



# Data Report

Sexual and Reproductive Health  
Multicultural Centre for Women's Health  
2021



MULTICULTURAL  
CENTRE FOR  
WOMEN'S HEALTH



MULTICULTURAL  
WOMEN'S HEALTH  
AUSTRALIA

## **Acknowledgement of Aboriginal sovereignty**

Multicultural Centre for Women's Health (MCWH) acknowledges and pays respect to the Wurundjeri people of the Kulin nation, on whose land this guide was written. Aboriginal sovereignty was never ceded.

We recognise that as migrants to this country, we benefit from the colonisation of the land now called Australia and have a shared responsibility to acknowledge the ongoing harm done to its First Peoples and to work towards respect and recognition.

Aboriginal and Torres Strait Islander people experience greater health inequities compared to non-Aboriginal and Torres Strait Islander people. Aboriginal women are disproportionately impacted by adverse sexual and reproductive health outcomes. We acknowledge that Aboriginal and Torres Strait Islander people have been active leaders in health promotion and advocacy and our work should be accountable to the same aims.

## **Multicultural Centre for Women's Health**

MCWH is a feminist organisation led by migrant and refugee women to achieve equity in women's health and wellbeing.

## **Multicultural Women's Health Australia**

The Multicultural Women's Health Australia Program (MWA) aims to improve the capacity of migrant and refugee women to make informed choices about sexual and reproductive health through research, health promotion and advocacy. It is made up of a network of services in Australia with a shared commitment to migrant and refugee women's health.

## **Acknowledgement of funding**

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## Background

This report has been developed by the Multicultural Centre for Women's Health (MCWH) for the Multicultural Women's Health Australia (MWA) Program. MCWH is a national, community-based organisation led by and for women from migrant and refugee backgrounds. Established in 1978, MCWH's mission is to promote the health and wellbeing of migrant and refugee women through advocacy, social action, multilingual education, research and capacity building.

The first Sexual and Reproductive Health (SRH) data report was developed by MCWH in 2010 and updated in 2016. Both reports strongly demonstrated that significant data gaps continue to exist in Australia in relation to SRH. In addition to highlighting the lack of data and research about migrant and refugee women's SRH, the report drew attention to the SRH inequities experienced by migrant and refugee women, as well as the challenges they face in accessing culturally appropriate SRH services.

The aim of this updated report is to:

- summarise the latest available data across a range of areas that impact on the SRH of migrant and refugee women in Australia;
- use the available data and evidence to outline key and emerging issues pertaining to migrant and refugee women's SRH, as well as considerations for policy, programs and service delivery.

The data and research in this report have been obtained from a variety of sources ranging from national, population-based studies to small community-based studies.

Where national, disaggregated data sets are not available, state and territory based research has been used. Where Australian data or research is not available, international research is used. Community-based studies have also been included to highlight the issues relating to migrant and refugee women's health.

## Our approach

MCWH applies an intersectional lens to understanding and analysing women's sexual and reproductive health. This lens goes beyond explanations that use single categories such as gender or ethnicity to describe issues. Instead, it recognises that individuals are shaped by many factors and that women's experiences and inequities are influenced by specific social and political contexts, systems and structures.

This report describes the experiences of women who identify as coming from a migrant or refugee background. This includes women living in Australia temporarily or permanently, across diverse visa categories and conditions, as well as first- and second-generation citizens. While MCWH focuses on migrant and refugee women's health and wellbeing, migrant and refugee women are not a homogenous group, and the prevalence of particular SRH issues varies across populations.

This report has referenced research and publications that often position women in hetero-normative and cis-normative ways, or research that did not clarify their understanding of gender. MCWH recognises that this approach is limiting and is not always inclusive of non-binary and gender diverse people, who face significant barriers to accessing SRH support and services.





## Introduction

Australia is one of the world's most culturally and linguistically diverse nations.

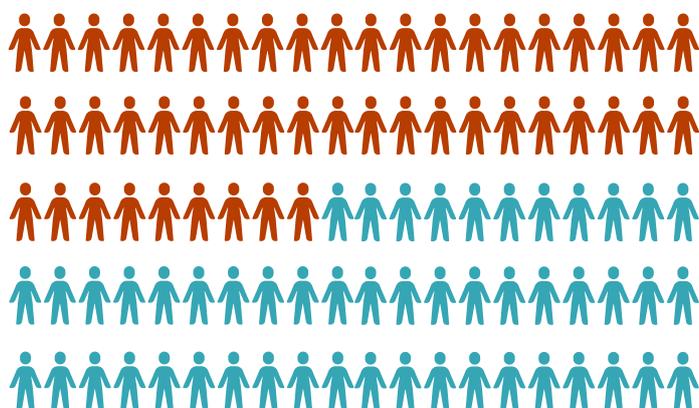


**identified  
languages  
spoken**



**Aboriginal & Torres  
Strait Islander  
languages  
spoken**

(ABS 2017a)



**49%**

**of Australians had been  
born overseas or have one  
or both parents who had  
been born overseas**

(ABS 2017a)

**59%**

**of recent migrants were women. Women  
from non-English speaking backgrounds  
comprise a significant proportion of the  
total Australian population**

(ABS 2020a)

While there is a lack of research and data pertaining to migrant and refugee women's SRH, the available research shows that migrant and refugee women have poorer health outcomes and are at greater risk of developing adverse health outcomes than the mainstream, Anglo population. For example, compared to Australian-born, non-Indigenous women, migrant and refugee women are:

- at a greater risk of suffering poorer maternal and child health outcomes;
- less likely to have adequate information about modern contraceptive methods;
- at greater risk of contracting a sexually transmitted condition (such as HIV and hepatitis B); especially migrant women who are from countries where the condition has a high prevalence.

