasn't an emergency.***

In regional focus groups, women spoke about the impacts of persistent ambulance shortages. One participant shared her experience of providing support for a woman with disability [see blow]:

One participant spoke positively about the use of fly-in fly-out (FIFO) doctors in the Northern Territory, to address the lack of services:

> ***If there is no treatment can be done in NT due to no doctors, lack of doctors, or the facilities, they do either fly in fly out doctors or they fly the patient to Adelaide, Melbourne wherever it is, and they cover the accommodation.***

However, another participant spoke about the lack of primary healthcare infrastructure and how GPs in the Northern Territory "don't do bulk billing", continuing:

> ***I think there is maybe one or two clinics but … they're not easy to access. It's always out of pocket now. And also it's very difficult to know how much you're going to pay.***

> **"I worked for disability industry so I had a patient who… was having high fever. We called the ambulance but they told us like we have only have two ambulances, so we can't send it…I can't take a risk driving her because she is in the bed…we need to get a wheelchair accessible bus… [T]hat night they didn't come, they only came the next day during the lunch time and then she was taken to the emergency care and the next day she passed away. So here, Darwin the ambulance is shitty, like, I always tell everyone if you are about to die just drive yourself."**

As another participant based in a regional area explained:

> ***I was pregnant and I went to the hospital and the doctor charge was 500 something and the midwife charge was 300 something, so all together it was 800 or 900. When I applied to Bupa, they only refund me $80 … I asked why was it only that one, and they said $80 was for the ambulance fee to the hospital that government was paying … if you don't have Medicare, the situation is really hard.***

Some participants connected the lack of services in specific areas to bias and discrimination. For example, one participant questioned whether the lack of services in regional and remote areas was the result of the unequal allocation of government funding:

> ***Is it because Cairns is a remote area? … Is that why people receive treatment late? I think this should be asked.***

Participants based in metropolitan areas also reported a lack of healthcare services, particularly ones that specialised in women's health and were ethno-specific:

> ***We need more hospitals. The reason is if we want to go to [name of hospital] it takes us more than 30 minutes so it's difficult when we are far away from public hospital. We have very few hospitals and we need more.***

> ***There are not a lot of these clinics, and for the immigrant ladies, as much as I know, our GPs are fully booked. I mean for the next three or four months, usually they are fully booked, and this shows that there is a shortage of services.***

## Discussion

Healthcare access in Australia is geographically stratified, where those residing in regional and remote areas experience greater structural inequities in the provision of healthcare. This constitutes a form of structural bias and discrimination, as inequitable resource distribution, persistent lack of funding, and workplace shortages tend to disproportionately impact already underserved populations, including migrant and refugee women.

ABS data found that people living in outer regional, remote or very remote areas were more likely to delay or not see a GP when needed compared to those living in major cities (30.8% vs 28.6%) (ABS, 2023-24). Despite this, Australian migration policy has incentivised migrants to settle, often as a condition of their visa, in regional areas to address short-term labour shortages (Boese & Moran, 2023).

The literature suggests that structural challenges are especially pronounced in gendered forms of healthcare, such as sexual and reproductive health, where costs can be prohibitive for those without access to Medicare (Shannon, 2021). Moreover, reproductive health is even more limited in some parts of regional Australia, sometimes described as 'abortion deserts' because women are forced to travel more than 160km to access abortion services (Noonan et al., 2024). While FIFO services are a critical component of health services in rural and remote communities, they are 'not always able to provide an adequate continuity of care for patients' (Osborn et al., 2022, p.11), which is essential for women's antenatal health (Billett et al., 2022). It has further been suggested that an over-reliance on FIFO services will erode local services and infrastructure over time (Hussain et al., 2015).

In this study, 17 percent of participants were living in a regional area and one percent in a remote region. As the proportion of migrants in regional and rural areas rises, insights into how migrant and refugee women encounter bias and discrimination in regional healthcare will become increasingly important.

# Barriers to digital health equity

## Findings

A number of participants mentioned digital technology as both an enabler and barrier to accessing healthcare, with a clear generational divide between the experiences of younger and older participants. Younger participants reported feeling ease when accessing healthcare, citing the convenience of apps like HotDoc and Healthengine and the importance of telehealth in the provision of healthcare. Comparatively, older migrant and refugee women reported having to rely on their adult children for translation, interpretation, and technical support when navigating digital health tools. For example, one woman shared how she prefers to rely on her daughter "for more certainty". On having to rely on adult children for healthcare access, another woman said:

> ***I would prefer to handle it myself, but I can't access that website. I don't know how to use it. First of all, I don't know which website to use for booking appointments with the doctor.***

## Discussion

Given the geographic stratification of healthcare access in Australia, telehealth and digital technology has often been cited as bridging inequity. However, the increasing reliance on app-based booking systems and digital modes of service delivery can act as a form of bias and discrimination by privileging those with digital access and literacy and excluding those who face systemic barriers to navigating or accessing digital health, such as older adults and people with disability.

As clinics, services and public health efforts increasingly transition to digital platforms, assuming that everyone can access devices and navigate these systems independently risks discriminating against migrant and refugee women who may be most in need of accessible healthcare services. These assumptions reinforce systemic inequities, restrict the autonomy of migrant and refugee women who already face healthcare marginalisation, and undermine efforts toward gender-equitable care.

> **"… if you don't have Medicare, the situation is really hard."**

# Systemic discrimination in healthcare

In every focus group, participants reported receiving, or being denied, culturally and linguistically responsive care. This can be broadly understood as care that provides proactive interventions to ensure that unfamiliarity with the system, its administration, or the language in which healthcare is delivered does not reduce a patient's access to quality healthcare (Kirmayer & Jarvis, 2019; Peprah et al., 2023).

While some participants felt positively about Australia's health system, and reported feeling highly supported, many participants described an unresponsive and unsafe health system, in which they felt discriminated against, not necessarily or only by any one individual healthcare provider, but by the health system as a whole. This included cultural and linguistic bias in health service information and procedures, discrimination related to, or exacerbated by the lack of services, particularly in regional and remote areas, as well as a lack of interpreters. In this report, we have collected these experiences and reflections under the broad theme of systemic discrimination.

# Cultural and linguistic bias in health service information

## Findings

In all 13 focus groups, participants reported a significant cultural and linguistic bias towards English language information that assumed familiarity with the Australian health system, with limited resources for migrant and refugee communities to learn about and navigate the Australian health system, including mental health services, sexual and reproductive health services, and emergency clinics. As one participant shared:

> ***When I first came here, I didn't know how to search for information, and I felt that it was quite complicated. People would talk about things like a GP referring you to specialists, which was complicated for me. So I relied on my friends, asking if they had any relevant experience … when I wanted to see a … [language other than English]-speaking specialist, doctor, GP, dentist, etc., I would search on … [overseas-based social platform] for that.***

Another participant reported the complexity involved in accessing mental healthcare, and the lack of culturally and linguistically responsive information:

> ***I want to seek mental health care, I need a care plan and a GP referral. I have to go through these steps, which are different from the process in … [her country of origin). But why aren't there clear, step-by-step instructions in … [participant's preferred language]? This information should be easily accessible.***

Several international student participants also discussed their need for accessible sexual and reproductive health information. As one participant said:

> ***I have been in Australia for less than a year as an international student. When I planned to get the HPV vaccine here, I found that, in this process, the search channels available to me were relatively limited … and it's often difficult for me to find detailed answers to many questions.***

One participant reported a similar lack of information or education available about how or when to access urgent care and emergency services. A participant shared:

> ***What we did was we just called friends who had lived here for so long, so they helped us on how to get to the emergency care clinics. So they told us all the information, so for me of course the lack of information was one of the problems.***

As their comments make clear, many participants were highly proactive and resourceful in seeking health and health service information. When asked about changes that would improve their experience of healthcare, some participants identified in-language health education and information sessions as a way of bridging the information gap.

> ***Information sharing sessions, supporting migrants, these kinds of projects is really, really important, because the health system is totally different, the literacy level that migrants have from Australians is very, very different, how we manage our health systems, is very, very different, so we need more, more information sessions or these kinds of supports from the government if it's possible.***

> ***In [my state] I have found more than 90 organisations that are multicultural organisations … what they can do is inform the resident or the community the details and give them a training so they can explain that information towards their community.***

In addition, participants wanted greater access to culturally and linguistically responsive information about a range of health topics. This included calls for more translated materials, the use of plain language, and community-led approaches to health communication that reflects the values and needs of migrant and refugee communities. Participants said:

> ***As a migrant background, there are a lot of times and things we don't know about so it would be more information, more detail and cultural appropriate information, so different cohorts get different information sheets and different questions and answers that can be catered to their needs.***
>
> ***[I] hope they can promote medical information in different languages. There is too much information, and when it's written in English, it might fill a whole booklet, but in [my language], it takes only one and a half page. There's a huge gap in the information we receive.***

Additionally, two participants also mentioned gender-specific health education programs, in addition to sharing information within social networks, particularly for sexual and reproductive health:

> ***There are many sisters who cannot speak or understand [language] clearly. What is that? What does this word mean? What does it mean? Those who doesn't understand [language], but if we speak it with expression, we understand the intention. We know our community. Those sisters must still be crying a lot due to pain inside, because they have their own health issues … some are related to the uterus, and some are related to the breast, pap smear test … We sisters who understands a little bit more must do awareness about these.***

## Discussion

The reported lack of healthcare and health service information available to migrant and refugee women points to discrimination on the basis of a person's ability to read and speak English. Participants' accounts of proactively seeking health information and utilising social networks indicates that migrant and refugee women are themselves proactive and highly motivated to understand the health system. However their experiences demonstrate a lack of in-language resources and confusion around where to seek help, putting these women at an informational disadvantage.

