Select Committee on Women's Health Submission

Prepared by the Multicultural Centre for Women's Health

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Multicultural Centre for Women's Health is a feminist organisation led by migrant and refugee women to achieve equity in women's health and wellbeing.

About the Multicultural Centre for Women's Health

This submission has been developed by the Multicultural Centre for Women's Health (MCWH), a women's health service established in 1978 that works both nationally and across Victoria to promote the health and wellbeing of migrant and refugee[1] women and gender diverse people across Australia[2]. We do this through research and publication, participation in advisory groups and committees, written submissions, and training and capacity building. Additionally, MCWH has been providing bilingual health education for migrant and refugee women for over 40 years (see **MCWH Annual Report 2024 - 2025**). We reach migrant and refugee women where they are to deliver tailored health information and education, in their own languages, on a variety of women's health topics.

MCWH welcomes the opportunity to make a submission to the Select Committee on Women's Health as it relates to migrant and refugee women and gender diverse people in Australia. Our submission addresses the Inquiry's Terms of Reference and is based on our work with migrant and refugee women in advancing mental health, sexual and reproductive health and rights.

MCWH also welcomes the opportunity to share our recommendations at a public hearing and/or future consultations.

[1] The term 'migrant and refugee' refers to people who have migrated from overseas from main non-English speaking countries and their children, regardless of visa status. It includes people who are part of both newly emerging and longer established communities.

[2] MCWH advocates for the health, safety and wellbeing of migrant and refugee women and gender diverse people. However, within this submission we refer predominantly to women which reflects our existing evidence base and program experience. We note, however, that our advocacy to prevent gender-based violence strives to include gender diverse migrants and refugees.

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Executive Summary

In Australia, more than half the population was born overseas or has at least one parent born overseas, while more than 2.6 million women in Australia were born in a country where the main language is not English (Australian Bureau of Statistics, 2021). Increasingly, more mothers in Australia are migrants or refugees themselves. In 2023, one third of those who gave birth in Australia were born overseas (AIHW, 2026a). Despite the numbers, migrant and refugee women continue to experience unequal access and outcomes in women's health. Yet Australia has many of the tools needed to change this, particularly by drawing on the strengths and expertise of migrant and refugee communities.

As the national voice for migrant and refugee women's health and wellbeing, MCWH brings an intersectional approach to the issues outlined by the Select Committee on Women's Health. In this submission, we draw on over 47 years of practice and research insight to share migrant and refugee women's experiences in the antenatal, pregnancy and postpartum periods, with a focus on pain conditions, medical misogyny, fertility, assisted reproduction, and medical devices, including in relation to barriers to accessing healthcare, supports, and treatments; best practice approaches and models; education and training; research and data; and medical devices regulation and complaint processes.

MCWH provides recommendations for improving health access and outcomes for migrant and refugee women and gender diverse people. In doing so, we respond to all terms of reference for the Select Committee into Women's Health, providing evidence on:

- **Experiences of postpartum health and healthcare services (TOR a,b,c,d,g):** Migrant and refugee women commonly report that migration-related social isolation, and an inaccessible healthcare system affect their mental health during and after birth. Many women report experiencing birth trauma and obstetric violence in Australia's healthcare system due to discrimination, bias and a lack of culturally and linguistically responsive care. Postpartum care can be costly for many migrant and refugee women who are often economically marginalised, including those on temporary visas who are excluded from Medicare. In addition, culturally and linguistically responsive care is often not provided. However, promising models of care demonstrate that better postpartum health experiences are possible for migrant and refugee women, including continuity of care and bilingual support models.
- **Antenatal and postpartum reproductive health support and education (TOR e):** Some migrant and refugee groups access antenatal care at lower rates than Australian-born, non-Indigenous women, and are also less likely to use forms of contraception that rely on a health provider as an intermediary (i.e. IUDs, contraceptive pill). This access disparity is likely linked to insufficient multilingual health information, and affordable and accessible contraceptive options available to migrant and refugee women. To address access gaps, MCWH has been providing in-language sexual and reproductive health information to migrant and refugee women since 1978 on a range of topics including stillbirth prevention, pregnancy choice and contraception, and infant care.
- **Education and training on pregnancy and postpartum care for healthcare professionals (TOR f):** Migrant and refugee women often experience Australia's healthcare system as unresponsive and unsafe, especially in the pregnancy and postpartum period. They report experiences of not being taken seriously, being dehumanised, having care and treatment

denied or delayed and experiencing forms of discrimination based on their age, race, ability, migration status and access to health insurance. These experiences stem from a system that does not adequately and sustainably support healthcare professionals to provide culturally and linguistically responsive healthcare. For example, coordinated and consistent education for health professionals on issues like female genital mutilation/cutting (FGM/C).

- **Data and research relating to postpartum health (TOR h):** There are significant evidence gaps in the collection and reporting of national health data which reflect the experiences and health outcomes of migrant and refugee women and gender diverse people. This evidence gap is evident when it comes to antenatal and postpartum health, including across maternal mortality, suicidality, congenital anomalies, and infant deaths. In addition to these limitations in national data, qualitative data that centres the voices of migrants and refugees is limited.
- **Experiences of pain and seeking care (TOR i,j,k):** Pain experienced by women and gender diverse people is disproportionately under-researched, ignored and misdiagnosed. For migrant and refugee women, issues like medical misogyny intersect with racial discrimination and discrimination based on sexual orientation, impacting the way healthcare providers respond to pain. Discrimination in clinical settings is compounded by access barriers like cost, wait times, disproportionate caring responsibilities, lack of access to leave entitlements, and limited LGBTIQA+ responsive healthcare options. Further, limited access to interpreters or practitioners who speak the same language mean that many migrant and refugee women find their pain is ignored. All these factors can have serious implications for migrant and refugee women's experiences of pain, further impacting their health, relationships and ability to work and study.
- **Approaches and access to fertility and assisted reproductive treatments (TOR l,m):** For fertility and assisted reproductive treatments, migrant and refugee women encounter barriers to access, including care that is not culturally appropriate, limited or no in-language resources and information, rising costs, and visa discrimination. To improve health equity and inform best practice approaches, there is considerable opportunity for more research that is led by migrant and refugee women and gender diverse people, is intersectional and takes a reproductive justice approach.
- **Use, access, regulation and monitoring of medical devices used in women's healthcare (TOR n,o):** Migrant and refugee women report that culturally appropriate information on medical devices such as IUDs is scant. Further, support to make decisions about using these devices is often limited and the costs associated are unclear. Additionally, migrant and refugee women consistently shared their challenges navigating unclear and complex complaint pathways, further highlighting a culturally unresponsive and unsafe health system.

To support better access, care and practice for migrant and refugee women and gender diverse people, MCWH puts forward the following recommendations:

1. Invest in the integration of bilingual/bicultural service navigators into hospitals, clinics, and centres to assist migrant and refugee women and gender diverse people experiencing structural barriers to healthcare.

2. Incentivise equitable long-term partnerships across alliances, foundations and community-led organisations to ensure preterm, stillbirth, infant loss and birth trauma programs, initiatives, campaigns, supports and resources are co-designed with migrant and refugee

women and gender diverse people and their representative organisations to ensure they are responsive to their needs.