## Sexual and reproductive health: data and research

Sexual and reproductive health encompasses a range of health issues and rights, including efforts to eliminate preventable maternal and neonatal mortality and morbidity; ensuring quality and appropriate SRH services for everyone, including contraceptive services; and addressing sexually transmitted infections (STI) and cervical cancer, violence against women and girls, and equitable and respectful relationships (Temmerman et. al 2014; UNDPI 1995).

**Good sexual and reproductive health refers to a state of complete physical, mental and social well-being in all matters relating to the reproductive system.**

**It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide, if, when and how often to do so.**

**– United Nations Population Fund**

While universal access to SRH is essential to achieving health and gender equity, significant health disparities exist among different population groups. In many countries, including Australia, the significant data gaps in SRH make it difficult to understand the complex factors that shape women's SRH, as well as to develop holistic and comprehensive strategies that address the needs of those who are most disadvantaged.

The timely and reliable collection of data is integral for understanding trends in health

status, identifying gaps in service delivery, and developing policies and programs, among other things.

**However, in 2021, Australia does not have a National Sexual and Reproductive Health Strategy or a coordinated system for collecting SRH data.**

In 2002, the Australian Institute of Health and Welfare created 44 Reproductive Health Indicators (covering fertility, subfertility, family planning, pregnancy, childbirth, sexually transmitted infections and cancers of the reproductive tract), which are described in their report, *Reproductive Health Indicators Australia 2002*. The report found that almost half (21 indicators or 48%) lacked adequate national, state and territory based data. While fertility rates are available, other indicators such as maternal morbidity, infertility and family planning generally reflect a lack of standardised definitions and data collection tools (Ford et. al 2003).

For example, there are significant gaps in our knowledge of reproductive health because no data is routinely collected on:

- **Abortion:** it is currently not possible in Australia to reliably estimate the rate of surgical and medical abortions. Information is also lacking on the extent of induced abortions among population sub-groups; socio-demographic characteristics of women having abortions; out-of-state procedures (i.e. when the state or territory where the procedure was performed is not the woman's usual state or territory of residence); and reasons for abortion.
- **Contraceptive use:** understanding of trends and patterns of contraceptive use is fragmented and limited. There is also a lack of social, geographic and demographic data on contraceptive users.

- **Unintended pregnancy:** there are currently no processes in place to collect data on unintended pregnancy, including socio-demographic information and decision-making information (e.g. the provision of resources and support, including counselling regarding pregnancy options).

In addition to these issues, the current evidence base is significantly lacking in specific data about migrant and refugee women. If data collection does include migrant and refugee groups, classifications used to measure ethnicity are often ambiguous or homogenising, potentially misleading or inconsistent across studies and rather include region of birth, country of birth and/or language spoken.

Mengesha et. al notes that only 2.2% of published health research has focused on the health of migrant and refugee communities (Mengesha et. al 2017).

**The lack of available evidence-based information, underpinned by research, and systematic data collection places migrant and refugee women's sexual and reproductive health at greater risk.**

Since the release of our first data report in 2010, there remains a paucity of SRH data, particularly pertaining to migrant and refugee women.

## Recommendations

Following the 'Reproductive Health Indicators Australia 2002' report that confirmed the need to strengthen the quality, breadth and cohesiveness of information available on reproductive health in Australia (Ford et. al 2003), this report strongly recommends:

- development of national conceptual information for reproductive health;
- more accessible data;
- comprehensive and cohesive coordination and analyses of collected data;
- data disaggregated by gender, sex, ability, ethnicity, place of birth and visa status; and
- more comprehensive research focusing on migrant and refugee women's SRH to build the evidence-base for policy and practice.

**Further recommendations for action are outlined in our document, *Act Now to advance health equity for migrant and refugee women's sexual and reproductive health.***



## Key issues

Sexual and reproductive health outcomes are determined by a range of social, cultural, economic and biological factors. This report examines some of these factors in relation to migrant and refugee women's health. It does not cover all of the issues that affect migrant and refugee women, rather, the issues discussed reflect the data and research that is available, as well as the key and emerging issues for migrant and refugee women's sexual and reproductive health in Australia.<sup>1</sup>

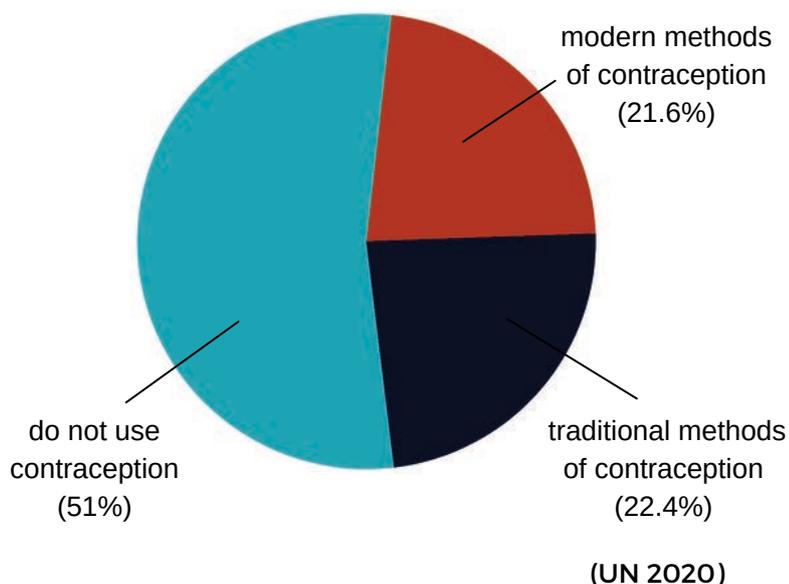
## Contraceptive use

Access to safe, effective and affordable contraception and family planning is a key component of sexual and reproductive health. The growing use of contraceptive methods has resulted in improvements in health and social related outcomes, including reductions in unintended and high-risk pregnancies and improvements in economic outcomes for women.