For example, those who speak a language other than English at home form an extremely low portion (1.4%) of patients visiting free Urgent Care Clinics (Nous Group, 2025), suggesting that these new services are not well promoted among migrant and refugee communities. And while Urgent Care Clinics fill important gaps in the healthcare system, care and treatment options are still unclear for those on temporary visas who cannot access Medicare.

Our findings reflect the well-documented inadequacies of current healthcare information and resources for migrant and refugee communities and how this limits the ability of migrant and refugee women to make decisions about their own health (Aryal, 2017; MCWH, 2024a; MCWH & GEN VIC, 2021; Tran et al., 2023). As a result, migrant and refugee women are left to deal with critical healthcare needs on their own and must rely on informal networks such as friends or international platforms for further information and support.

For women who may not have written or spoken literacy in their mother tongue, in-language, in-person health education programs are a powerful tool in bridging accessibility gaps. These programs recognise the multiple forms of marginalisation that women might face in sexual and reproductive health and respond by providing information in culturally sensitive ways that allow women to make informed decisions about their health and wellbeing. As such, there is a need for sustained investment into peer-led health education initiatives that are tailored to the experiences of migrant and refugee communities.

> **As a migrant background, there are a lot of times and things we don't know about so it would be more information, more detail and cultural appropriate information, so different cohorts get different information sheets and different questions and answers that can be catered to their needs.**
>
> **[I] hope they can promote medical information in different languages. There is too much information, and when it's written in English, it might fill a whole booklet, but in [my language], it takes only one and a half page. There's a huge gap in the information we receive.**

# Discrimination related to gaps in service provision

## Findings

Across many of the focus groups, migrant and refugee women spoke about how structural gaps in service provision affected their access to healthcare, including long waitlists, slow triaging in hospitals, short consultations, and health workforce shortages. For example, a patient shared her experience of seeing a specialist doctor:

> ***The specialist we see puts a timer in front of him, then talks to us whilst staring at it. Before you finish talking, he grabs papers and accompanies you to the door and continues the conversation outside - his eyes still locked on the timer. You're allowed 10 minutes of his time, despite paying him. It's not covered by Medicare. He grabs your paperwork whilst accompanying you out with his still eyes on the timer. That's how specialists are now, they only care about the time.***

After relating this story, there was wide agreement within this participant's focus group that being rushed through consultations by specialists, enduring long wait lists, and paying exorbitant out-of-pocket costs for unsatisfactory care were common occurrences.

Some participants perceived these experiences as discrimination. For example, one participant described feeling like she was being deliberately pushed down the queue when waiting see a specialist:

> ***I waited so long while others went in, I have no idea. Maybe with specialist, it could be that there was an emergency, I don't know. So I sat and waited for quite a while, I asked. It's often because we don't speak English. They might discriminate against us because we don't speak English or because we're Asian. Maybe it's discrimination because of skin colour or because with specialists, people who go see specialist might be more classy than us, we are too ordinary for them to see us. This is just my feeling.***

Many women in her focus group similarly interpreted their experiences of being made to wait for healthcare without clear communication about why as the result of racial or language-based discrimination. These responses suggest that poorly communicating issues, delays or processes within the healthcare system to migrant and refugee women, can potentially be interpreted and experienced as bias or discrimination.

Similarly, a number of participants described feeling neglected and invisible in hospital emergency departments. Participants cited lack of appropriate seating, slow triaging, lack of COVID-19 measures, and having to wait outside in the cold as factors that made them feel that the hospital system lacked concern for their dignity and wellbeing. For instance, a mother shared her experience in the emergency waiting room:

> ***I know they have human rights and all the rights we are aware of … but when you go to the hospital, where are these rights?! There are no rights. When I took my daughter to the hospital, there was no place to sit. I covered her in a blanket, placed her on my lap and sat on the floor. On the floor, I swear. They can check the camera footage.***

Some migrant and refugee women also identified lack of continuity of care as a structural gap in service provision. One participant shared how lack of continuity of care negatively impacted her birthing experience:

> ***When I was giving birth, I went through the public system. That means every month, when I went for prenatal checkups at the public hospital, different doctors would help me, like the one who did the ultrasound or checked my blood pressure. I actually experienced medical malpractice during that time. Throughout my pregnancy, I had pre-eclampsia, which is a severe condition. However, it was a missed diagnosis, and they didn't discover it … Each time they would say it's okay, a little high blood pressure doesn't matter, just go home and rest. But in fact, there was something wrong with my body.***

Participants across a number of focus groups described preferring health practitioners from the same cultural and linguistic background to overcome language barriers and avoid bias and discrimination. However, opting for an ethno-specific health provider sometimes greatly limited participants' choices and opportunities for timely treatment. One woman explained why, despite long waiting times, she preferred to stay with a GP who spoke her main language:

> ***I experience the same like the others [in the focus group] … you have to wait for a long time … I'm afraid to leave because of the shortage of doctors [who speak my language] … There are two issues when seeing a Western doctor. We have to pay [as the clinic doesn't bulk bill], we don't want to, and number two we can't communicate well. We're afraid that when we go see them and we tell them about our illness and they don't understand us. So we have no choice but stick with that doctor.***

Other participants shared that, despite their cultural and religious preferences, they felt they must accept "male doctors, especially Western ones", or wait for extended periods of time to see practitioners that met their needs. As one participant explained, finding a preferred practitioner from the LGBTQIA+ community, and in the mental health field added further complexity:

> ***I often try to find an Asian female, preferably from the LGBTQ+ community. But I don't think this can be used as a selection criterion. My partner also chose someone with the same cultural, gender, and religious background … I don't think there is a reliable way to seek suitable doctors, especially in the field of mental health treatment, where it can be even more challenging.***

Faced with limited choices for adequate, affordable, timely, and culturally responsive care in Australia, a significant number of participants shared their preferences for travelling back to their home countries to seek healthcare and support:

> ***I feel like I can't get good medical resources here, but if I go back to [my country of origin], we can find, for example, a specialist clinic for just a few hundred yuan and you can get excellent medical resources. Based on my own experience, I think it's better that way.***
>
> ***Everything here is slow … I'd rather go back to [name of country] to get things done. Like when I needed to get a gastroscopy done, I just bought a ticket for the next day and flew back, got it done, and then came back. It felt so much faster.***

While returning to home countries for healthcare was a reasonable choice for some participants, it was unfeasible for many due to visa restrictions and cost. On the need to address workforce shortages in Australia, one woman commented:

> ***A friend of mine works in the health system in [name of state], and there has been a huge deficit this year. The***

> ***healthcare system is already under a lot of pressure. She said they can't find enough staff, so they fly to the UK to recruit doctors and nurses at a lower cost to work in [name of state].***

Discrimination against migrants and refugees was raised in several focus groups as a potential contributor to workforce shortages. One participant from a regional area explained how employment discrimination and visa conditions for practitioners contributed to the health practitioner shortage in her area and ultimately limited her access to healthcare:

> ***I've noticed, [name of the hospital] is not recognising the certain doctors or the surgeons to keep them in [name of the state] so they are leaving [name of the state]. And I'm - I actually did speak to someone last week who is actually leaving [date] and it's a surgeon ... So we have a lack of doctors and anaesthetics and all that, but just because they can't give an employment contract to get into their visas, they're leaving [name of the regional city].***

Other participants perceived the shortage of doctors from migrant and refugee backgrounds as racial discrimination, which also appeared to be clearly gendered. As one participant observed:

> ***Because we have doctors in [her country of origin]. If we apply here in Australia, they don't accept the doctors from [her country of origin], there is racism for that, that's why all our doctors going to nurses because nurses are acceptable here, then the doctors.***

The intersection of racial and gendered bias in education was also raised by one participant discussing discrimination against her and her friend, as prospective medical students from migrant backgrounds:

> ***It was very difficult to start university in medicine because people were not believing in us. They were saying 'you are not able to do it, because it is difficult, it is not for you, you can be a good nurse.' So she asked, 'Why? I want to be a doctor, I want to be a GP.' So, she said at the beginning it was very difficult to start and study medicine because people were not believing us because we are refugees and from migrant backgrounds.***

In several focus groups, participants expressed concern for the wellbeing and workloads of healthcare workers, noting that the strained healthcare system runs the risk of inadvertently harming both workers and patients:

> ***There should be do some program or plan to retain all the good doctors and you know, the surgeons and anaesthetists.***
>
> ***If we want to have a better health system we also need to take care of the staff ... it is very difficult, very draining job for nurses, doctors ... they are short staffed, they don't have enough people, so what do we do when they don't have enough people? ... they're so drained, they can't give sometimes a proper care to their patients because they are themselves running already like so low ... I think it is very demanding and I think a lot of people must leave the industry because of it, they don't get that support they work that overtime.***

## Discussion

Across the focus groups, many participants described how staff shortages and time-restricted consultations impacted the quality of care they received. Given that health providers are likely to need more time to discuss symptoms and treatment with migrant and refugee women who are new to Australia, who require an interpreter or who are not proficient English speakers, overly short or rushed consultations can undermine informed consent, exacerbate risk, and ultimately represent a breach in health providers' duty of care.

As some of the comments show, within the broader context of experiencing gender and racial discrimination, and without familiarity with how the Australian healthcare system works, some migrant and refugee women may perceive that a delay in treatment is the result of bias, if the reasons for delays are not communicated clearly. This reflects findings that patients frequently report feeling frustrated or 'forgotten about' in emergency departments, both in Australia and overseas (Bull et al., 2022; Nairn et al., 2004), as well as supporting findings of structural issues identified in the delivery of urgent care, particularly in regional and remote areas in Australia (ACEM, 2024; Looi et al., 2023).