3. Support the implementation of Group Pregnancy Care in collaboration with community-led organisations, across public hospitals in Australia to improve access to pregnancy and postpartum care.
4. Address institutional discrimination in access to healthcare by providing opportunities for migrant and refugee women and gender diverse people to co-design healthcare reforms and models of engagement, especially in rural and regional areas.
5. Expand the provision of Paid Parental Leave to a minimum of 40 weeks, considering a rate based on the weekly national median wage and extend to all parents in Australia regardless of visa status, industries and employment types.
6. Partner with community-led organisations to review organisational policy and to develop consistent culturally and linguistically responsive practice such as offering longer appointment times, and multilingual resources.
7. Fund community-led co-design and dissemination of multilingual evidence-based resources and campaigns, on antenatal, postpartum health and contraceptive care.
8. Support health education module development and delivery specifically on antenatal, postpartum and contraceptive care by implementing **Recommendation 25 (4.96)** of the Senate Inquiry into Universal Access to Reproductive Healthcare, for antenatal, postpartum and contraceptive health education*: 'The committee recommends that the Australian Government consider options and incentives to expand the culturally and linguistically diverse (CALD) sexual and reproductive health workforce including leveraging the success of the 'Health in My Language' program.'*
9. Fund community-led organisations to partner with tertiary institutions, medical and professional colleges to support the implementation of **Recommendation 24 (4.95)** of the Senate Inquiry into Universal Access to Reproductive Healthcare: '*The committee recommends that the Australian Government work with the relevant medical and professional colleges to support the development and delivery of training to health practitioners providing sexual, reproductive and maternal healthcare on: engaging and communicating with people with disability; providing culturally aware and trauma-informed services to culturally and linguistically diverse migrants and refugees; and ensuring culturally safe healthcare for First Nations people in mainstream non community-controlled organisations, by ensuring practitioners are aware of intergenerational trauma, cultural norms and taboos.'*
10. Collaborate with universities, professional colleges, accreditation bodies and specialist migrant women's health organisations to embed FGM/C education into undergraduate and postgraduate health professional curricula and continuing professional development, including through initiatives such as MCWH's **SWIFT** (Supporting Workers in FGM/C Training) Project. This should include building health practitioners' capacity to provide culturally responsive care, recognise FGM/C-related health needs and facilitate appropriate referrals to specialist services.
11. Develop a framework for collecting and reporting disaggregated health data (by gender, sex, ethnicity, disability, place of birth, interpreter use, language(s) spoken at home, and visa status) and outcomes data relevant to migrant and refugee populations and ensure medical research reflects the principles of racial and gender equity.

12. Invest in community-led, participatory research on migrant and refugee women and gender diverse people's experiences related to postpartum healthcare.
13. Invest in the expansion of community-led organisations to provide comprehensive, long-term, nationwide, specialist advice via consultations and professional development to ensure Endometriosis and Pelvic Pain Clinics and Excellence Centre for LARCS are culturally responsive and accessible across Australia.
14. Ensure accessibility to translation and interpreting services by investing in a secure, well-paid translation and interpreting workforce with expertise in cultural safety, women's health and gendered violence.
15. Address the multiple forms of structural inequalities that limit migrant and refugee women's and gender diverse peoples' access to healthcare by implementing **Recommendation 30 (4.111)** of the Senate Inquiry into Universal Access to Reproductive Healthcare: *'The committee recommends that the Australian government, in consultation with state and territory governments, consider options for ensuring the provision of reproductive health to all people living in Australia, irrespective of their visa status.'*
16. Commission new community-led research on migrant and refugee women and gender diverse people's experiences of fertility and assisted reproduction treatments, including barriers, accessibility and best practice approaches.
17. Address the multiple forms of structural inequalities that limit migrant and refugee women's and gender diverse peoples' access to fertility and assisted reproduction treatments, including direct investment in assisted reproductive treatments alongside the implementation of **Recommendation 32 (4.114)** of the Senate Inquiry into Universal Access to Reproductive Healthcare: *'The committee recommends that the Australian Government explores the feasibility of Medicare rebates for in vitro fertilisation (IVF) services for cohorts not currently eligible for subsidised services.'*
18. Support informed decision-making and consent by advocating for manufacturers, regulators and related agencies to provide publicly available, non-technical and multilingual information about medical devices. This should include reporting on the medical device's clinical trial history, risks, side effects, recalls and safety concerns.
19. Ensure pathways to reporting concerns and complaints in healthcare settings and to regulators of medical devices, are multilingual, transparent and accessible. Include information on the obligations of healthcare institutions and agencies to respond to complaints.
20. Ensure regulators and agencies responsible for medical devices in Australia engage with community-led organisations to co-design complaint pathways and processes which are transparent, accessible and responsive to migrant and refugee people's needs.

Response to the Terms of Reference

Experiences of postpartum health and healthcare services

Response to Terms of Reference (a) (b) (c) (d) and (g)

In Australia, definitions of the postpartum period differ. In some clinical guidelines, and in datasets provide by the Australian Institute for Health and Welfare, the postpartum period refers to the period from birth to six weeks after birth (AIHW, 2025b; Blair et al., 2024). However, many organisations advocate for a more expansive understanding of the postpartum period in recognition of the longer-term effects pregnancy and birth can have on a person's health and wellbeing. For example, COAG Health Council recommended expanding access to postnatal and postpartum care to the 12-month period to support maternal health and wellbeing (COAG Health Council, 2019). Similarly, the Centre for Perinatal Excellence defines the postpartum and postnatal period as being the 12 months following birth (Centre for Perinatal Excellence, 2023). MCWH supports this expansion, understanding the postpartum period as the period from birth, or pregnancy loss and miscarriage, to 12 months after (Kumarasinghe et al., 2024).

In Australia, over one third of people who give birth are migrants, with the majority coming from non-English speaking countries. Evidence shows that migrants and refugees are far more likely to experience adverse maternal and child health outcomes than the Australian-born, non-Indigenous population, often due to barriers to accessing, safe, affordable and culturally and linguistically responsive care. For instance, migrant and refugee women:

- Have a higher risk of gestational diabetes mellitus (GDM), which can increase risks for other pregnancy-related conditions such preeclampsia, macrosomia, caesarean birth, birth asphyxia, and preterm birth (AIHW, 2026a; Takele et al., 2025), with incidence rates as high as 33.1% for women born in Southern and Central Asia, compared to 16.0% for Australian born women (AIHW, 2026c).
- Experience higher rates of stillbirth, as high as 12.0 per 1,000 births for women born in North Africa, compared to a rate of 8.8 for Australian-born (AIHW, 2026b).
- Experience higher rates of neonatal deaths, as high as 4.1 per 1,000 births for women born in South Eastern Europe, compared to a rate of 2.4 for Australian-born women (AIHW, 2026b).
- Have higher risk of adverse perinatal mental health outcomes, including significantly higher rates of postnatal depression (Palani et al., 2025).

In MCWH's work, migrant and refugee women have shared their experiences of accessing postpartum care and health services in Australia. Many shared the ways that migration-related social isolation and an inaccessible healthcare system affected their mental health during and after birth (Labra-Odde et al., 2025; Tran et al., 2023). They also reported experiencing birth trauma and obstetric violence in Australia's healthcare system due to discrimination, bias and a lack of culturally and linguistically responsive care (Labra-Odde et al., 2025). Further, postpartum care was costly for many migrant and refugee women who are often economically marginalised, including those on temporary visas who are excluded from Medicare. Similarly, migrant and refugee women reported that lack of culturally and linguistically accessible services remained a barrier to care. However, there are promising models of care showing that better postpartum health experiences are possible for migrant and refugee women, including continuity of care and bilingual support models.