However, recent reports demonstrate that the COVID-19 pandemic has adversely impacted the SRH of women and girls in many parts of the world. Analysis conducted for 115 low-and middle-income countries in January 2021 found the pandemic disrupted contraceptive use for 12 million women, with a consequence of nearly 1.4 million unintended pregnancies during 2020 (UNFPA 2021).

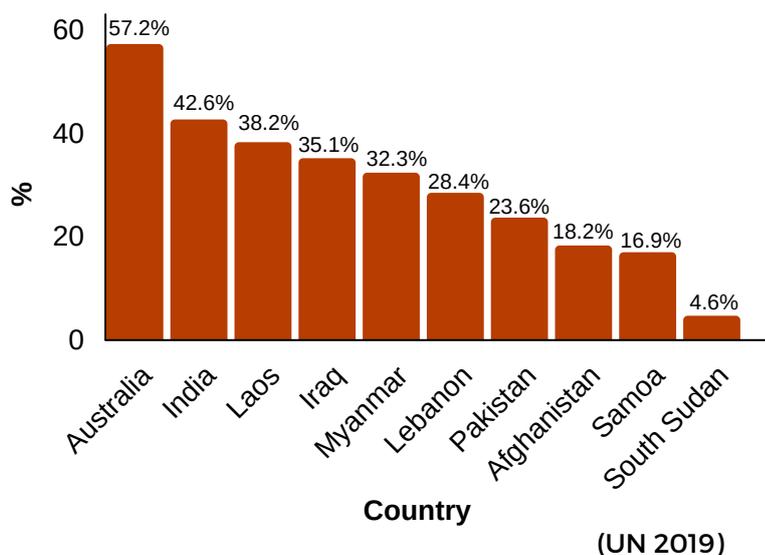
The rate of contraceptive use around the world may serve as an indicator of the likelihood that a newly-arrived woman will be familiar with a range of available contraceptive methods on arrival in Australia.

Contraceptive methods used by women of reproductive age<sup>2</sup>



In 2019, the rate of contraceptive use in Australia was 57.2% (UN 2019), a decline from nearly 70% in 2015 (UN 2015). While the rates of birth have also declined from 2015 in Australia, the rate of contraceptive use remains significantly lower in the countries of origin of migrant women who have the highest birth rates in Australia (see also 'Fertility').

Contraceptive use (%) in country of origin in 2019



<sup>1</sup> Due to the ongoing COVID-19 pandemic, there have been delays in the release of data pertaining to certain issues.

<sup>2</sup> Modern methods of contraception include female sterilisation, male and female condom, IUD, and the contraceptive pill. Traditional methods include withdrawal, rhythm methods and prolonged abstinence (UN 2019).

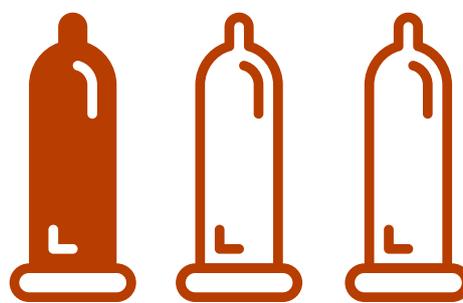
## Contraceptive use in Australia

(FPNSW 2020)



**Condoms are the most used method by those born in non-English speaking countries (32%)**

(FPNSW 2020)



## Contraceptive management in Australia

According to a 2012 study by Mazza et. al., increased age, ethnicity, Indigenous status and holding a Commonwealth Health Care Card were significantly associated with lower rates of contraception consultations with GPs. Patients who spoke a language other than English at home had a rate of management of general contraception that was half of that of women from English-speaking households (Mazza et. al 2012).

The Second Australian Study of Health and Relationships (ASHR2) shows that while the pill remains the most popular contraceptive method among women in Australia, there is a high use of condoms and withdrawal among women who speak a language other

than English at home (Richters et. al 2016). In another study by Yusuf and Siedlecky (2007), the use of the contraceptive pill was found to be lower among women from non-English speaking backgrounds.

A recent study involving Chinese women who had been living in Australia for no more than 10 years showed that condoms, sometimes in combination with 'natural' methods such as withdrawal or safe period method is the preferred method of contraception, as women in this study expressed fear toward hormonal methods. This study highlights that Chinese migrant women's perceptions and experiences of contraceptive methods are shaped by complex personal, cultural, societal and inter-relational factors (Dolan et. al 2021).

## Family violence and sexual and reproductive health

Violence against women takes many different forms and includes physical, sexual and emotional violence. The World Health Organisation (WHO) estimates that about 1 in 3 or 35% of women worldwide have experienced either physical and/or sexual intimate partner violence (IPV) or non-partner violence in their lifetime (WHO 2019).

In Australia, the prevalence of violence against women is unacceptably high: 1 in 3 Australian women have experienced physical or sexual violence and/or emotional abuse in their lifetime. For migrant and refugee women, there is evidence that prevalence rates are even higher, and that violence is more severe and prolonged (Lum On et. al 2016). In addition, although the data is scarce, international reports suggest that there has been an increase in domestic violence cases since the COVID-19 outbreak began (WHO 2020).