Similarly, participants connecting workforce shortages with bias and discrimination speaks to the broader climate of discrimination that many migrant and refugee women feel. Despite the fact that in 2024, over 50 percent of the health workforce in Australia was born overseas (Butler, 2024), existing research shows that the lack of recognition of overseas qualifications has forced many migrants to work outside of their trained profession, in lower-skilled, lower-paid work (Refugee Council of Australia, 2017; Ziersch et al., 2022; Ziersch et al., 2022). Australia's immigration strategy currently offers priority processing for health professionals committed to regional work (e.g. Subclass 482 Temporary Skill Shortage and Subclass 494). However, this is dependent on securing employment, which requires both regional funding and employers to recognise the value of migrant and refugee practitioners.

Several participants' comments point to the intersection of gender and racial bias and discrimination, insofar as migrant and refugee nurses are seen as "acceptable" where doctors are not. This reinforces gendered stereotypes and erodes migrant and refugee women's agency and opportunities. Without sustainable equity measures in place, workforce shortages can reinforce existing patterns of systemic discrimination and structural exclusion.

The decision of some participants to seek out health professionals who shared their cultural and linguistic background seemed to overcome many of the barriers and biases that migrant and refugee women were likely to encounter. However, this was not an option or preference for everyone and, for some, came at the cost of timely treatment. Seeking health professionals from a shared background is discussed further in the Promising Practices section of this report.

> **If we want to have a better health system we also need to take care of the staff**

# Discrimination related to the availability and use of interpreters

## Findings

In many of the focus groups, participants raised the importance of interpreters in healthcare and identified limited access to quality interpreters as a barrier to equitable healthcare which were experienced as, or led to, biased or discriminatory treatment. Participants' discussions of interpreting in healthcare settings was nuanced and included examples where interpreters played both a protective and contributing role in migrant and refugee women's experiences of bias and discrimination.

Several focus groups raised the shortage of interpreters and translators as the key issue, with clinics having to rely on interstate phone-based services, which were described as often being of low quality. One participant explained that the lack of interpreter availability led to significant treatment delays and discrimination in access to timely healthcare:

> ***In some medical centres, appointments are given to patients according to the availability of the interpreter … There might be so many patients already waiting for the interpreter in the queue … How difficult it might have been for that extremely ill patient. While he waits for the availability of the interpreter, his condition might get worse. And if the interpreter is not available, they will book him only for the day he is available, but what will the condition of that person be by then, if he has to wait for 2 or 3 weeks? … Many such incidents have happened.***

Some participants also reported that clinics and hospitals often failed to book or offer interpreters. One participant shared her observations of working in antenatal health, suggesting that patients were ignored on the basis of their English proficiency:

> ***Once they get to the postnatal ward, when they are brought upstairs, it's almost true that no nurses would come in to check on them. That's what people say. Like first, it's because they don't speak English and there are no on-site interpreters, so many people, mothers often when they press the call button for help, no one comes in. No-one would come in for 3-4 hours.***

Lack of choice about the interpreter's gender and the wrong language being booked by hospitals were also raised, particularly as indicators of a lack of cultural and linguistic awareness. One participant stated:

> ***In an emergency situation, we don't want a male interpreter. We are Muslims. But they bring a male interpreter and say there are no female interpreters. They bring a Persian interpreter from Iran or a Dari interpreter. Again, we don't understand them.***

Participants also reported unprofessional behaviours exhibited by interpreters, poor translation quality, and verbal abuse:

> ***Sometimes they yell at us. I told my interpreter that I don't understand, can you tell me again please? But she yelled at me and told me, "Are you deaf?" something like that. So sometimes I feel bad.***

> ***I opted to use the translation service. The experience was terrible. The interpreter was a middle-aged man. He was quite rude. … The interpreter was very rude to me, just to me. Sometimes he even blamed me or interrupted me.***

Participants acknowledged that poor experiences of interpreting were not limited to health services, and were often symptomatic of an overstretched and unsupported workforce:

> ***We communicate over the phone because of the shortage. They need to be thorough when training interpreters. Some are sent to work right after a brief training due to the shortage, which can lead to inaccuracies.***

> ***The job of interpreters should be vetted thoroughly.***

> ***Now we need interpreters for everyone. And in many places, not to mention in all the healthcare system facilities, in many places, when we go and ask for an interpreter, we are also asked to bring a family member or a friend to help us speak.***

Despite the concerns raised, participants all agreed that interpreting services play a vital role in supporting culturally and linguistically responsive healthcare. One participant shared a harrowing story, which speaks to the necessity and complexity of interpreting and providing interpreting services.

> ***The lady, who brought her son to the hospital for surgery after he was injured in a domestic violence incident … She was in a state of despair, worried that her partner might come to the hospital and harm them, while also feeling helpless about her child's injury and her lack of English skills … Fortunately, she found a Chinese-speaking woman through a phone call … the interpreter assisted in coordinating between the police, doctors, and the mother when the police came to collect information. This is not arranged by the clinic, but they gave her a phone number and she called it herself. This is how she used this service. And I heard it was free, so she was not charged anything no matter how many phone calls she made.***

The proactiveness of services in connecting women to interpreters helped them feel acknowledged, respected, safe and able to exercise their agency in accessing health services. As one participant explained:

> ***I think the hospitals are really doing good, because I have noticed if you are speaking in a different language at home, they are even smart and ask you 'do you speak a different language at home other than English?' If your answer is yes than they will go to the next question 'would you like an interpreter', I really appreciate that one.***

## Discussion

These findings point to broader structural issues related to workforce development in the interpreting sector. Literature indicates a lack of trauma-informed and culturally appropriate training within the sector, especially when interpreting concepts relating to gender equity and women's health (Sullivan et al., 2023; Vaughan et al., 2016). Some of the participants' comments also point to the under-resourcing of interpreter services for rare and emerging languages, leading to an increase in instances of inappropriate interpreting practices (Sullivan et al., 2023; White et al., 2018).

As the participants' comments make clear, interpreting services are an area that crosses into both institutional discrimination—because interpreting services are managed externally to the health system—and systemic discrimination—because participants report that interpreting services are engaged inconsistently by health services and sometimes not at all. Moreover, the interpreting workforce is one that is largely made up of migrants and refugees, making them subject to the same experiences of institutional bias and discrimination, which can include exploitation, poor remuneration and professional support, insecure employment and undervaluing of their role.

While the healthcare sector relies on the National Interpreting and Translation Service, and in that sense has as little control over the quantity or quality of interpreters as communities, the failure to provide interpreters can be considered a breach of ethical responsibilities and leads to healthcare discrimination. Addressing these challenges requires systemic change through funded and continuous training and professional development for interpreters who are integral to the equitable provision of healthcare for migrant and refugee communities.

> **I have noticed if you are speaking in a different language at home, they are even smart and ask you ‘do you speak a different language at home other than English?’ If your answer is yes than they will go to the next question ‘would you like an interpreter’, I really appreciate that one.**

# Cultural and linguistic bias in the healthcare settings

## Findings

When asked about their experiences of healthcare and treatment, many participants described instances when their healthcare provider was either unaware or unaccommodating of access barriers for migrant and refugee women, including assuming patient familiarity with Western medical terminology and processes, lack of consideration in providing explanations to people for whom English was not their main language, and lack of concern for some cultural preferences. This led to miscommunication and misunderstanding, misdiagnosis, medical errors, and failures on the part of health providers to adequately explain treatment and options to patients. For example, one participant, recalled how her doctor's explanation used unfamiliar or technical jargon, and was delivered too quickly to be understood.

> ***… with STI testing … the doctor was quite experienced and used many terms that were common and frequently used in her cultural background. But I couldn't understand a single word. These terms just slipped out of my mind. I really failed to catch what she was trying to say, including some of the birth control advice she listed for me. A lot of them were hard for me to understand quickly.***

Another participant recounted how her mental health provider's lack of understanding about the impact of racism on mental health, significantly and negatively impacted the quality of care she received:

> ***I was explaining how racism, and specifically colourism affected me, and my psychologist … he was a white Australian man, and he was like 'I've never heard of that before' and he asked me to explain it to him and I was like 'oh ok' and I did and he was quite cavalier about it and the way he wanted me to address this in my life, I was like I didn't really feel very supported by that … I think when I was explaining things about my life to him, I felt like he didn't really have knowledge of how family dynamics are different in migrant families and stuff like that. So, I was explaining all this stuff to him and he didn't really know how to guide me through that … this was a while ago, so the psychologists I had at that time were all … white Australians.***

Other participants reported experiences where little to no attempt was made to explain treatment or options in ways that participants could understand or question. One participant gave an example of a healthcare provider providing treatment options in the form of an ultimatum:

> ***They don't explain your condition … [the] doctor told my mother, 'Either take two injections in the back or you'll become disabled, you choose.' We didn't stay more than five minutes, we left … He didn't mention the side effects either.***

Additionally, some participants talked about their preference for women health practitioners and interpreters being disregarded. One participant shared a distressing experience in which her cultural values were violated, her privacy was disregarded, and she was treated without consent, despite having other family members advocating with her:

> ***So they wanted to give me a suppository. They sent in a male nurse. I did not accept. I asked for my sisters***

> ***and daughters to be with me. We said we do not want a male; we want a female nurse. Eventually, I was forced … they did not accept the idea that we are Arabs and that we are Easterners, unlike them. We are shy and these matters are important to us.***

Whether or not this situation was driven by the types of workforce shortages discussed previously, and/or the urgency of the health intervention, the outcome of this interaction was intensely distressing for the participant and her family and starkly illustrates the harmful impacts of cultural and linguistic bias in healthcare.