This section explores postpartum experiences, issues and potential solutions. In doing so, it responds to the following Terms of Reference:

- **(a) best practice approaches to postpartum healthcare, including the delivery of physical and mental health support and services for mothers and their partners including those who have experienced infant loss;**
- **(b) women's experiences in the postpartum period, including the physical, psychological, emotional and economic impacts of birth;**
- **(c) best practice pregnancy and postpartum care models to support long-term maternal physical and mental health;**
- **(d) the cost and accessibility of postpartum healthcare, including:**
  - **(i) infant feeding supports,**
  - **(ii) mental health supports and services,**
  - **(iii) physiotherapy services, including pelvic health services, and**
  - **(iv) related allied health services;**
- **(g) existing Commonwealth, state and territory government policies, programs and healthcare initiatives addressing postpartum care;**

Impacts of birth trauma and obstetric violence

Birth trauma refers to the 'experience of interactions and/or events related to childbirth that cause overwhelming distressing emotions and reactions, leading to short and/or long-term negative impacts' (Birth Trauma Australia, 2026). In Australia, more than one in ten Australian women experience a traumatic birth, often due to health provider maltreatment of patients during birth – a phenomenon referred to as obstetric violence (Keedle et al., 2023, 2024). For racialised groups like First Nations and migrant and refugee women, birth trauma is often compounded by gendered racism, and lack of culturally and linguistically appropriate care (Select Committee on Birth Trauma, 2024). International literature has found that women of colour more often experience obstetric racism, with providers deploying racial and gendered stereotypes during birth, impacting the ways mothers are treated (Dmowska et al., 2024).

In our national research report examining experiences of bias in the healthcare system, ***End All Bias***, migrant and refugee women described severe experiences of birth trauma, obstetric violence and obstetric racism. Women shared how birth trauma had a lifelong impact on their health and wellbeing. They described how negligent and culturally unresponsive care, such as not engaging an interpreter, impeded their ability to communicate and consent to treatment, while discriminatory practice meant their preferences for care were overlooked. Participants also shared experiences of non-consensual physical interventions, which resulted in injuries for some, breached their reproductive rights and bodily autonomy, and denied their agency and decision-making.

Obstetric violence also intersected with other forms of discrimination (Labra-Odde et al., 2025). For example, a migrant woman shared how discrimination based on her ethnicity and English proficiency intersected with an unresponsive healthcare system to result in 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] […]" (Labra-Odde et al., 2025, p. 45)

Another woman who participated in our *End All Bias* research shared how she felt dehumanised when healthcare providers deprioritised her health in favour of birth outcomes. The participant described the physical and psychological impacts of childbirth, including permanent damage to her eyesight, which she attributed to the health provider's disregard for her health:

"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."

"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." (Labra-Odde et al., 2025, p. 46)

This woman's experience demonstrates how bias and discrimination in healthcare can lead to instances of trauma and obstetric violence across the maternity journey, impacting all aspects of life, including overall wellbeing, employment opportunities, caring responsibilities, long-term physical and mental health outcomes. Unfortunately, resources, supports and services for birthing parents who have experienced birth trauma remain limited (Select Committee on Birth Trauma, 2024). This is especially true for culturally appropriate, in-language resources, reflecting a gap in evidence and knowledge translation informed by the experiences of migrant and refugee women and gender diverse people.

Psychological and emotional impacts of birth

Research indicates that migrant and refugee women experience postnatal depression at a rate of 28.8%, compared to 15% for the general Australian population (Palani et al., 2025). Despite the data and research indicating the increased risk of adverse mental health risks, migrant and refugee women and gender diverse people continue to encounter intersecting barriers to culturally responsive care. Migrant and refugee women often have limited social support and experience isolation through the migration process, further exacerbated by inadequate formal support services (Tran et al., 2023; Vazquez Corona et al., 2025; Westcott & Robertson, 2017). Social isolation and inadequate formal supports directly impact help-seeking behaviours and can increase psychological and emotional impacts during pregnancy and after birth (MCWH, 2022). Migrant and refugee birthing parents can also miss out on essential postpartum support provided by overseas family and

relatives who may be restricted from travelling to Australia due to visa discrimination (Westcott & Robertson, 2017). Across our Victorian and national programs and projects, issues related to social isolation, racial and gender discrimination have been a strong theme. For instance, a woman shared her experience of being dismissed multiple times when she sought healthcare support after having her baby:

> *"I was alone here and struggling with my baby, there were no one else to help […] I used to feel so scared of everything and consistently I feel that something is going to harm me and my baby… I thought it was depression and went to see the GP five times and asking her to that I have depression symptoms but every time she kept saying it was not depression." (MCWH, 2024b, p. 26; Tran et al., 2023)*

The importance of perinatal mental support services, such as Perinatal Anxiety and Depression Australia (PANDA) cannot be overstated. PANDA provides support to parents and families during pregnancy and throughout the first year of parenthood through online and phone counselling services and other initiatives. While PANDA has some online in-language resources, including MCWH's video on perinatal mental health, and telephone counsellors can work with interpreters, their capacity to engage with migrant and refugee communities is limited. There are very few services in perinatal mental health that are tailored specifically for migrant and refugee women and their families, highlighting an area of need. There is an opportunity to expand the capacity of mainstream services to work directly with migrant and refugee communities, through partnership with community-led organisations such as MCWH. For example, bilingual health educators could work alongside phone counsellors to provide multilingual information, support and referrals.

Cost and accessibility of postpartum healthcare

Migrant and refugee women's mental health, including in the postpartum period, can be exacerbated by the financial insecurity they often experience in Australia. Discriminatory policies within Australia's migration and healthcare systems restrict access to healthcare services and treatment for certain groups. For example, only permanent residents in Australia are eligible for Medicare, Pharmaceutical Benefits Scheme (PBS), Health Care cards, financial support (Centrelink), and childcare or housing support. Many migrant women who are asylum seekers, and those on temporary and bridging visas, are denied access to essential services and treatments due to their visa status. In some rural areas, antenatal care is provided only through GP clinics which require Medicare cover.

Barriers to access for international students have existed for more than a decade, as they are required to purchase Overseas Student Health Cover (OSHC) as a condition of their visa (MCWH, 2013). This adds additional financial burden for international students, particularly when navigating pregnancy and postpartum healthcare. Despite promising amendments in 2025, the OSHC Deed continues to financially and disproportionately impact the sexual and reproductive choices, health and wellbeing of migrant and refugee women and gender diverse people (MCWH, 2026b).

Even for those with access to Medicare, high gap fees and extra costs for recommended tests and supports across the pregnancy and postpartum period, such as for genetic testing, physiotherapy, birthing classes, and lactation are common (Vazquez Corona et al., 2025). The cost of contraceptives

is another key contributing factor to migrant and refugee women's decision making during the postpartum period (Botfield et al., 2026; Jean Hailes for Women's Health et al., 2025). When discussing available contraceptive options, women wanted cost as essential content for inclusion in health resources (Botfield et al., 2026).