The relationship between family violence and poor physical and psychological health outcomes is well established in international literature. The consequences can be immediate and acute, long-lasting and chronic, and/or fatal (VicHealth 2017). The WHO (2019) reports that intimate partner and sexual violence have serious short and long-term physical, mental, and SRH problems for survivors and their children:

- Violence against women can have fatal results including homicide or suicide;
- It can lead to injuries, with 42% of women who experience intimate partner violence reporting an injury as a result of this violence;

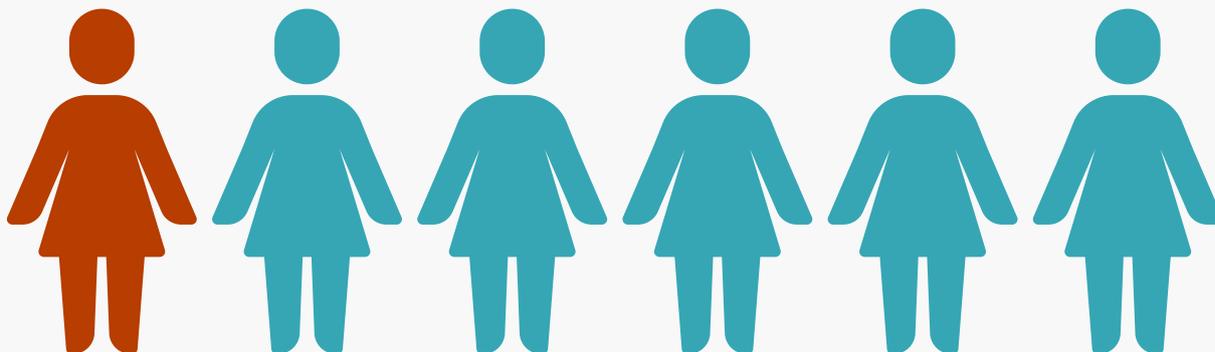
- Women who have experienced intimate partner violence are 1.5 times more likely to have a sexually transmitted infection, and in some regions, HIV, compared to women who have not experienced such violence;
- Intimate partner violence is associated with increased likelihood of mental health disorders including post-traumatic stress disorder, sleep difficulties, eating disorders and emotional stress.

Pregnant women may be at increased risk of male intimate partner violence (State of Victoria 2016). Family violence can start or worsen during pregnancy, and can cause complications such as miscarriage, foetal injury and foetal death (State of Victoria 2018). Intimate partner violence is associated with unintended and unwanted pregnancy, abortion and unsafe abortion, and pregnancy complication. According to the WHO, intimate partner violence is associated with a two-fold increase in induced abortion; 16% increase in low birth weight babies and 43% increase in preterm births (WHO 2019).

Additionally, mothers, babies and children who experience or are exposed to family violence have poorer health, social and economic outcomes than those who do not experience violence (CCOPMM 2021).

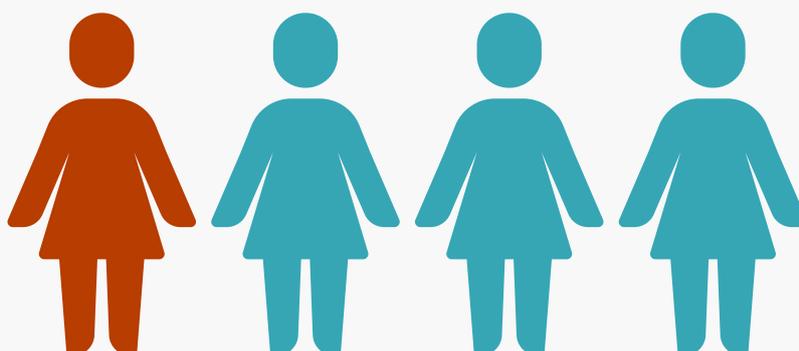
Evidence shows that factors such as immigration policy, temporary and dependent visa status, along with social isolation and economic insecurity from the settlement process can increase migrant and refugee women's vulnerability to violence. In addition, migrant women may endure violence for longer periods and experience structural and interpersonal barriers to accessing support services (Vaughan et. al 2015).

**A national study in 2019 by Navodani et. al found that:**



**1 in 6 Australian-born mothers experienced intimate partner abuse in the first 12 months postpartum (16.9%)**

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**1 in 4 migrant mothers experienced intimate partner abuse in the first 12 months postpartum (22.5%)**

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**Migrant mothers had higher odds of experiencing emotional abuse alone, and slightly raised odds of experiencing physical and emotional abuse.**

## Sexual and reproductive coercion

Sexual and reproductive coercion is understood as behaviour interfering with a person's reproductive autonomy. It is usually perpetrated by a male partner and can encompass violence, threats, or coercion to force a person to become or remain pregnant, or to terminate pregnancy. Family members can also be instigators of reproductive coercion (Tarzia et. al 2019; Tarzia and Hegarty 2021). Reproductive coercion may occur alongside other forms of violence, or in isolation, and in either case, is associated with a range of negative outcomes, including poor mental health, unintended pregnancy, and sexually transmitted infection (Tarzia et. al 2019).

**Reproductive coercion is exercised in both the interpersonal and the structural domain.**  
(Marie Stopes Australia 2020)

A recent (2020) report by Marie Stopes Australia outlines the intersecting interpersonal and structural factors that create the conditions for reproductive coercion to occur:

- **Interpersonal:** the intentional, controlling behaviours that are directly exerted on a person's reproductive health by another person or persons. Research suggests that violence, including reproductive coercion against migrant and refugee women can be perpetrated by both the intimate partner and other family members (Vaughan et. al 2016).
- **Structural:** the social, cultural, economic, legal and political drivers that create an enabling environment that supports or allows reproductive

coercion. For example, gender inequality, government policy and legislation, workplace practices, limited access to appropriate healthcare and enabling cultural and social norms.