## Discussion

Across the focus groups, many participants reported receiving inadequate care due to health providers' limited awareness of the barriers to accessing healthcare migrant and refugee women face, including English proficiency and medical knowledge. This speaks to a bias in healthcare practices that assumes a level of familiarity with uniquely Australian healthcare procedures, terminology and culture, that may not always be present. Furthermore, inadequate and poor communication erodes migrant and refugee women's agency, inhibiting their ability to make informed decisions about their health and impacting their trust in practitioners as well as the healthcare system. In the context of reproductive health in particular, inadequate explanation of options from healthcare providers may also be considered reproductive coercion, a form of violence where migrant and refugee women are unable to make free and informed choices about their reproductive autonomy (Sheeran et al., 2023; Suha et al., 2022).

Some participants' experiences in relation to mental health indicate a lack of training among practitioners to deliver culturally responsive care, reflecting existing evidence on how current mental health models and treatments are often at odds with culturally informed perspectives, and do not meet the needs of some migrant and refugee communities (Orygen & CMY, 2022; Powman & Izzo, 2021; Tran et al., 2023). Evidence on perinatal mental health support and antenatal care in Australia also shows a consistent lack of culturally and linguistically responsive care, affecting the health outcomes of migrant and refugee women (Billet et al., 2022; Bradford et al., 2024; Olcoń et al., 2023; Shafiei & Flood, 2019).

> **I never wanted this [IUD] but they always will pushing to do that and I felt like,' oh but what are the other options' you know? And they always say, 'No, this is the good one, we have so much data that says it's great.' But I also have all my friends who experience really bad bleeding for so long … So, just not giving all the options sometimes, yeah and giving us maybe you know pros and cons for each option in this specific instance.**

# Interpersonal discrimination in healthcare settings

Across all focus groups, migrant and refugee women reported experiencing direct discrimination or bias from healthcare professionals, including clinical, administrative and support staff. These experiences included participants' pain being dismissed or disbelieved, having their decisions or requests for more information ignored, being forced to undergo treatment without consent, being disrespected, and being denied treatment.

Participants also described feeling ignored and disempowered to make complaints about the healthcare system, with a few describing they were afraid of going to specific health settings. Some focus group participants were quite reluctant to criticise health providers at all because they were afraid of negative consequences for themselves and their communities.

# Being dismissed and disbelieved

## Findings

In every focus group, participants recounted instances of being dismissed and disbelieved, which most of them attributed to negative assumptions and biases that health practitioners held about migrant and refugee women. For example, one participant shared how providers repeatedly disbelieved her own account of her medical history, resulting in multiple misdiagnoses and impacting her access to timely and effective treatment:

> ***I did a hysterectomy 24 years ago, there was no menstrual cycle, and they're telling me that the uterus is still intact … they drove me crazy. I mean, I was hysterical because of them … A month ago, he said, you are right, you did have a hysterectomy. Then, I went to the specialist who made up a whole different story about the intestines.***

Many participants reported that health practitioners' perceptions of their English proficiency impacted how seriously their pain was taken. One participant who sought hospital treatment due to a painful miscarriage shared with her focus group how she felt that she needed to communicate her pain in English to receive care:

> ***I felt that my pain was neglected, yeah. They saw that I was screaming, I couldn't stay without crying, I was very loud … usually when I am in pain I will scream in my own language! But, because I wanted to get attention I was screaming in English, 'Can someone please come and help me?'***

A number of participants also reported experiences of older women being neglected and ignored. One participant recounted observing an older migrant woman in a hospital setting:

> ***One elderly lady was in pain, but no one cared. I went to see her, but no interpreter had helped her. The nurses didn't even listen to her. We went, and her condition was getting worse. She kept saying, 'I'm in pain', but no one helped her. Eventually, I told the nurse in English that she's in pain and needs medicine, and then she got help. But no one was with her.***

Another woman described witnessing a GP dismiss her mother's pain and capacity to make her own informed decisions by foreclosing treatment options based on his own assumptions:

> ***My mum was like having issues with like knee pains … the doctor said there is nothing to do … if you are 55 years we can do an operation, if you are not, so there is some options, I think they are expensive options, so until you are 55 you should deal with the pain.***

Another participant reported being dismissed by multiple counsellors on the basis of inaccurate racially based assumptions about her mental health concern:

> ***One thing I noticed is that many of the white female counsellors would say the same thing: 'Do you think you're just overthinking?' … I sometimes wonder if they would say the same thing to someone from a local English-speaking background … It was just because they couldn't understand, so they thought I was overthinking. Perhaps I was sharing difficulties that they had never experienced.***

## Discussion

Experiences of being dismissed, disbelieved or not taken seriously within the healthcare system are a common occurrence for women in Australia (Jenkinson et al., 2024). In the 2023–24 financial year, females reported significantly fewer positive experiences with hospital emergency doctors, specialists, and nurses compared to males (ABS, 2023-24). The dismissal of women's pain is also increasingly well documented, especially in the context of sexual and reproductive health (Merone et al., 2022).

Participants' descriptions of being dismissed and disbelieved reflected a combination of both gender bias and racial discrimination, which supports the findings of other studies (Billett et al., 2022; Entwistle et al., 2024; Filler et al., 2020). Participant responses suggest that migrant and refugee women encounter gender bias in the Australian healthcare system in ways that are inextricably interwoven with, or compounded by, other racial and migration-related biases and assumptions.

Participants attributed being dismissed or disbelieved by health professionals to a range of possible biases, including their gender, class background, age, ability to pay, migration status, and English proficiency. Some participants described being dismissed because of assumptions that the health practitioner knows better, which resulted in migrant and refugee women being denied information about treatment options, or in some cases, denied treatment altogether. The impacts of these experiences included delays in treatment, misdiagnosis and psychological distress from participants having their own perceptions of reality denied.

> **“ I felt that my pain was neglected, yeah. They saw that I was screaming, I couldn't stay without crying, I was very loud … usually when I am in pain I will scream in my own language! But, because I wanted to get attention I was screaming in English, 'Can someone please come and help me?'**

# Being disrespected, denied treatment and dehumanised

## Findings

Across multiple focus groups, migrant and refugee women reported dehumanising experiences, including feeling disrespected, humiliated, ridiculed, devalued, undermined, and not treated with dignity. Many of these experiences were connected with overt racism. For example, one woman described her GP's dismissal of her health concerns as culturally inappropriate:

> ***I asked him if I might have Long COVID and if I could get my lungs checked. He told me that, usually, they don't conduct lung checks here, and that my concern was a Chinese way of thinking.***

The participant went on to explain how multiple doctors had dismissed her expectations for medical care, especially when she described treatment she had received in her home country. Another Asian participant described being denied treatment by a dentist during the COVID-19 pandemic:

> ***He made me lie down on the dental chair while he stood at the doorway and spoke to me from there. I sought his advice, and he kept saying, 'You just need to have this tooth extracted. We don't do extractions here. You need to see a specialist.' He seemed very afraid of me. He stood at the door, covering his face. He was very scared of me. I felt extremely uncomfortable at the time. It was a feeling of being distrusted and of being a threat to others. Later, I sought other dental opinions, and it turned out that I didn't need an extraction. But that dentist just made up an excuse to get rid of me.***

Several participants' reports included weight-based discrimination. In one example, a participant described feeling ridiculed and humiliated by a GP who made racially based assumptions about her weight and diet:

> ***I had gone to GP because of my pain, and he finally referred me to the dietician. And when I reached the dietician, he told me, 'Asian people eat more food or rice, that's why all this obesity has happened.' Then when I went to that GP, he would probably talk about rice again … He would call me fat as soon as he sees me … That's what I thought. [Chorus] That's discrimination.***

Participants often reported encountering microaggression relating to their name, such as one participant, who described being called by a nurse:

> ***… we don't forget negative experiences, so I was just sitting in front of everyone, it's a big hospital, she came with the paper … she just looked at my name and said, 'It must be you? There is no way I can say your name.'***

## Discussion

For migrant and refugee women, experiences of being patronised or treated paternalistically were not only informed by practitioners' gender bias, but negative assumptions of medical care overseas, particularly in the Global South. These encounters reflect the well-explored phenomenon of Western health practitioners and institutions denying or dismissing the health knowledge practices of those in the Global South, even when these practices conform to Western medical standards (Abimbola et al., 2024).

The reports of several participants from Asian backgrounds being denied treatment reflects the documented emergence and rise of COVID-19-related anti-Asian racism and Sinophobia, which Ang and Mansouri (2023) describe as the most recent resurfacing of anti-Asian racial anxieties that have persisted in Australia since Federation.

Participants' reports of weight discrimination support the #EndGenderBias survey (Jenkinson et al., 2024) findings and points to the ongoing and widespread misapprehension that weight is highly controllable and thus the responsibility of individuals (Major et al., 2017). For marginalised individuals, weight discrimination intersects with racism, sexism and heterosexism to contribute to health disparities (Gerend et al., 2022; Stoll 2019).

Participants' experiences of feeling neglected and invisible were often exacerbated by forms of discrimination, especially 'name microaggression', a form of language-based discrimination where women's names were disrespected, mocked or mispronounced (Dovchin, 2022). Deliberate mispronouncing, mocking, or refusing to use someone's name can exclude, dehumanise, and erase the identity of a patient, undermining trust and discouraging engagement with the healthcare system. This, along with experiences of being patronised or demeaned can further impact migrant and refugee women's ability to seek care and access treatment.