Difficult to navigate health system and limited access to interpreters

Australia's healthcare system is complex and difficult to navigate and migrant and refugee women and gender diverse people do not always have access to timely and quality interpreters in healthcare settings. Specifically in maternal healthcare, the combination of private and public healthcare systems and lack of explanations on different models of maternity care, reinforces inaccessibility to timely healthcare services and support for migrant and refugee women (Vazquez Corona et al., 2025).

In *End All Bias*, we found that limited access to quality interpreters was a significant barrier to receiving equitable healthcare, in some cases contributing to experiences of birth trauma (Labra-Odde et al., 2025). For example, negligent care towards those with low English proficiency was noted by one woman in relation to postpartum healthcare:

> *"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." (Labra-Odde et al., 2025, p. 35)*

Inadequate language services, short consultation times, limited continuity of care, and interpersonal discrimination, all intersect with each other to negatively impact migrant and refugee women's postpartum experiences, health and wellbeing.

Best practice pregnancy and postpartum healthcare approaches, services, supports, models and policies

Timely access to antenatal care is associated with better maternal health, fewer interventions in late pregnancy and positive child health outcomes. The *Australian Pregnancy Care Guidelines* recommend that the first antenatal visit should be within the first 10 weeks of pregnancy (Australian Living Evidence Collaboration, 2026). Despite this, many migrant and refugee women are missing out on essential care in their first trimester. For example, for women born in Vietnam, the proportion who had their first antenatal care visit at less than 14 weeks gestation was as low as 69.3%, compared with 80.8% for women born in Australia (AIHW, 2026a). There are many factors influencing the low uptake of antenatal care, such as unfamiliarity with the healthcare system, pre-migration trauma, social inequality and financial constraints, social isolation and limited transport options, visa constraints, and lack of culturally and linguistically appropriate services (Mengesha et al., 2016; Penman et al., 2023).

Continuity of care and bilingual/bicultural support models

Bilingual/bicultural care coordinators or service navigators have proved beneficial in supporting migrant and refugee women to overcome structural barriers to healthcare and social services (Mistry et al., 2023). Recent evidence which combines use of interpreters, bilingual/bicultural peer support, continuity of care and trauma-informed care, shows a promising model for supporting women from migrant and refugee backgrounds through pregnancy and postpartum. This model, termed 'Group Pregnancy Care', involves a multidisciplinary team including two midwives, a maternal and child health nurse, a professional interpreter, and a community and language specific bicultural worker, delivering care and support across pregnancy and postpartum (up to 4 months) (FitzPatrick et al., 2026).

State and territory based Maternal and Child Health (MCH) services are often the main point of contact new parents have with healthcare professionals during postpartum and the early childhood years. In Victoria, these services provide routine health and wellbeing support from maternal and child health nurses, include an initial home visit, and are free to all Victorians, regardless of visa status (Department of Health. Victoria, 2026). It is important to ensure similar initiatives are sustainably funded to offer culturally and linguistically responsive healthcare to migrant and refugee women and communities consistently across Australia. The Victorian MCH service also links first time parents into local parenting groups, which is essential for reducing isolation. However, parenting groups assume English language proficiency for participation. New parent groups in languages other than English are largely left to local councils, libraries and community clubs to organise often with limited to no funding. There is an opportunity to sustainably fund and embed trained bilingual health educators into the maternal and child health system to provide culturally appropriate, in-language information about parenting in the early childhood years.

Models and programs, such as MCWH's *Health in My Language* program, that are free, in-language, trauma informed, and in locations accessible and familiar can provide migrant and refugee women and new parents with the information and support they need to navigate the health system and make informed decisions about their health and wellbeing in the postpartum period.

Access to Commonwealth Paid Parental Leave Scheme

Currently, the Commonwealth Paid Parental Leave (PPL) scheme offers 26 weeks of paid parental leave, based on the national minimum wage, for eligible families in Australia with a child born or adopted from 1 July 2026. However, the eligibility criteria based on income test, work test, residency rules and waiting periods, significantly impact access for many migrant and refugee communities in Australia (Parental Leave Pay - Services Australia, 2026).

The barriers to pregnancy and postpartum healthcare outlined earlier are amplified by the loss of income during parental leave for many migrant and refugee parents who are not eligible for financial supports. For instance, migrants on some temporary visas and those who have insecure employment and irregular hours are often ineligible for PPL.

Even for those who do have access, the duration, rate and flexibility of the current PPL offers limited support for the health and wellbeing of the birthing person and infant. For example, the extension of PPL to 26 weeks and option to share leave with the non-birthing parent does not align with current recommendations on breastfeeding or where longer recovery may be needed from complicated births. This can deprive birthing parents from vital recovery and bonding time, while leaving non-birthing partners unable to take leave to provide essential caregiving support, ultimately reinforcing existing gender inequalities (Baird et al., 2021; Selvarajah, 2024). To ensure families are sufficiently

supported during the postpartum period, leave entitlements and policies must be shaped by the lived reality of migrant and refugee women and families, with considerations to gender equality in caregiving and employment long term.

Recommendations to improve experiences of postpartum health and healthcare services:

- Invest in the integration of bilingual/bicultural service navigators into hospitals, clinics, and centres to assist migrant and refugee women and gender diverse people experiencing structural barriers to healthcare.
- Incentivise equitable long-term partnerships across alliances, foundations and community-led organisations to ensure preterm, stillbirth, infant loss and birth trauma programs, initiatives, campaigns, supports and resources are co-designed with migrant and refugee women and gender diverse people and their representative organisations to ensure they are responsive to their needs.
- Support the implementation of Group Pregnancy Care in collaboration with community-led organisations, across public hospitals in Australia to improve access to pregnancy and postpartum care.
- Address institutional discrimination in access to healthcare by providing opportunities for migrant and refugee women and gender diverse people to co-design healthcare reforms and models of engagement, especially in rural and regional areas.
- Expand the provision of Paid Parental Leave to a minimum of 40 weeks, considering a rate based on the weekly national median wage and extend to all parents in Australia regardless of visa status and this should extend across industries and employment types.
- Partner with community-led organisations to review organisational policy and to develop consistent culturally and linguistically responsive practice such as offering longer appointment times, and multilingual resources.

Antenatal and postpartum reproductive health support and education

Response to Terms of Reference (e)

In Australia, migrant and refugee women have inequitable access to antenatal and postpartum reproductive health support and education often due to a lack of accessible and culturally and linguistically appropriate information. A recent study conducted in partnership with MCWH found that migrant and refugee women do not have adequate knowledge of fertility return postpartum and contraception options, often using condoms as their major method of contraception. The form of contraception used often reflects a lack of education and information provided on these topics during both the antenatal and postpartum periods. Limited resources and inconsistent postpartum contraception discussions with maternity providers hindered contraceptive choice and decision making for migrant and refugee women (Botfield et al., 2026).

In response to migrant and refugee women's unequal access to healthcare information, MCWH has been delivering our Health Education Program using trained, bilingual health educators since 1978. We have delivered sessions in different settings including workplaces, community settings and prisons. For close to 50 years, we have developed innovative and effective models for delivering

health education to migrant and refugee communities on a range of topics including stillbirth prevention, mental health, pregnancy choice and contraception, and infant care.