There is evidence that unintended pregnancies are up to two or three times more likely to be associated with intimate partner violence than planned pregnancies. Reproductive coercion has been identified as one mechanism that may explain the association between intimate partner violence and unintended pregnancy (Children by Choice 2017).

While the data on reproductive coercion in Australia is scarce, reports from service providers indicate that it is an issue that affects women from migrant and refugee communities. For example, Children by Choice notes that up to one in five women from migrant and refugee backgrounds have reported reproductive coercion (Children by Choice 2019).

The research that is available points to a range of interpersonal and structural factors that can impede reproductive autonomy for migrant and refugee women. These include differing interpretations about what constitutes coercive behaviour, abuse and violence in relationships (Chung et. al 2018); a lack of knowledge of Australian laws and available support services; pre-migration experiences and trauma, which combined with patriarchal power structures can contribute to perpetrators' coercive or controlling behaviour (Marie Stopes 2020). In addition, visa policy restrictions and fear of deportation can be exploited by perpetrators to stop women from seeking support and treatment. In some instances, women are unable to access support services such as contraception, maternal, and abortion services due to certain visa restrictions (Marie Stopes 2020).

## Fertility

Sexual and reproductive health includes the ability to manage fertility. When people decide to have children, they have a right to access affordable and appropriate services that can help them have a healthy pregnancy, a safe delivery, and a healthy baby.

According to the 2019 data (ABS Births Australia), there were 305, 832 registered

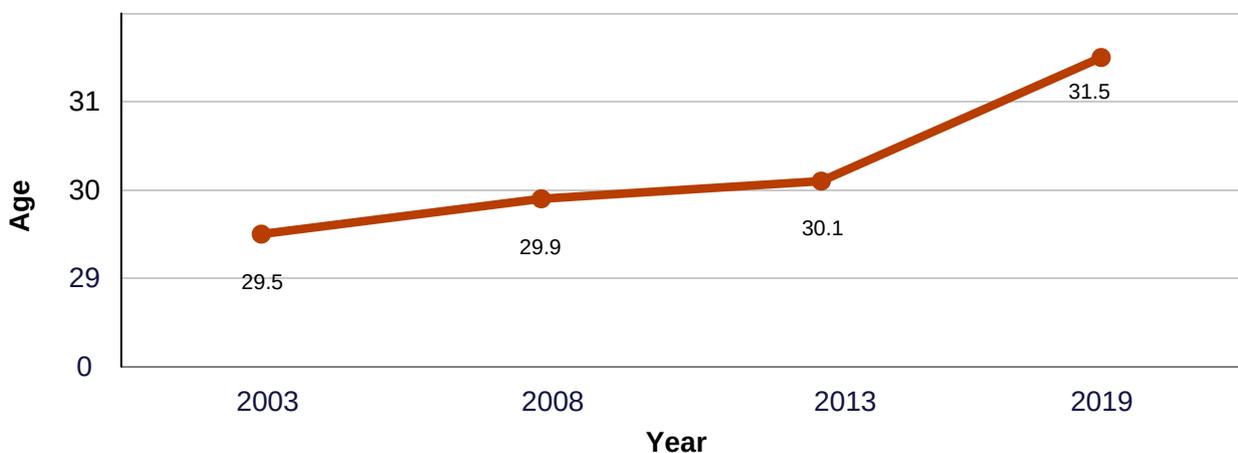
births in Australia in 2019.<sup>3</sup> The fertility rate Australian-born mothers is 1.69 births per woman.

Among overseas-born women, rates vary widely with the highest rate at 3.79 (for mothers born in Lebanon), more than double the Australian rate. The age-specific rate for some overseas-born women aged 15-19 years, is between three to four times higher than that of the Australian rate for the same age category.

Australian fertility rates 2019 (of mothers giving birth in Australia)		
Country of birth of mother (selected)	Total rate	Age-specific rate (15-19 years)
Australia	1.73	10.4
Lebanon	3.79	37.5
Laos	2.49	32.3
Samoa	3.31	20.0
Iraq	2.38	9.3
Myanmar	2.14	8.9
Pakistan	2.89	7.6
Afghanistan	2.81	7.2
Total Sub-Saharan Africa	6.9	1.95
India	1.65	1.1

(ABS 2020b)

### Average age of mothers by year



(ABS 2020b)

<sup>3</sup> The AIHW report 'Australia's mothers and babies' released 28 June 2021 reports 303, 054 births in 2019 (AIHW 2021a).

## Maternal and perinatal health

The perinatal period refers to the time immediately before pregnancy through to the first year after birth. This period of a person's life is a significant transitional life stage that can be associated with increased vulnerability to experiencing physical and mental health issues.