# Experiences of birth trauma

## Findings

Birth trauma emerged as a sub-theme across five of the 13 focus groups. Although not prompted to discuss birth specifically, several women shared personal experiences of discrimination during labour. Their experiences exemplify the complex ways in which institutional, systemic and interpersonal levels of bias and discrimination intersect and contribute to migrant and refugee women's overall experiences in healthcare. For example, one international student shared her experience of perinatal loss and how her pain was dismissed by hospital staff due to her visa status:

> ***I faced a miscarriage two years ago so I was like in a very bad pain … I went to the hospital so that time I was a student so I was in a student visa … I couldn't even breathe, I was in so much pain. Even though I was crying, they were asking for my insurance information … my passport … I can't even breathe can you please take me in and do that later because … Do they let people die if they don't have any insurance?' This is Australia we don't expect that.***

In another example, a migrant woman shared how racial discrimination, and an unresponsive healthcare system, led to a traumatic birth:

> ***I told the hospital that I want operation in advance because my condition wasn't well … When I gave birth, they didn't do that. In reality, they pulled my baby. I told them I will die because I can't stand the pain anymore but three people helped and pulled the baby. A good country shouldn't do this … I signed up for the operation but they keep pulling my baby till I am in an operation room.***

> ***I feel bad because I can't speak English and I thought that they discriminate against us because we are of [ethnicity] … I can't speak English so I can't do anything. The interpreter whom I hired didn't translate what I wanted to say.***

Moreover, one participant shared how she felt dehumanised when the focus of healthcare providers was solely on birth outcomes, rather than her health and/or birthing experience.

She said:

> ***I had a premature birth at six months. I expected to lose the children, not give birth … I went to them [the hospital] with diabetes and high blood pressure. I usually take insulin five times a day … I had been in the hospital since 8am and I was told to push and push harder, and with every push there was unbearable pain because of my blood pressure. Eventually, my husband told them, 'She's dead, she's dead, she's gone and turned black from all the pressure and pushing' … They have documents that show I have diabetes, high blood pressure … I'm afraid to fall pregnant again. I imagine all the suffering and pain happening again … They tell me to get over what happened, but I can't forget.***

This participant went on to share that the birth had done permanent and irreparable damage to her eyesight, which she attributed to her health providers' disregard for her health during the birthing process:

> ***The high blood pressure ruptured the cornea … Deprived of driving, deprived of reading, deprived of doing many things I want to do because my vision is gone … I don't want money, I want my eye, which is irreplaceable.***

## Discussion

Migrant and refugee women's experiences of birth trauma often stemmed from the absence of culturally responsive and safe care. Participants spoke of feeling unheard, disrespected, and at times coerced during labour and delivery. Experiences of being dismissed or dehumanised on the basis of race or ethnicity, spoken language or migration status increases the risks of obstetric violence, causing significant harm to migrant and refugee women's physical and mental health and wellbeing as well as their trust in the healthcare system.

International evidence suggests around one-third of birthing women, and more than one in ten Australian women, experience a traumatic birth (Keedle et al., 2022; Keedle et al., 2023). Health provider maltreatment of patients during birth, miscarriage or stillbirth is recognised as a form of gender-based violence, often referred to as obstetric violence. This includes actions that de-prioritise the health of the mother in favour of the child, as it fundamentally disregards the autonomy, dignity, and wellbeing of the birthing person (New South Wales Parliament, 2024). As the testimonies of participants in this study suggest, for migrant and refugee women, experiences of obstetric violence often intersect with other forms of discrimination including obstetric racism, or the dehumanisation and neglectful treatment of patients of colour (Dmowska et al., 2024; Odems et al., 2024).

Alarmingly, focus group participants' accounts of birth trauma included multiple non-consensual physical interventions, breaches of participants' reproductive rights and bodily autonomy, denial of women's agency and decision-making both by health providers but also in the interpreter's refusal to communicate her requests and lack of informed consent. All these examples point towards obstetric violence and/or obstetric racism, as well as a lack of culturally safe and trauma-informed care amongst providers.

In a recent national survey, Australian women of all backgrounds reported wanting to have more control over their birthing experience and more information about the process and how to advocate for themselves (Keedle et al., 2023). For migrant and refugee women, impediments to self-advocacy and access to health information that is both linguistically accessible and culturally appropriate make asserting control and agency during childbirth even more difficult.

> **“ I'm afraid to fall pregnant again. I imagine all the suffering and pain happening again … They tell me to get over what happened, but I can't forget.**

# Being disempowered and silenced

## Findings

Across the focus groups, numerous participants described feeling silenced and disempowered to speak up in healthcare settings. In particular, participants expressed fear that sharing their opinions would impact the care they receive. In one group, a participant said: “We’re afraid they won’t treat us if we say something, so we stay quiet.” Others in the focus group then agreed, and another participant added: “I don’t speak English well enough to speak up.”

Similarly, there was hesitancy among migrant and refugee women to share negative experiences during the focus group discussions for fear of potential repercussions, despite the rapport that Bilingual Health Educators had built with participants. Participants felt that they had to keep their health problems to themselves, as one woman explained:

> ***There are sisters who can’t say even that much. They keep their health issues locked inside themselves. They keep the illness under control. Later, the same illness comes out in a serious way. That has had an impact.***

Another participant shared her experiences of not knowing where to go and complain after experiencing verbal abuse from a health professional:

> ***I decided not to proceed. The doctor left angry. He left angrily, but I didn’t know, at that time, my mum was sick, so I was confused and didn’t know what to do. But now after having been many times, I know things, I should find out where to file a complaint.***

Following her comment, there was agreement in the focus group that the complaint process was unclear, with many saying they would give up pursuing their complaints due to the tiring and lengthy process.

Several participants noted that the focus group was the first time they felt they had an opportunity to express their opinions about the health system. One participant, who had been living in Australia for almost 50 years, said:

> ***… because of our lack of English and literacy, we do not know where to voice our concerns … no one has ever asked us whether we have any problems, nor respected our opinions about the health system … MCWH was the first ever organisation in Australia who cared and showed interest about migrant and refugee women’s health, knowledge, and well-being.***

Another participant remarked:

> ***If we voice our issues, then someone can address them and things can improve … in all the years we’ve been here, when has anyone ever come to ask us how we’re doing?***

## Discussion

Participants’ gratitude for the focus group discussion highlights the limited opportunities migrant and refugee women have in providing feedback on how the healthcare system can be improved. Our findings around bias and discrimination contrast with Australian policy literature and research, which often frames migrant and refugee women as being ‘hard-to-reach’ or a ‘voiceless’ population in data collection. However, our findings indicate that migrant and refugee women appreciate and desire opportunities to be engaged on their views around health reform.

In our focus groups, migrant and refugee women shared how the healthcare system itself was disempowering and reinforced invisibility. Participants shared experiences of attempting to express their concerns, only to be silenced, threatened, or made to feel unsafe. In our analysis, we consider this silencing to be a form of epistemic injustice (Fricker, 2017) where migrant and refugee women's testimony is undermined by the healthcare system itself, leading to their concerns being ignored or misunderstood.

Our findings contribute to current literature reflecting the voices of those who have been medically silenced, highlighting how power imbalances in healthcare can lead to repeated incidents of not being believed or heard, ultimately disempowering migrant and refugee patients from voicing their concerns (Dhairyawan, 2024; Dotson, 2011).

Lack of transparency in complaint pathways is also another form of epistemic injustice. Migrant and refugee women shared that when they wanted to make a complaint about medical errors, misdiagnosis, or encountering bias and discrimination, there were no clear avenues to proceed. The healthcare complaint process across Australia is complex and complaints of bias and racial discrimination in healthcare are often inadequately responded to (Truong et al., 2021). In this system, migrant and refugee women are unlikely to voice their complaints, especially if an adequate response is unlikely. This, combined with experiences of systemic, structural and interpersonal bias and discrimination, makes the complaints process particularly challenging for migrant and refugee women. As a result of epistemic injustice within the healthcare system, migrant and refugee women are ultimately disincentivised to seek help.

> **“MCWH was the first ever organisation in Australia who cared and showed interest about migrant and refugee women's health, knowledge, and well-being.**

# Broader consequences of bias and discrimination

## Findings

Participants across focus groups, regardless of age or length of time living in Australia, consistently highlighted how negative healthcare experiences impacted their physical and mental health and wellbeing, with flow-on effects across all aspects of their lives, including their employment, finances, work and educational opportunities. Poor access to care and damaged trust in healthcare providers meant that some participants and their family members delayed treatment, with negative and worsening impacts on their health, employment, families and communities.

As one participant reflected:

> ***In the [ethno-specific community], there are many chronic patients … They have not been diagnosed yet, it has been 14, 15, 16, 17 years or more. Those patients have been suffering from that pain … And another family member also has to stay with him to take care of him … he has to stop working, and after leaving work, there is no income … Guilt is felt, and because of that one chronic patient, the whole family is affected, and they are also affected economically. And after that financial impact, various misunderstanding starts at home. Things like I am the only one earning, you all are staying at home. The patient cannot do anything. How can they survive if only one person earns? And family destruction starts. Violence can also occur. It can end up negatively and, in the end, it can even lead to suicide.***

Throughout the focus group discussions, migrant and refugee women shared how gender bias and discrimination in healthcare led to increased psychological distress and mental ill health. This was especially the case for migrant and refugee participants who arrived in Australia after experiencing displacement and war, whose experiences of bias and discrimination in their healthcare added to a sense of disillusionment with life in a new country. Poor experiences of the healthcare system coupled with the lack of adequate support exacerbated stress and trauma for a number of participants:

One woman shared an emotional story of her husband's delayed cancer diagnosis and death and her ongoing frustration, grief and suffering at being utterly failed by the health system:

> ***When we arrived here, we felt relieved. But the trauma we received here is worse than a hundred traumas. I can't handle it anymore.***
>
> ***We're stressed. We're upset that we came here to find peace after the war, but things are getting worse.***

Frequently, when discussing the effects of bias and discrimination, participants tied their individual experiences to the wellbeing of their families and the impact on their communities:

> ***My mental health, body, confidence and weight are decreasing. I am not getting enough sleep. I am gradually not feeling like talking to anyone***

> ***or even walking. And I feel like I am becoming a burden to everyone.***

> ***When health becomes poor, self-confidence also decreases because a person loses their hope of being cured. When this chronic condition becomes a severe condition day by day, in their mind, they do not feel like going to the house of any friend, brother, or relative.***

In one focus group, participants expressed fear of engaging with the Australian healthcare system, because of negative past experiences. One woman remarked "We are afraid to go to hospitals", which was widely supported and echoed by her focus group.