This section responds to the following Terms of Reference:

(e) antenatal and postpartum reproductive health support and education, including contraceptive care;

Barriers to postpartum support and education

Recognising migrant and refugee women and gender diverse people's barriers to postpartum support and education is an integral part of policy development and systems change. Broader structural challenges including employment and visa discrimination, ableism, financial insecurity and migration-related issues, must be addressed alongside cultural and linguistic barriers.

Significant gaps in culturally and linguistically appropriate health information and education for migrant and refugee people across antenatal and postpartum health persist. There is ineffective guidance and limited health information on breastfeeding, mental health, exercise, pain management, wound care and nutrition (Vazquez Corona et al., 2025). Additionally, there is a need for education and information on postpartum fertility return and contraceptive options to be meaningful, tailored and timely, especially as migrant and refugee women may experience higher rates of closely spaced and unintended pregnancies (Botfield et al., 2026). Although migrant and refugee women express interest and are eager to learn more about postpartum health, education and information is rarely shared or delivered in ways that are accessible to them during this period (Botfield et al., 2026; Vazquez Corona et al., 2025). The significant information gaps across antenatal and postpartum care limit migrant and refugee women's contraceptive choice and decision-making.

Promising practice for culturally and linguistically responsive information and education

For postpartum information and education to be relevant, accessible and culturally appropriate, migrant and refugee women and gender diverse people should be meaningfully engaged in co-design. Their lived experience, expertise and guidance should shape the development, content, delivery and dissemination of resources and education modules.

MCWH has experience co-designing Victorian and nationally relevant resources to support migrant and refugee people during their pregnancy, which can be leveraged to address gaps in information. For example, MCWH participated in co-designing culturally appropriate resources to support migrant and refugee communities who are disproportionately impacted by stillbirth (AIHW, 2026b; MCWH, 2024a). This work included adapting the evidence-based **'Safer Baby Bundle'** resource with communities and healthcare professionals for Arabic, Dari, Dinka and Karen speaking communities, and tailoring content into a variety of formats to ensure accessibility (MCWH, 2024b; Stillbirth Centre of Research Excellence).

Co-designed resources are vital for essential health information sharing; however, it is only one part of designing and delivering culturally and linguistically accessible information for migrants and refugees. Equally important are safe, peer-led spaces where migrant and refugee people can come together, ask questions and receive support in navigating Australia's healthcare system. MCWH's health education model is uniquely successful because health information is provided in participants' preferred languages, in locations and in ways which respect their experiences, knowledge and cultural contexts.

Through our national *Health in My Language* (HiML) program, migrant and refugee women learnt more about sexual and reproductive health and felt more confident sharing their knowledge with others and accessing health services. The program could achieve this outcome because of strong national partnerships, trusted bilingual educators, and evidence-based education. HiML evaluation showed that 96% of participants who attended sessions were likely to encourage others to attend health education sessions (MCWH, 2026a).

Session participants specifically shared how valuable health education sessions were in informing them about their choices and how it impacted their help-seeking:

> *"Attending sessions on contraception provided me with valuable knowledge at a time when I needed it most. I learned that there are many different contraceptive options available, which gave me the confidence to discuss these options with my GP and choose the method that best suits my needs" (MCWH, 2026a, p. 28)*

Currently, MCWH delivers health education on sexual and reproductive health topics and mental health to migrant and refugee communities. The topics, 'Navigating the Australian mental health system' and 'Let's talk mental health' had the highest attendance rate in the financial year 2025/26 (MCWH, 2026a), highlighting their importance. As one session participant shared:

> *"As a migrant and a single mother of two teenagers, I have struggled to settle into a new country, and navigating complex systems, including healthcare, has been challenging. Learning how to maintain mental wellbeing and identifying where to access professional support has been very helpful to me" (MCWH, 2026a, p. 25)*

MCWH also delivers topics aimed at supporting new parents. In partnership with Western Public Health Unit in Victoria, MCWH Bilingual Health Educators completed INFaNT facilitator training and subsequently delivered health education on infant nutrition, care and active play. Sessions were delivered to almost 400 migrant and refugee people, and almost 300 resources were distributed in Vietnamese, Punjabi, Mandarin, Arabic, Urdu and English. Internal evaluation showed that participants thought the sessions were supportive, informative, and essential to their early parenting journeys, especially when navigating an unfamiliar health system.

Recommendations to improve Antenatal and postpartum reproductive health support and education:

- Fund community-led co-design and dissemination of multilingual evidence-based resources and campaigns on antenatal, postpartum health and contraceptive care.
- Support health education module development and delivery specifically on antenatal, postpartum and contraceptive care by implementing **Recommendation 25 (4.96)** of the Senate Inquiry into Universal Access to Reproductive Healthcare, for antenatal, postpartum and contraceptive health education*: 'The committee recommends that the Australian Government consider options and incentives to expand the culturally and linguistically*

diverse (CALD) sexual and reproductive health workforce including leveraging the success of the 'Health in My Language' program.'

Education and training on pregnancy and postpartum care for healthcare professionals

Response to Terms of Reference (f)

MCWH's research and programs have identified that healthcare professionals are not always equipped to provide culturally responsive and safe care for migrant and refugee women (Labra-Odde et al., 2025). For example, MCWH has been building the capacity of health professionals for over 10 years to better respond to the needs of women affected by FGM/C, first through our *National Education Toolkit for Female Genital Mutilation/Cutting Awareness* (**NETFA**) program and more recently through *Supporting Workers in FGM/C Training* (SWIFT) Project. This work has demonstrated the need and desire from health professionals for a nationally coordinated practice and prevention approach on FGM/C.

Health professionals should have ongoing opportunities to learn about best practice and to share knowledge and resources, so they can provide optimal care for migrant and refugee women and gender diverse people during pregnancy and postpartum.

In exploring these issues, this section responds to the following Terms of Reference:

(f) research, education and training on pregnancy and postpartum care for healthcare professionals working in maternal care;

Workforce capacity building: a whole of systems approach

Culturally responsive and safe care should be embedded throughout the whole healthcare system through organisational policy and systems change. There is however a lack of adequate training or professional development in providing culturally responsive care. Culturally responsive care refers to the ability to engage, respect and respond to the needs of migrants and refugees. It looks beyond concepts of 'cultural competency' that focus on cultural difference, towards understanding how dominant systems, structures or practices in Australia may need to be adjusted to provide care that is more responsive to the needs of migrants and refugees. Migrant and refugee women have shared promising practice from healthcare professionals in *End All Bias*, but there is a need to standardise these approaches to ensure consistent and culturally responsive care is available to all:

> *"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." (Labra-Odde et al., 2025)*

To ensure the entire workforce is responsive to the needs of migrant and refugee women, relevant training should be integrated into education at undergraduate and postgraduate levels, and as part of continuing professional development for healthcare workers. Short and reductionist trainings

which offer simplistic understandings of culture and rely on stereotypes and assumptions, does little to improve care for migrant and refugee communities, and may cause further harm. What is needed is a whole-of-systems approach to workforce capacity building, spanning research, education and training in maternal care that recognises the role of the individual, organisational and structural in reinforcing unsafe and discriminatory practice. Community-led organisations have a significant role to play in this work, sharing their specialist knowledge and expertise on intersectional policy and service delivery and what key elements would make a difference to patient experience and care in the pregnancy and postpartum period.