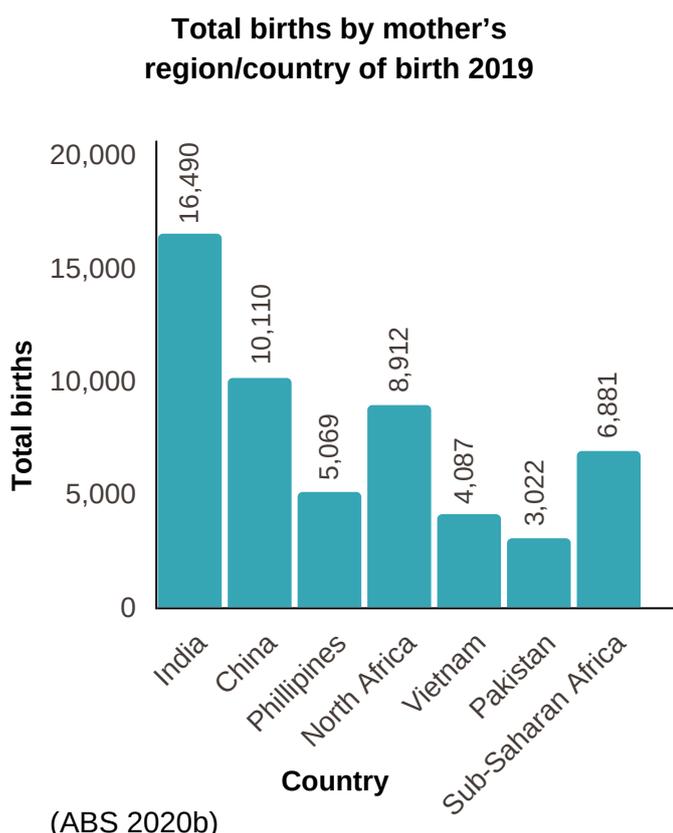
The changes associated with the perinatal period can be particularly challenging for migrant and refugee women. The evidence consistently shows that migrant and refugee women are at a greater risk of suffering

poorer maternal and child health outcomes, including poorer sexual and reproductive health.

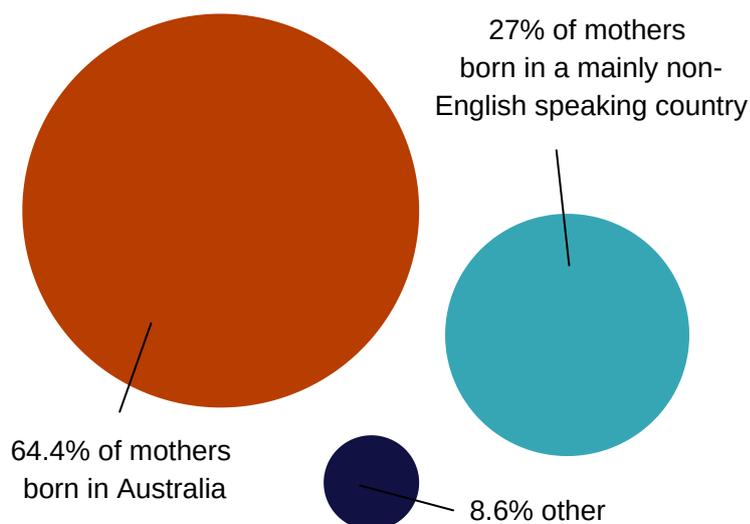
While it is critical that people and families have access to maternity care that is affordable, safe and culturally responsive, most of the perinatal health research and data, particularly in relation to perinatal anxiety and depression, focuses on the mainstream, Anglo population. There are relatively few studies that focus on the perinatal support needs of migrant and refugee women and their preferred support interventions.

## Maternal country of birth

There are a number of factors that can contribute to an increased risk of experiencing adverse perinatal health outcomes, including maternal country of birth. For example, maternal country of birth can be an important risk factor for low birth rate and perinatal mortality.



## Country of birth of mothers in Australia



(ABS 2020b)

In 2019, 64.1% of mothers were born in Australia and over one-quarter (27%) of mothers who gave birth were born in a mainly non-English speaking country (AIHW 2021a). The proportion of mothers born in a mainly non-English speaking country has increased from 8% in 2008. In 2019, the most common countries of birth (from mainly non-English speaking countries) were India, China and the Philippines (ABS 2020b).

## Antenatal care

Antenatal care is preventive healthcare aimed at assessing and improving the health and wellbeing of the mother and the baby during pregnancy. Timely access to antenatal care is associated with better maternal health, fewer interventions in late pregnancy and positive child health outcomes.

The WHO recommends receiving antenatal care at least four times during pregnancy and the Australian Antenatal Guidelines recommend that the first antenatal visit occur within the first ten weeks of pregnancy. The Department of Health Pregnancy Care Guidelines recommends a schedule of ten visits for a person's first pregnancy without complications (Department of Health 2020).

**According to Australian Institute of Health and Welfare (2020a), mothers who were born in mainly non-English-speaking countries were less likely to attend antenatal care in the first trimester (70% compared with 76% of those born in Australia and other mainly English-speaking countries).**

The uptake of antenatal care can be due to a number of factors such as unfamiliarity with the health care system of the host country; pre-migration trauma; social inequality and financial constraints; social isolation and limited transport options; and lack of culturally and linguistically appropriate services (Mengesha et. al 2016). Women who are asylum seekers may be ineligible for Medicare or Centrelink Health Care Cards. Women on temporary visas such as international students may not have



Medicare entitlements. Although international students need to have Overseas Student Health Cover (OSHC) while they are in Australia, pregnancy-related services may not be covered in the first 12 months of membership (see also 'International Students').

## Maternal health and pregnancy outcomes

There is little specific information on the pregnancy outcomes of migrant and refugee women. This is because information on ethnicity is not routinely collected for perinatal data collections and data collection methods vary across states and territories. A systematic review summarising the current evidence base on perinatal health outcomes and care among women with asylum seeker or refugee status found that migrant women have predominantly worse perinatal outcomes than women from host countries. In particular, migrant women have poorer maternal mortality, preterm birth, congenital abnormalities and mental health outcomes (Heslehurst et. al 2018).

## Preeclampsia and eclampsia

Preeclampsia is a condition that can develop during pregnancy, and is characterised by hypertension and increased protein in the urine. Preeclampsia can progress into eclampsia.