Following this, another participant recounted a traumatic encounter she had with police in a hospital. She described her son being wrongly arrested due to a misdiagnosis, and how the experience affected her mental and physical health for years after:

> ***… [T]hey gave him the wrong injection that affected his mind and put him in a hysterical state … The police came and asked us: 'Who is the patient? Where is the patient?' The police arrested him, saying he's on drugs … A person seeks their help, instead they cause further harm, furthermore, the police come and hit him.***

## Discussion

Our insights on the broader implications of bias and discrimination reflects the findings of the #EndGenderBias survey (Jenkinson et al., 2024) which also indicated the far-reaching impacts of gender bias and discrimination in the healthcare system on women's lives. Furthermore, the findings of this study underscore that, for migrant and refugee women, the harms of bias and discrimination extend far beyond individual experiences to impact the wellbeing of migrant and refugee families and communities more broadly.

Our findings support emerging evidence suggesting migrant and refugee women experience significantly high rates of post-traumatic stress disorder and psychological distress during resettlement, driven by socioeconomic factors (Handiso et al., 2024). They also reflect existing literature finding post-migration trauma and living with uncertainty can result in long-term poor mental health outcomes for refugees and asylum seekers (Willey et al., 2022).

Many of the participants' experiences highlight how long waiting times can intersect with other migration-related issues, such as lack of local support and social isolation, to create compounded challenges for migrant and refugee women, impacting them and their families' long-term mental health and wellbeing. This highlights an urgent need to address the intersecting challenges of resettlement and systemic barriers to create a more responsive healthcare system for migrant and refugee communities.

Furthermore, participants' stories highlight the long-lasting and shared impact of racism and bias on the wider community and suggest that the negative experiences of one person can become widely known and influence an entire community to trust or not trust healthcare and other services. The deeply troubling account of one woman's experience with law enforcement serves as a potent example of how the institutional, systemic and interpersonal can interact in devastating ways. Literature on the impacts of police activity in healthcare settings noted that it reduced patient trust, and increased risk of bias and discrimination, risks to patient privacy and risks of mental and physical harm (Gallen et al., 2023; Harada et al., 2021). Experiences of police brutality and violence have also been shown to impact marginalised groups' trust in institutions, including healthcare (Alang et al., 2020). Additionally, Javandi et al. (2023) found that racialised people are discriminated against in the healthcare system by having their concerns met with criminal justice, rather than healthcare responses. This one participant's sense of being betrayed by the healthcare system had strong ripple effects in her focus group and illustrates the shared pain of communities when they experience bias and discrimination.

# Promising practices

## Findings

Many participants shared very positive experiences of the Australian healthcare system, and the types of care that made them feel included and respected. They spoke about being supported by providers across the whole healthcare system, including receptionists, nurses, doctors, and providers that administer at-home care:

> ***My mother was sick for three months in the hospital. They treated her very well. The physiotherapists were helpful … In the hospital, the caregivers were very good. They gave us financial help materials to bring home.***

> ***I personally have a bit of anxiety disorder, and I see a psychologist every month. I feel that compared to [country of origin], Australia places a great emphasis on mental health. Sometimes, the psychologist will follow up with me. Even before my next appointment, the nurse or reception staff will call me every two weeks or so to ask how I'm doing. This experience has been quite positive for me. I feel that they truly care about me.***

Several participants and focus groups indicated how much they valued being able to see a health professional from the same cultural and linguistic background, which also often meant long-term continuity of care. As one woman reflected:

> ***My experience with my GP has been quite good. I've been seeing her for many years, and she understands my physical condition very well, including my personality. Sometimes I tend to overthink, and she knows this and tries to address my concerns. Also, my GP is from [country of origin] who speaks [language], so when I don't understand certain terms, she switches to [language] to explain.***

Another participant expressed the comfort she drew from her feeling of having a shared understanding:

> ***Most of us we are used to go to a doctor who we really know and we feeling comfortable with and to talk with. We are of [ethnicity] so we prefer to see a doctor [of the same ethnicity] so we can tell all the symptoms clearly … they know if there's anything which is specific to our background, because they are used to knowing what we eat … they can simply say so we're comfortable with that and we're really lucky.***

Other participants described feeling supported by health providers who acknowledged the specific barriers migrant women may face:

> ***The young female counsellor was from Greece. Among the things she told me, I think the most impactful advice is: first, she suggested I find a counsellor***

> ***with the same cultural background, especially one who speaks the same language. She explained that when the incident happened, my inner language was Chinese, so, speaking Chinese in counselling would better evoke my emotions and help me understand my change of thoughts at that time. Second, she told me that the relationship built through counselling was like any other relationship. To avoid repeating short-term relationships, it's best to build a long-term relationship with a consistent counsellor, and then bring this healthy pattern into other relationships in your life. These two pieces of advice were the most valuable things she left me with. … In the second visit the doctor was [of migrant background] so she saw my documents, everything, and she found that I don't have Medicare and she asked me do you want to apply for a waiver? And she showed me every documents and she told me everything, how can I apply, after that she gave me the form, I filled that form, and I applied. And after that I learnt about the waiver … it's like same as the Medicare so I didn't pay after that. Fortunately, I had that doctor.***

In some focus group discussions where culturally and responsive care was raised, participants expressed that practitioners from migrant and refugee backgrounds were better able to identify and bridge gaps in the healthcare system by drawing on both their lived and professional experience. As one participant explained, 'they know our situation because they come from that situation.'

However, more generally it was important to participants that health practitioners were non-judgemental:

> ***If a patient goes to them with her problem, they should listen to her properly without judging her. They should listen to her properly about the disease. And if they or their place cannot treat it, they should also advocate for that patient to go to another place. That patient should go to another place and get the right service.***

> ***I told the GP that in our culture, we usually take preventive measures for menstrual pain. We might drink warm water or brown sugar water and use a towel to warm the belly. Although the GP, who is a local, didn't fully understand, she said, 'My daughter also has menstrual pain. I'll ask her to try this.' So I think they're open-minded and willing to communicate.***

Moreover, participants spoke about the importance of feeling treated like an individual human being, rather than as a condition or set of symptoms:

> ***Good doctors, I believe, need patience and time to build a relationship with their patients. In Australia, there should be more emphasis on treating your patient as a living person, not just going through the motions of a medical visit.***

Many of the positive experiences that migrant and refugee women shared in focus groups centred around having choice and agency in their health decisions, which enhanced their feelings of trust and safety. Participants described decisions such as choice of treatment options, the gender of the healthcare provider, consent before procedures, and being given time and information to consider next steps:

> ***He heard all the issues carefully. Whatever questions we asked he never got bothered and he always answers each and every question and when we are not clear on any question, he like explains the thing. Even he gave the options for medicines or anything that's needed.***

> ***It was about getting a breast ultrasound. While I was waiting, someone from the front desk came out and asked me if I would mind a male doctor doing the ultrasound. He said they had a male doctor available, but if I preferred, they also had a female doctor, but she was very busy and I would have to wait for over an hour. I hesitated for a moment. I felt respected by the way he asked me … I felt safe.***

A number of participants also raised the importance of embedding culturally responsive and person-centred care in healthcare provider training.

> ***Provide medical students, from the very beginning, what do we call it cultural humility or cultural sensitivity, please know about our culture, learn about our culture, and what positive or negative is imposing on us.***

## Discussion

Focus group participants shared many examples of ways in which practitioners had provided culturally and linguistically responsive care, sometimes going out of their way to ensure that women felt included in their treatment and had the tools and information they needed to make informed decisions about their health. Many of these practices also align with or encompass trauma-informed and person-centred approaches to care.

Feeling that health practitioners understood the barriers and challenges specific to migrant and refugee women made a positive difference in participants' experiences of healthcare. This included health providers taking the time to confirm participants' understanding and recognition from providers of the social and economic challenges migrants and refugees face when coming to Australia. Women also positively mentioned timely communication, proactive follow-ups and the use of social and family supports. These practices were especially meaningful for the migrant and refugee women we spoke to, who face persistent barriers to accessing and navigating care.

In many cases, participants described seeking out healthcare providers with similar cultural and linguistic backgrounds, as a way of addressing many of the barriers migrant and refugee women are known to face. Other studies suggest that seeing a provider who shares a similar cultural background and/or language increases trust and improves migrant and refugee women's access to and experience of healthcare (Hammond & Bottriell, 2023; Tran et al., 2024). However, the limited number of practitioners led to extended waiting periods and limited options. Across all focus groups, health practitioners who were non-judgemental, did not rush and treated patients as capable individuals were strongly valued.

In the context of migration and settlement – periods that are often marked by uncertainty and limited decision-making power in other areas of life – being treated like a human being and having choice and agency in healthcare is vital for migrant and refugee women. This is particularly so for women who have experienced forced displacement, and may have experienced interrupted education, institutional corruption and violence.