Gaps in FGM/C knowledge and training

Female Genital Mutilation/Cutting (FGM/C) refers to a range of procedures that alter or injure the external female genitals for non-medical reasons (WHO, 2025). While it is primarily practiced in parts of Africa, the Middle East and Asia, women and girls who have experienced FGM/C live in many countries, including Australia (MCWH, 2026c).

FGM/C has short- and long-term health consequences, including impacts to pregnancy and childbirth such as prolonged labour, tearing and bleeding. However, both community, primary and specialist health practitioners still lack the capacity to properly support and treat migrant and refugee women who have experienced FGM/C. As part of MCWH's **SWIFT** Project, our needs analysis highlighted substantial gaps in referral systems for women who have experienced FGM/C to access specialist care, including gynaecological and de-infibulation services (MCWH, 2026c). For example, in Australia de-infibulation and reconstructive surgery access is often limited due to a shortage of appropriately trained practitioners. The SWIFT project also identified significant gaps in practitioners' confidence to ask about FGM/C, understand its clinical implications and identify appropriate referral pathways (MCWH, 2026c). Limited practitioner knowledge of FGM/C contributes to missed opportunities to provide culturally responsive and sensitive healthcare to women affected by FGM/C, including gynaecological care, sexual health, fertility care, pelvic health, and pain management.

Recommendations to improve education and training on pregnancy and postpartum care for healthcare professionals:

- Fund community-led organisations to partner with tertiary institutions, medical and professional colleges to support the implementation of **Recommendation 24 (4.95)** of the Senate Inquiry into Universal Access to Reproductive Healthcare: '*The committee recommends that the Australian Government work with the relevant medical and professional colleges to support the development and delivery of training to health practitioners providing sexual, reproductive and maternal healthcare on: engaging and communicating with people with disability; providing culturally aware and trauma-informed services to culturally and linguistically diverse migrants and refugees; and ensuring culturally safe healthcare for First Nations people in mainstream non community-controlled organisations, by ensuring practitioners are aware of intergenerational trauma, cultural norms and taboos.'*
- Collaborate with universities, professional colleges, accreditation bodies and specialist migrant women's health organisations to embed FGM/C education into undergraduate and postgraduate health professional curricula and continuing professional development, including through initiatives, such as MCWH's **SWIFT** Project. This should include building

health practitioners' capacity to provide culturally responsive and sensitive care, recognise FGM/C-related health needs and facilitate appropriate referrals to specialist services.

Data and research relating to postpartum healthcare

Response to Terms of Reference (h)

There are significant evidence gaps in the collection and reporting of national health data which reflect the experiences and health outcomes of migrant and refugee women and gender diverse people. This is particularly evident in antenatal and postpartum health, specifically across maternal mortality, suicidality, congenital anomalies, and infant deaths. In addition to these limitations in national data, research that centres migrant and refugee voices and perspectives is limited.

This section explores these issues by responding to the following Terms of Reference:

(h) data collection, reporting and monitoring processes and allocation of research efforts relating to postpartum healthcare;

Limitations of national data collection, reporting and monitoring processes

When it comes to understanding migrant and refugee women's health access and outcomes, significant gaps remain in disaggregated data by gender, sex, ethnicity, disability, place of birth, interpreter use, language(s) spoken at home, and visa status. The lack of disaggregated data provides an incomplete picture of antenatal and postpartum access, experiences and outcomes in Australia.

While collecting and reporting maternal country of birth is an initial step in the right direction, the indicator is not consistently or comprehensively reported in national data on antenatal and postpartum access and outcomes. Data gaps also persist for the following topics:

Maternal mortality and suicidality

Currently, the maternal mortality is defined in national datasets as 'the death of a woman while pregnant or within 42 days of the end of pregnancy' (AIHW, 2025a), meaning deaths linked to pregnancy and postpartum mental health or medical issues beyond this timeframe are insufficiently recorded (Lawson, 2025). Comparatively in Victoria, mandatory state reporting defines maternal mortality as 'all maternal deaths during pregnancy and within a year of birth' (Safer Care Victoria, 2025), indicating inconsistent definitions in data collection on maternal mortality.

Suicide is one of the leading causes of maternal deaths in Australia. However, substantial gaps and inconsistencies in the availability and quality of data related to migrant and refugee individuals and suicide remain (Bowden et al., 2020; Pham et al., 2024; Truong et al., 2023). The major data gaps across perinatal mental health, suicidality and domestic, family and sexual violence (DFSV) are noted and discussed in MCWH's recent ***Submission to the Inquiry into the relationship between domestic, family and sexual violence and suicide*** (MCWH, 2026d).

Congenital Anomalies

National **Congenital Anomalies data** is currently not disaggregated by country of birth or other indicators which may provide insights to migrant and refugee outcomes. However, research has indicated that infants from mothers born overseas may be at increased risk of congenital abnormalities (Palani et al., 2025). Current national data also identifies congenital anomalies as one of the leading causes of infant deaths (AIHW, 2022).

These data limitations have serious implications on our understanding of health outcomes for migrant and refugee women and gender diverse people, and the extent of issues that may need urgent attention.

Allocation of research efforts

Quantitative data can reveal important insights into population health, wellbeing and outcomes. However, qualitative evidence is needed to provide missing contextual information on access to healthcare and the barriers and enablers that shape it.

To ensure a more accurate and inclusive evidence base that advances policy on health equity, migrant and refugee women and gender diverse people should be positioned as experts in their own experience. As such, qualitative research should be intersectional, prioritise community-led approaches and use in-language engagement.

Recommendations for data and research relating to post-partum care:

- Develop a framework for collecting and reporting disaggregated health data (by gender, sex, ethnicity, disability, place of birth, interpreter use, language(s) spoken at home, and visa status) and outcomes data relevant to migrant and refugee populations and ensure medical research reflects the principles of racial and gender equity.
- Invest in community-led, participatory research on migrant and refugee women and gender diverse people's experiences related to postpartum healthcare.

Experiences of pain and seeking care

Response to Terms of Reference (i) (j) (k)

The gender pain gap is a public health and human rights issue, and for too long, women's pain has not received the proper attention it deserves. Initiatives such as the Senate Select Committee on Women's Health and the Victorian Government's Inquiry into Women's Pain are welcomed and vital.

While the pain experienced by women and gender diverse people is disproportionately under-researched, existing evidence indicates their pain is routinely ignored and misdiagnosed. Systematically disadvantaged groups such as women with disability, migrant and refugee women, people from the LGBTIQA+ community and Aboriginal and Torres Strait Islander people, are more likely to live with chronic pain and greater severity due to structural barriers to access and discrimination in care (Altun et al., 2022; Anderson et al., 2009; MCWH, 2024b; Wallace et al., 2021). Migrant and refugee women report that when it comes to pain management, their healthcare needs are often not addressed or met due to long wait times, costly services, lack of access to sick leave and caring responsibilities, limited access to LGBTIQA+ responsive healthcare, interpreters or practitioners who speak the same language.

This section outlines the issues experienced by migrant and refugee women and gender diverse people when it comes to pain and seeking care and responds to the following Terms of Reference:

(i) the ways in which women and girls experience recurrent, severe, or long-lasting pain conditions;

(j) women's experience in seeking appropriate healthcare responses to pain, including experiences of medical misogyny;

(k) barriers to effective pain management, including the range and affordability of available treatments;

Medical misogyny and racial discrimination

For migrant and refugee women and gender diverse people, multiple forms of discrimination intersect to limit access to pain care, management and treatments. From our research, we heard how racial stereotypes, heteronormative assumptions, medical misogyny, discrimination on the basis of English proficiency resulted in migrant and refugee women being ignored, dismissed, silenced, misinterpreted or discredited by clinicians (MCWH, 2024b).