Preeclampsia is a major pregnancy complication which can lead to substantial maternal morbidity and mortality. It is associated with various pregnancy complications including pre-term birth,

fetal growth restriction, perinatal death and adult long-term health problems in offspring.

In Australia, mild preeclampsia occurs in 5-10% of pregnancies and severe preeclampsia in 1-2% of pregnancies. A cross-country comparative study of six industrialised countries (including Australia) showed that migrants from Sub-Saharan Africa, Latin America and the Caribbean were at higher risk of preeclampsia (Urquia et al 2014).

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## Gestational diabetes mellitus

Gestational diabetes mellitus (GDM) is a form of diabetes that occurs during pregnancy. GDM is the fastest growing type of diabetes in Australia. In 2016, 12% of women who gave birth had gestational diabetes, and 11% of women who gave birth in 2019 had gestational diabetes (AIHW 2018; AIHW 2020a, AIHW 2021a).

Ethnicity is a known risk factor for diabetes (Yuen and Wong 2015). Women from African, Melanesian, Polynesia, South Asian, Chinese, Southeast Asian, Middle Eastern, and Hispanic backgrounds are at increased risk of developing GDM (Diabetes Australia 2021). Socioeconomic disadvantage can also increase the incidence of gestational diabetes (AIHW 2019a).

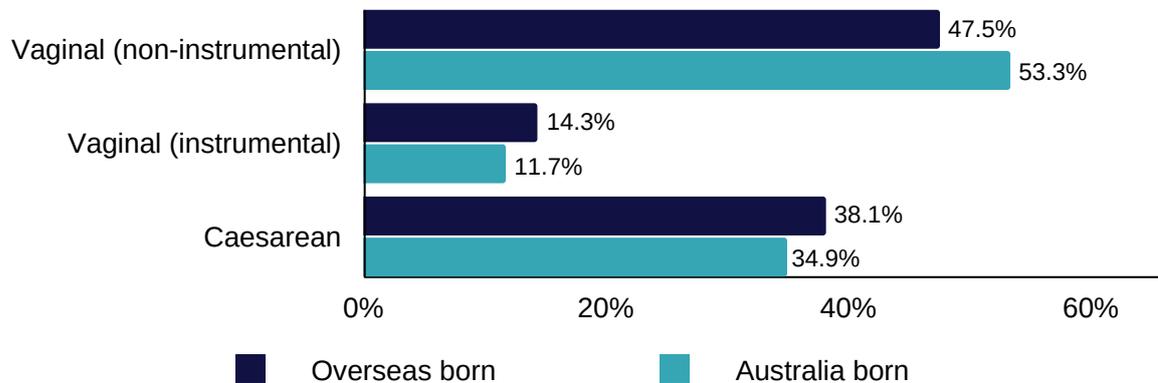
An Australian study of migrant South Asian women who were recently diagnosed with GDM found that before diagnosis, women's knowledge and awareness of any diabetes was low (Banyopadhyay et al 2011).

Two systematic reviews which looked at the perinatal health of women with asylum seeker and refugee status showed increased risk of GDM among this population group (Heslehurst et. al 2018). Another study comparing migrant women of refugee background from African countries with women who migrated for non-humanitarian reasons, found that mothers giving birth from humanitarian source countries in Middle and East Africa were more likely to experience GDM (Gibson-Helm 2014).

**In 2016-2017, women born in Southern and Central Asia were more than twice as likely to be diagnosed with GDM, compared with women born in Australia (28% and 13% respectively). Women born in South-East Asia (22%) were 1.7 times as likely while women born in North Africa and the Middle East (21%) were 1.6 times as likely to be diagnosed with GDM (AIHW 2019a).**

## Birth type, including caesarean section

Method of birth by women who gave birth (%) in 2019



(AIHW 2021a)

In 2019, 64% of mothers in Australia had vaginal births, while the remainder (36%) had a caesarean section birth. Of the mothers who gave birth in 2019, those born overseas were less likely to have a non-instrumental vaginal birth than mothers born in Australia (47.5% compared to 53.3%).

**Mothers born overseas were more likely to have instrumental vaginal birth (14.3%) or a caesarean section (38.1%) compared with Australian born mothers (11.7% and 34.9% respectively) (AIHW 2021a).**

A caesarean section may be performed where there is a risk of adverse outcomes for the mother and/or baby. In 2016-2017, women with gestational diabetes were more likely than women with no diabetes to experience caesarean section (44% compared with 37%) (AIHW 2019).

A NSW population-based study found that compared with low risk women born in Australia and women born overseas, Indian-born women had the highest caesarean section (31%), instrumental birth rates (16%) and episiotomy rates (32%) (Dahlen et al 2013).

A 2016 study of caesarean rates for African migrants in Australia found that first-time mothers and mothers who had previously given birth from Eastern African countries (Eritrea, Ethiopia, Somalia and Sudan) had elevated odds of unplanned caesarean section in labour. In addition, the study found that first-time mothers from Eritrea, Ethiopia and Somalia were more likely to have caesarean (planned or unplanned). The odds of having a caesarean were again, slightly elevated for mothers who had previously given birth Ethiopia and Somalia (Belihu et al 2016).