# Conclusion

Across all focus groups, migrant and refugee women reported numerous, regular and intersecting experiences of bias and discrimination in healthcare access and delivery, which occurred across institutional, systemic and interpersonal levels. This points to an urgent need to comprehensively address gender bias, racial bias and structural racism within Australia's healthcare system to provide culturally safe and responsive services to migrant and refugee communities and improve health equity.

Bias and discrimination manifested in many ways: as institutional barriers to accessing healthcare, systemic failures in providing responsive and safe healthcare, and in healthcare professionals' stereotyping of migrant and refugee women as lacking agency or concern for their own bodies. Analysis of the focus group discussions also found that bias and discrimination are the key mechanisms that limited participants' health agency and autonomy.

As a result of bias and discrimination, migrant and refugee women encountered persistent barriers to accessing treatment and received a diminished quality of care. In some instances, migrant and refugee women were dismissed, dehumanised, disrespected and disbelieved within the healthcare system. Ultimately, these issues resulted in misdiagnosis, medical neglect, medical errors, indefinitely delayed treatment, high-out-of-pocket costs for treatment, and a failure to provide migrant women with adequate duty of care, particularly in instances where consent was not adequately obtained prior to and during treatment. The consequences of bias and discrimination reached beyond the immediate health concern of migrant and refugee women, impacting their ability to work, play and care for themselves and others, with consequences for their families and broader communities.

Despite many migrant and refugee women in our study experiencing bias and discrimination, participants also shared instances where they felt supported by healthcare professionals and the healthcare system to achieve positive health and wellbeing. Enablers included access to culturally and linguistically responsive care, especially from practitioners of similar backgrounds who understood the barriers they faced; experiences of person-centred care; and opportunities to access and participate in bilingual and responsive health education programs.

The impacts of bias and discrimination for migrant and refugee women and their wider communities are significant, and as such, require urgent action at all levels, to improve healthcare accessibility, healthcare safety and responsiveness, and health provider capacity. This includes review and reform of government health policies, as well as broader institutional frameworks and regulations that reinforce discrimination and bias against migrant and refugee women.

Moreover, the testimony of migrant and refugee women makes clear that these forms of bias and discrimination stem from the normalisation of broader systemic and structural disempowerment. Their experiences must therefore be understood within the wider context of social, political, economic and migration-related inequities in Australia.

We express our gratitude to the migrant and refugee women we spoke to, who shared their knowledge and testimonies—sometimes for the first time—honestly and powerfully.

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# Appendix 1: Research approach and ethics

MCWH follows an intersectional feminist approach that analyses how structures of power can produce or reinforce gender, racial and social inequity for migrant and refugee women and gender diverse people. We recognise that inequalities are never the result of any single or distinct individual factor but rather are the outcomes of different social locations and power relations that shape experiences (Chen, 2017; Crenshaw, 1991; Hankivsky, 2014). Within the group termed 'migrant and refugee women', there is enormous diversity in the ways discrimination is experienced, based not only on ethnicity, but gender, sexuality, class, visa status, ability, age, and more. Only an intersectional approach and analysis can adequately illuminate the ways in which these myriad factors shape people's experiences of bias and discrimination.

Within the context of understanding bias and discrimination in health, we are also guided and informed by the work of First Nations scholars and activists who have developed robust theoretical and conceptual understandings of how race and gender impact experiences of discrimination within the healthcare system (Moreton-Robinson, 2009). While we undoubtedly acknowledge that migrants and refugees experience of racism differs from the experiences of First Nations people, our analysis of the health system is informed by much of the work laid out in the Lowitja Institute's 'Partnership for Justice in Health's Scoping Paper on Race, Racism and the Australian Health System'. This paper stresses the importance of understanding discrimination as not merely an interpersonal phenomenon, but a continuous historic process which has been embedded in systems and infrastructure, namely the health system (Watego et al., 2021). In being informed by this approach, we acknowledge how the historic processes of colonisation, racist population policy, and sexism have informed the dominant norms, practices and assumptions that persist in Australia's healthcare system, leading to inequities in health access, care and treatment, and at times violence (Anderson, 2006; Watego et al., 2021). Our analysis reflects this understanding that racialised groups experience racism differently based on the assumptions, norms, and practices applied to them by dominant institutions, systems and individuals.

Migrant and refugee women have often been excluded from conversations about their experiences of discrimination and bias in healthcare, often for the same reasons they are discriminated against. As such, our research approach also works to combat what Fricker (2017) terms 'epistemic injustice', where people from systemically disadvantaged groups are excluded from research and knowledge creation and 'are denied opportunities to create knowledge and derive meaning from their experiences' (Okoroji et al., 2023 p.1). In the healthcare context, the lived experiences and knowledge of migrant and refugee women are often devalued and not recognised as a credible source of information in shaping policies to provide adequate care (Haghiri-Vijeh, 2025; Okoroji et al., 2023).

Published studies that apply an intersectional lens to exploring migrant and refugee women's experiences of the healthcare system and how the intersection of gender bias, structural racism and racial discrimination in healthcare compounds health inequities are also limited in number and scope. However, when appropriate research methods are used, and migrant and refugee women are provided with a safe, suitable space, they are able to share their experiences and insights with honesty, clarity and expertise.

Co-design and community-based participatory approaches are central to our approach. We apply these principles by valuing migrant and refugee women's voices, knowledge, and wisdom, centring their lived experience and recognising them as co-producers of knowledge and evidence. These values are embedded not only in our data collection methods but also in our overall analysis. Only through centring the testimony of migrant and refugee women can we begin to ensure future health programs and policies are responsive to their needs and experiences.

## Research ethics

MCWH takes an ethical and collaborative approach to research that aims to achieve transformative change in migrant and refugee women and gender diverse people's lives, as outlined in our Research and Advocacy Statement (MCWH, 2025). The End All Bias Research Project was conducted in accordance with this approach, alongside principles set out in the Australian Code for the Responsible Conduct of Research (2018), and the National Statement on Ethical Conduct in Human Research (the National Statement). These frameworks and principles inform the design and conduct of our research with and for migrant and refugee women and communities, including the production of an ethics statement specifically for this project which was shared with all Bilingual Health Educators and made available to participants across all focus groups.

# Appendix 2: Literature review on bias and discrimination

Gender bias, discrimination, and racial discrimination in healthcare often intersect to create compounded challenges for certain populations who are systemically disadvantaged. This issue can reinforce health disparities in both access to and quality of care, exacerbating pre-existing health inequities (Bastos et al., 2018; Bourke et al., 2018; Willey et al., 2022).

While the Australian Government has made progress to advance gender equality and address gender-specific health challenges through the earlier National Women's Health Policy (Australian Government, 2010) and the current National Women's Health Strategy 2020-2030 (Australian Government, 2019), gender bias remains a persistent public health issue in Australia. For example, two-thirds of participants in the #EndGenderBias national survey reported bias or discrimination in the healthcare system, including dismissed symptoms, delayed diagnosis and treatment, and disbelief from healthcare providers (Jenkinson et al., 2024). Gender bias also permeates costing and medical rebates for gendered medical procedures, leading to women across Australia having to spend more out-of-pocket for healthcare related to pelvic pain, mental health, and sexual and reproductive health (Khot, 2024). Data shows that Australian women at all stages of life experience poorer health outcomes than men, with higher rates of chronic health conditions and poorer mental health (Australian Government, 2024; Fetherston & Craike, 2019).

The ongoing impacts of colonisation and racial discrimination are also deeply entrenched in Australia's healthcare landscape and interlink with other forms of discrimination based on gender, class, sexuality and ableism. Ultimately, these intersecting forms of discrimination manifest as barriers to health access, limiting care and treatment choices for many populations who already experience health inequity (Bastos et al., 2018; Willey et al., 2022). For example, evidence consistently shows how ongoing colonisation, structural racism, and discriminatory practices heavily impact the health of First Nations people, preventing them from seeking healthcare support (Gatwiri et al., 2021; Strong et al., 2015). The persistence of racial discrimination in healthcare settings for First Nations people and other racialised communities remains one of the greatest public health challenges in Australia (Australian Human Rights Commission, 2024; State of Victoria, 2024).

For migrant and refugee women, the intersecting impacts of structural racism, sexism and migration-based discrimination have significant impacts on key social determinants of health, leading to systemic health inequity (Gee & Ford, 2011). Australia's migration system can perpetuate gender injustice and inequality because it denies many migrants, especially temporary migrants, basic protective rights and social support against employment, housing, health, social and gendered injustice. For example, visa status determines a person's access to services such as Medicare, Centrelink and some family violence services, creating barriers to security, safety and health for women on temporary visas, including international students and women on spousal visa scheme (MCWH, 2021; Shannon, 2021; Tran et al., 2024). Precarious and contingent migration status can prevent migrants, particularly women, from seeking support for their health and safety if they experience domestic violence or sexual assault (Tarzia et al., 2025; Vasil, 2023a; Vaughan et al., 2016). Further, Australia's lack of recognition of overseas qualifications, along with general employment discrimination, can force many migrant women to take up low-paid, sometimes risky work that entails a lower level of skill than their qualifications or experience (Tran et al., 2023; Ziersch et al., 2023; Ziersch et al., 2021). This inequitable employment landscape, coupled with other resettlement challenges, puts many migrant and refugee women and gender diverse people under significant financial strain, impacting both health access and outcomes (Shannon, 2021; Tran et al., 2023; Ziersch et al., 2021). Additionally, recent housing research has also found that racial discrimination in the private housing market pushes many refugees into low-quality, poorly maintained, and overcrowded homes, which can have significant impacts on their safety, mental health, wellbeing and general health (Ziersch, Loehr et al., 2024; Ziersch, Walsh et al., 2024).