Evidence from **MCWH's submission to the Victorian Government Inquiry into Women's Pain**, found the experience of not being taken seriously or being dismissed was a persistent issue and was a significant barrier for migrant and refugee people seeking help (MCWH, 2024b).

When sharing experiences of seeking help for endometriosis and pelvic pain, women mentioned how gender and racial discrimination resulted in self-advocacy fatigue:

> *"I have experienced physical pelvic pain for about a year. I have sought help from health professionals and have attended many appointments. There is still no diagnosis. The fatigue from self-advocating for a diagnosis for my pelvic pain also made it difficult for me to receive healthcare. It was tiresome to actively ask for tests and checkups to investigate my pain. Sometimes I wanted to give up and this would delay me getting medical attention." (MCWH, 2024b)*

Medical misogyny and gender bias was also compounded by stereotypes based on race, class and sexuality.

As an LGBTQIA+ migrant individual described:

> *"My Endometriosis pain wasn't taken seriously by doctors for many years. The screening for reproductive healthcare also assumes that I'm in a hetero relationship. Racism has also affected our experience of healthcare in my family." (MCWH, 2024b)*

A health professional from a migrant background similarly shared how migrant and refugee women's pain is often dismissed on the basis of gendered and racial assumptions:

> *"The healthcare system and hospitals are designed with a certain white, ablebodied, cis gender normative and operate with stereotyping everyone outside of this. There is an assumption that women of colour (should) have a high pain tolerance and when they ask for pain support, they are often labelled - for example as "an Indian princess" or that it's just "Asian show" or "difficult". This makes for a very poor health experience resulting in detrimental physical and mental health outcomes." (Multicultural Centre for Women's Health, 2024, p. 31)*

Affordability and long waiting times as barriers to pain management

Extended waiting periods and costly services were also cited as barriers to accessing adequate support for pain management in our submission to the Victorian Government Inquiry into Women's Pain (MCWH, 2024b).

Migrant and refugee women and gender diverse people shared their experiences of enduring pain from one year to as long as 17 years before gaining a diagnosis due to long wait times. In regional Victoria, women shared they had to wait up to three months for a medical appointment. Others described travelling back to their countries of origin to receive timely care due to high cost and wait times.

Numerous responses in our submission on Women's Pain also highlighted the unaffordability of, and limited access to, mental health services. For example, one respondent described how cost and lack of culturally appropriate and LGBTIQA+ responsive healthcare options limited their access:

> *"Cost was a large factor that prevented me from accessing consistent and regular mental health appointments. The wait times and lack of information and availability of suitable therapists who had expertise in working with queer migrant and refugee women made it difficult for me to access mental health services at an early point." (MCWH, 2024b)*

On pain relating to sexual and reproductive health, the costs of hospitalisations and treatments for conditions like endometriosis is extremely high, especially for migrants on temporary visas, who are excluded from Medicare coverage and whose health insurance may not cover all health treatments. One participant said:

> *"[I] have to take ultrasounds and go to gyno every six months – amounting 600 dollars not covered by private insurance or Medicare."*

As discussed in the earlier section on pregnancy and postpartum health, affordability of healthcare services significantly impacts migrant and refugee women and gender diverse people who may be ineligible for Medicare, PBS, and social security payments. The costs associated with healthcare can contribute to poorer health outcomes, and economic and health insecurity.

We heard numerous accounts of visa discrimination and how this leads to migrant and refugee women's pain being dismissed at an interpersonal level by healthcare staff and deprioritised by healthcare institutions and the healthcare system as a whole. For instance, an international student shared her experience of perinatal loss which was made further distressing by the dismissal of her pain:

"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 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?'" (Labra-Odde et al., 2025, p. 45)

In terms of pain management, cost can also impact choice in contraceptive options. For example, IUD insertion can be a painful experience, however, costs associated with pain management can range considerably across Australia with some options as high as $500 (Sexual Health Advocates for Reproductive Equity et al., 2026). Sexual Health Advocates for Reproductive Equity (SHARE), MSI Australia, Sexual and Reproductive Health Australia, MCWH and other organisations have recently called 'on all state and territory governments to make methoxyflurane ('the green whistle') fully subsidised for IUD insertions to ensure that women and people with uteruses can access a pain-management option that aligns with their preferences and needs'(Sexual Health Advocates for Reproductive Equity et al., 2026). Access to pain relief for IUD insertions alongside routine conversations about pain and multilingual information on contraceptive choices is urgently needed to begin addressing the gender pain gap.

Additional barriers to pain management: casualised work and care responsibilities

Casual and contract workers – of which migrant and refugee women are overrepresented (Multicultural Centre for Women's Health & Ethnic Communities Council of Victoria, 2021) – do not have access to sick, parental and annual leave, meaning time to access pain diagnostics and management is often restricted. As one migrant woman shared:

"I was low income for many years. It is difficult to get leave from work to attend medical appointments. The quality of services was very low in the area I lived… It took 15 years of back and forth with the medical system to receive a diagnosis of endometriosis, I've missed studies and work due to this. I have also worked while in severe pain as I haven't been sure if my workplace will be understanding/or provide me with leave for this." (MCWH, 2024b, p. 30)

In our research on informal care work, migrant and refugee women shared their experiences of having to juggle paid employment with multiple caring responsibilities including caring for children, grandchildren, children with disability, elderly parents, and spouses with chronic illness (Aryal-Lee, 2017). These circumstances can make it more difficult to find the time to access care necessary to manage pain, especially when facing a complex, fragmented health system that is difficult to navigate.

Limited in-language information and interpreting services as barriers to receiving appropriate healthcare

Having access to healthcare and information in one's own language increases trust in the system, reduces the risk of misunderstanding, supports informed decision making and leads to better health outcomes overall. Unfortunately, migrant and refugee people with low English proficiency are at

increased risk of experiencing pain for longer periods of time, especially in regional and remote areas of Australia. Healthcare providers in regional areas have less access to onsite interpreters and more difficulty locating interpreters for certain languages, particularly those spoken by emerging refugee communities (MCWH, 2024b; Sullivan et al., 2023; Vaughan et al., 2016). Additionally, poor phone connection and limited access to reliable internet connection may also hinder access to language interpreting services (Labra-Odde et al., 2025).

Some migrant and refugee women are left waiting for long periods due to inconsistent availability of interpreters. For instance, one woman shared how she had *"to wait until [she] can speak English enough to seek further help for pain."* (MCWH, 2024b).

Another woman spoke about how the lack of in-language services and information meant she had limited options in seeking further help for her pain:

> *"I had to rely on same language speaking GP, which didn't give me much options. I have been told it's psychological, all in my mind nearly 10 years! While I was suffering physically. Nothing seemed make sense at that time because lack of information provided. I stopped looking for help because I didn't know where else I could go." (MCWH, 2024b, p. 12)*

Implications of lack of access to healthcare

In Australia, evidence consistently shows communities who are already disadvantaged are more likely to have their pain underestimated, under investigated, and undertreated (MCWH, 2024b).