In seeking care, migrant and refugee women and gender diverse people often experience being ignored, disrespected, and discriminated by health professionals, including within mental health and sexual and reproductive healthcare contexts. In the 2020 General Social Survey, the Australian Bureau of Statistics (ABS) reported that 16.1 percent of migrant participants had experienced discrimination within the last 12 months compared to those born in Australia (11.9%) (ABS, 2020). For recent migrants, this proportion was higher (18.0%) (ABS, 2020). Further, in our other study investigating the mental health experiences of migrant and refugee women and gender diverse people, we found that participants were often ignored or dismissed by mental health professionals (Tran et al., 2023). Similarly, in our submission to the Victorian Inquiry into Women's Pain, we shared participants' stories of being disrespected by healthcare professionals because of assumptions made about their cultural background, visa status, and/or English proficiency (MCWH, 2024b).

When it comes to addressing the needs of migrant and refugee women and gender diverse people, Australia's healthcare system has significant gaps. Australia's healthcare system is complex, fragmented and often difficult to navigate, with health and service information rarely offered in language, while interpreter services are often inadequate or unavailable, making it difficult for many migrant and refugee women to access the healthcare they need (Hach, 2012; Sullivan et al., 2023; Vaughan et al., 2016). Additionally, the high cost of services and long waiting times due to staff shortages are often reported as ongoing issues in Australia's healthcare, particularly for those without access to Medicare (Gatwiri et al., 2021; Khatri & Assefa, 2022; Radhamony et al., 2023). These ongoing systemic issues impact migrant and refugee women's help-seeking behaviours, leading to generally lower rates of healthcare use than that of the general population, putting migrant and refugee women and gender diverse people at greater risk of adverse health outcomes.

There is an urgent need to comprehensively address gender bias, racial bias and structural racism within Australia's healthcare system in order to provide culturally safe and responsive services to migrant and refugee communities and improve health equity. Currently in Australia, many migrant and refugee women have unmet mental healthcare needs because understandings of mental health and treatment centre European/ Western frameworks. As a result, migrant and refugee women report feeling misunderstood, unsupported and excluded from the decision-making process regarding their mental health (Orygen and CMY, 2020; Plowman & Izzo, 2021; Tran et al., 2023). Similarly, in antenatal care services, there is a lack of culturally responsive support, preventing many migrant and refugee mothers from appropriate and continuous care during the challenging time of pregnancy and birth (Billett et al., 2022; Bradford et al., 2024; New South Wales Parliament, 2024; Olcoń et al., 2023). Available evidence also shows that many migrant and refugee people from the LGBTQIA+ community experience discrimination and exclusion in accessing healthcare (Cochrane, 2023; Haire et al., 2021; Hill et al., 2020).

Despite knowledge of healthcare disparities, the voices of migrant and refugee women and gender diverse people remain systematically overlooked in medical research, especially in data collection and the development of diagnostic and treatment tools, resulting in little evidence of their healthcare experiences, as well as the bias and discrimination they face. The exclusion of marginalised voices in research and knowledge creation is a form of epistemic injustice (Fricker, 2017). In the healthcare context, the lived experiences and knowledge of migrant and refugee women are often devalued and not recognised as a credible source of information in shaping policies to provide adequate care (Haghiri-Vijeh, 2025; Okoroji et al., 2023).

Published studies that apply an intersectional lens to exploring migrant and refugee women's experiences of the healthcare system and how the intersection of gender bias, structural racism and racial discrimination in healthcare compounds health inequities are limited in number and scope. As such, these gaps illustrate the need for a gendered, intersectional approach to research that centres the testimony of migrant and refugee women and gender diverse people to ensure future health programs and policies are responsive to their needs and experiences.

# Appendix 3: Focus group questions

| FOCUS GROUP QUESTIONS | | |
|---|---|---|
| 1 | Main question | How did you find and book a healthcare appointment when you had a health concern or issue? |
| | Prompt questions | What made it difficult or hard? Or What made it easy or good? |
| | | Have you ever needed or requested a professional interpreter? If so, did the clinic help organise one? |
| | | Have you ever had to pay out-of-pocket to receive healthcare? What was it for? |
| 2 | Main question | As a migrant or refugee woman, how have your experiences been with health professionals when seeking and/or discussing care? |
| | Prompt questions | What made it a good experience? What made it a bad experience? |
| | | Were these experiences with a GP? What about experiences with other health professionals or specialists? For example, with a nurse, psychologist, gynaecologist, or midwife. |
| | | If you have used a professional interpreter during a healthcare appointment, can you describe if that was helpful or not and why? |
| 3 | Main question | Can you share your experiences where your health concerns or problems were not addressed by a healthcare provider? What happened? |
| | Prompt question | Have you ever felt that you were not believed, dismissed or not taken seriously about your health concern? How? |
| 4 | Main question | Have you ever felt you were treated differently or unfairly while getting healthcare because you were a migrant or refugee woman? If so, how? |
| | Prompt questions | Were there any moments where you felt the provider made assumptions based on your gender and/or cultural background? |
| | | Have you ever felt judged for your choices/needs in healthcare settings because of underlying gender and cultural stereotypes? |
| 5 | Main question | Do you feel like your cultural background and/or gender was respected by healthcare professionals? Did you feel safe? |
| | Prompt questions | Did a healthcare professional ever make you feel uncomfortable when talking about specific health issues or when receiving treatment? Can you provide any examples? |
| | | Did you have the choice to see a health professional who was a woman or someone from your culture? |
| 6 | Main question | Did you feel involved in making decisions about your healthcare and/or treatment options? |
| | Prompt questions | Did a health professional take the time to explain what care or treatment options were available to you? |
| | | Have you ever been denied healthcare? What was the reason? |
| | | Have you ever requested a treatment that was denied to you? What was the reason? |

### Focus group questions cont.

| | | |
|---|---|---|
| 7 | Main question | How did your experience of getting health support impact other aspects of your life? |
| | Prompt questions | How did it impact your long-term health and wellbeing? |
| | | How did it impact your career and job opportunities? |
| | | How did it impact your relationships? |
| 8 | Main question | What does 'good' healthcare look like to you? |
| | Prompt questions | What has made you feel supported or comfortable when seeing a healthcare professional? |
| | | What health information, services or support have been most helpful to you? |
| 9 | Main question | What changes would you like to see in healthcare? Would you like anything to be different? |
| | Prompt question | What would make getting healthcare better for you? |

# Appendix 4: Research methodology

## National collaboration

As part of our ongoing commitment to improving the health equity of migrants and refugees across Australia, MCWH leads a national partnership network of organisations within each state and territory to deliver bilingual health education through the Health in My Language Program. Bilingual Health Educators who are employed by our partner organisations are highly trained, with ongoing professional development and capacity building coordinated by MCWH.

### Collaborators:

**South Australia:** Australian Red Cross

**Tasmania:** Australian Red Cross

**Queensland:** true relationships & reproductive health

**New South Wales:** STARTTS

**Northern Territory:** Australian Red Cross

**Western Australia:** ishar Multicultural Women's Health Services

## Data analysis

The research team conducted data analysis and triangulation using a thematic analysis, guided by an intersectional framework. Intersectionality was integrated from the project's inception, shaping conceptualisation, engagement, collaborations, focus group question design, recruitment, data collection, and analysis. This approach enabled a more comprehensive thematic analysis of the data, allowing the research team to acknowledge the power relations and inequities that exist across and within groups (Spadacio et al., 2024).

Thematic analysis involves rigorous and systematic steps to identify repeated patterns of meaning in qualitative data (Braun & Clarke, 2006). Firstly, we familiarised ourselves with all data sets, before beginning to generate codes and organise data into themes. The team conducted the coding process using the qualitative and mixed-methods software Dedoose. These codes were subsequently refined, organised and mapped into themes and sub-themes, following a rigorous triangulation process.

The final stage of data analysis involved the review and contextualisation of the themes within the current literature and policy environment. A crucial aspect of combining a thematic method with an intersectional framework is the practice of reflexivity throughout the coding, interpretation, and final reporting process. Using an intersectional framework throughout the project allowed us to identify experiences of interpersonal bias or discrimination, but also structural and systemic forms of bias and discrimination that might otherwise have been overlooked.

# Appendix 5: Notes on language and content

At MCWH, we are committed to promoting the health and wellbeing of migrant and refugee women, including trans women, non-binary, and gender diverse people. We acknowledge the authors cited in this report often position and/or assume that the people they term 'women' are cisgendered. We recognise that this data is not inclusive of non-binary, gender diverse and trans migrant and refugee women living in Australia and does not always accurately reflect their experiences. This limitation also applies to our research, which predominantly reflects the experiences of cis migrant and refugee women.

We use the term 'migrant and refugee' 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.

# About MCWH

Established in 1978, Multicultural Centre for Women's Health (MCWH) is a Victorian-based women's health service that works nationally and across the state to promote the health and wellbeing of migrant and refugee women through advocacy, social action, multilingual health education, research, training, and capacity building.

MCWH applies an intersectional lens to understanding and analysing all health issues. This lens goes beyond explanations that use single categories, such as gender or ethnicity, to address structural inequality. Instead, it recognises that women's experiences of inequality reflect specific social, economic, and political contexts, systems, and structures.

Telephone (03) 9418 0999
or FREE CALL 1800 656 421

ABN 48 188 616 970

ISBN 978-0-6451608-8-8

www.mcwh.com.au
info@mcwh.com.au

MULTICULTURAL
CENTRE FOR
WOMEN'S HEALTH