Barriers to pain management have real life impacts on social inclusion, economic and financial stability, education and employment opportunities, and caring responsibilities.

For example, one survey respondent shared her story of chronic pain and the consequences it had across her life:

> *"It was both mental and physical pain I suffered years and years… It was muscular and joint pain accompanied with other symptoms, which seemed unrelated. I have been treated as symptomatic with all those different medications with no relief. When I am mentally down, it was worsen or vice versa. Then some good doctor finally diagnosed it, Fibromyalgia! … My family life impacted, I stopped socialising, I have missed many workdays, I missed many days of language classes. I couldn't look after my kids, they were always seeing me as a sick mum in the bed." (MCWH, 2024b)*

Recommendations to improve experiences of pain and seeking care

- Invest in the expansion of community-led organisations to provide comprehensive, long-term, nationwide, specialist advice via consultations and professional development to ensure Endometriosis and pelvic pain clinics and Excellence Centre for LARCS are culturally safe and accessible across Australia.

- Ensure accessibility to translation and interpreting services by investing in a secure, well-paid translation and interpreting workforce with expertise in cultural safety, women's health and gendered violence.
- Address the multiple forms of structural inequalities that limit migrant and refugee women's and gender diverse peoples' access to healthcare by implementing **Recommendation 30 (4.111)** of the Senate Inquiry into Universal Access to Reproductive Healthcare: *'The committee recommends that the Australian government, in consultation with state and territory governments, consider options for ensuring the provision of reproductive health to all people living in Australia, irrespective of their visa status.'*

Approaches and access to fertility and assisted reproduction treatments

Response to Terms of Reference (l) (m)

As discussed throughout this submission, migrant and refugee women and gender diverse people experience many barriers to accessing quality healthcare, and these barriers extend to fertility and assisted reproductive treatments. Within fertility and assisted reproductive treatments, migrant and refugee women can experience culturally inappropriate care, limited and inaccessible information, difficulties navigating a complex system, rising costs, and visa discrimination.

There is considerable opportunity to build the evidence base in this area, to better understand migrant and refugee women and gender diverse experiences in accessing fertility and reproductive treatments. Research that is led by migrant and refugee women and gender diverse people and that takes an intersectional and reproductive justice approach is needed to address systemic inequities and inform best practice approaches and policy development.

This section responds to Terms of Reference:

(l) best practice approaches to assisted reproduction treatments;
(m) access and affordability issues relating to fertility and assisted reproduction treatments;

Recent changes to the definition of infertility in Australia have expanded eligibility for Medicare rebates on some fertility treatments, now including single women or gender diverse people, and couples of all genders. While an important step towards more inclusive access to assisted reproductive treatments, it is critical to understand what these changes mean in practice for LGBTQIA+ migrant and refugee communities and how they impact experiences of access and affordability.

From the little evidence there is, migrant and refugee populations face barriers to accessing assisted reproductive treatments, including lack of culturally appropriate healthcare and health information, cost and limited eligibility. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists acknowledge that there remains 'limited representation of CALD populations in fertility research' leading to significant gaps in understanding of their experiences (RANZCOG, 2025). Investment in community-led research which explores fertility and assisted reproductive treatment experiences of migrant and refugee women and gender diverse people is crucial to build the evidence base to inform policy and practice.

In terms of affordability, increasing privatisation in the fertility and assisted reproductive healthcare space continues to contribute to rising costs (RANZCOG, 2025). This adds to the inaccessibility of

fertility and assisted reproduction treatments, particularly for those already experiencing visa discrimination and financial hardship.

Community informed best-practice

An intersectional and reproductive justice approach to fertility research, centring the voices and experiences of migrant and refugee women and gender diverse people can draw attention to systemic barriers to access and solutions for change.

While at present there is no consistent and evidence-based framework for best practice in this area related to migrant and refugee women and communities, we have seen a need and desire for culturally appropriate resources and education about fertility, navigating healthcare systems and accessing treatments. Best practice guidelines or resources for assisted reproduction treatments should be developed in collaboration with community-led organisations that work with migrant and refugee women and gender diverse people.

Recommendations to improve approaches and access to fertility and assisted reproduction treatments

- Commission new community-led research on migrant and refugee women and gender diverse people's experiences of fertility and assisted reproduction treatments, including barriers, accessibility and best practice approaches.
- Address the multiple forms of structural inequalities that limit migrant and refugee women's and gender diverse peoples' access to fertility and assisted reproduction treatments, including direct investment in assisted reproductive treatments alongside the implementation of **Recommendation 32 (4.114)** of the Senate Inquiry into Universal Access to Reproductive Healthcare: *'The committee recommends that the Australian Government explores the feasibility of Medicare rebates for in vitro fertilisation (IVF) services for cohorts not currently eligible for subsidised services.'*

Use, access, regulation and monitoring of medical devices used in women's healthcare

Response to Terms of Reference (n) (o)

Across MCWH's work, migrant and refugee women report that while they are encouraged to utilise medical devices such as IUDs for their reproductive care, in-language and culturally appropriate information about these devices is limited. Lack of information makes it difficult for migrant and refugee women to make informed decisions about which devices to use. When it comes to complaint pathways, migrant and refugee women express difficulties due to unclear and lengthy processes, as well as the emotional toll of raising complaints and the negative consequences for themselves and their communities.

In sharing these insights, this section responds to the following terms of reference:

(n) the regulation of medical devices used in women's healthcare treatments, including risk assessments, monitoring and reporting;

(o) the role of relevant regulators and other agencies in responding to complaints regarding medical devices.

Lack of accessible information on medical devices

Lack of accessible culturally and linguistically accessible information has been discussed in our earlier section on 'Antenatal and postpartum reproductive health support and education'. The lack of accessibility and the importance of supporting informed decision making and bodily autonomy are also highly relevant to the information on medical devices. For example, a migrant woman shared how she wished she could have been better supported to make an informed decision:

> *"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." (Labra-Odde et al., 2025, p. 39)*

Unclear reporting pathways and patient safety

Migrant and refugee women have reported a lack of clarity and transparency feedback and complaint pathways in healthcare settings. For example, in MCWH's *End All Bias* research report, several participants noted that they would not know where to go to complain, and also stating their reluctance to do so, due to negative consequences. While related to reporting pathways more broadly, findings from *End All Bias* are relevant to the issue of reporting pathways regarding medical devices.

Regulators and agencies responsible for medical devices have a duty to improve complaint pathways and processes. These pathways should be co-designed with migrant and refugee communities to ensure that they are multilingual, transparent, accessible and responsive to their needs. The costs of not embedding this as a core component of healthcare and regulatory safety infrastructure are far too great.

Recommendations to improve use, access, regulation and monitoring of medical devices used in women's healthcare

- Support informed decision-making and consent by advocating for manufacturers, regulators and related agencies to provide publicly available, non-technical and multilingual information about medical devices. This should include reporting on the medical device's clinical trial history, risks, side effects, recalls and safety concerns.
- Ensure pathways to reporting concerns and complaints in healthcare settings and to regulators of medical devices, are multilingual, transparent and accessible. Include information on the obligations of healthcare institutions and agencies to respond to complaints.
- Ensure regulators and agencies responsible for medical devices in Australia engage with community-led organisations to co-design complaint pathways and processes which are multilingual, transparent, accessible and responsive to migrant and refugee people's needs.

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