**The caesarean rate recommended by The World Health Organisation is between 10-15%. When medically justified, a caesarean section can prevent maternal and perinatal mortality and morbidity. However, there is no evidence showing the benefits of caesarean delivery for women or infants who do not require the procedure. As with any surgery, caesarean sections are associated with short and long term risk which can extend many years beyond the current delivery and affect the health of the woman, her child and future pregnancies (WHO 2015).**

## Stillbirth (perinatal or fetal deaths)

The rate of stillbirth in Australia is based on the AIHW definition of stillbirth as fetal birth occurring at 20 or more completed weeks of gestation or of 400 grams or more birthweight within 28 days of birth (AIHW 2020a). The AIHW definition differs from the WHO definition of stillbirth (a baby born with no signs of life at or after 28 weeks of gestation or more, and/or weighing 1,000 grams or more) (WHO 2018).

In 2017 and 2018 there were 5,808 perinatal deaths (74% or 4,290 were stillbirths and 26% or 1,518 were neonatal deaths (AIHW 2021a). The Australian perinatal mortality rate in 2018 was 9.2 per 1,000 births, compared to ten per 1,000 births in 2013 (AIHW 2020b).

**In 2018, the rate of stillbirths was 6.7 deaths per 1,000 births for mothers born in Australia and 7.3 deaths per 1,000 births for mothers born overseas.**

In 2017 and 2018, the highest rates of perinatal death were among babies of mothers whose country of birth was Melanesia (including Papua New Guinea) (24.3 perinatal deaths per 1,000 births), Central and West Africa (21.2 perinatal deaths per 1,000 births), North Africa (16.0 perinatal deaths per 1,000 births). Perinatal mortality rates were also highest among babies born to mothers who had accessed 0-2 antenatal visits (AIHW 2021b).

The Senate Select Committee of Stillbirth Research and Education notes that there are higher stillbirth rates among migrant and refugee communities in Australia.

**In 2013-2014, 1,531 (34.6%) of the 4419 stillbirths that occurred in Australia were born to women who were born in countries other than Australia. In Victoria, this is slightly higher, with 38.5% of women giving birth in 2016 born outside of Australia (Commonwealth of Australia 2018).**

A study by Davies-Tuck et. al found that compared to Australian/ New Zealand born women, women born in South Asia, Africa and the Middle East have higher rates of stillbirth. Additionally, they found an interaction between maternal region of birth and the gestation at which stillbirths occur. Women born in South Asia were more likely to experience term stillbirth (37 or more weeks pregnant) compared to preterm stillbirth, whereas women born in the Middle East were more likely to experience preterm stillbirth only (Davis-Tuck et. al 2017).

Australian state-based studies have also shown that:

**Compared with other refugee groups, women from West African humanitarian source countries were found to have the highest stillbirth incidence (4.4% compared to 1.2% and 1.6% from other regions).**

(Gibson-Helm et. al 2014)

**South Asian women were more than twice as likely to have a late pregnancy antepartum (i.e. not long before birth) stillbirth than either Australian-born or South-East Asian born women.**

(Drysdale et. al 2012)

**Lebanese women had the highest rates of stillbirth (7.2 per 1000 births) compared with low risk women born in Australia and other women born overseas.**

(Dahlen et. al 2013)

**According to a Victorian population-based study, women born in East African countries experienced increased perinatal deaths and other adverse perinatal outcomes compared with Australian-born women. Women from Eritrea and Sudan in particular, are at increased risk of adverse outcomes.**

(Belihu et. al 2016)

**A Western Australian population-based study found that women born overseas were more likely to have a stillbirth than Australian-born women, particularly among women with African or Indian backgrounds.**

(Mozooni et. al 2018)

## Maternal death

According to the AIHW, maternal death is the death of a woman while pregnant or within 42 days of the end of pregnancy (AIHW 2020c).

In 2009-2018, there were a total of 251 maternal deaths in Australia. In 2018, there were 15 maternal deaths, or 5 deaths per 100,000 women giving birth (AIHW 2020c).

The most common causes of maternal deaths in 2015-2017 were suicide, cardiovascular disease, and sepsis. Of the 59 maternal deaths that occurred in 2015-2017, the majority (42) of women who died were born in Australia. Twelve of the women (whose region of birth was known) were born in New Zealand, South-East Asia, Central and Southern Americas, Southern and Central Americas, Southern and Central Asia, Africa and the Middle East, and Northern Americas. Four were born in countries not stated (AIHW 2020d). It is important to note that information on ethnicity is not routinely collected in perinatal data collections and therefore, no information on whether women were recent migrants or refugees was available.

Victoria's CCOPMM mortality reviews and data analysis show poorer outcomes and over-representation of vulnerabilities among particular populations including refugees, migrants or others from a non-English speaking background (CCOPMM 2021).

The AIHW (2020d) outlines three main contributing factors in maternal deaths:

- **inadequate professional care (such as inadequate numbers and/or seniority of staff, failure or delay in emergency response, failure to offer and/or follow recommended best practice);**
- **delayed, or lack of, access to care (such as geographical isolation from appropriate services, socioeconomic situation affecting access to appropriate care);**
- **acute social and family situation (such as substance use, family violence, language barriers).**

## Perinatal mental health

As many as 1 in 5 mothers experience perinatal depression and anxiety in Australia (Reilly et. al 2013). Perinatal anxiety and depression is a serious health condition that can affect any new or expecting parent. It can be experienced differently by different people and manifest as panic, agitation, frustration, anger, low mood, sadness, hopelessness or long-term withdrawal. There is increasing recognition that maternal depression can lead to long term health consequences for women's health and the health of her infant and wider family (Yelland et. al 2010).

In the 2017-2019 period, suicide was reported as the leading cause of maternal death in Victoria (CCOPMM 2021).

**A literature review conducted by La Trobe University and commissioned by MCWH shows that women from migrant and refugee backgrounds have greater rates of perinatal mental health issues (Shafiei et. al 2018).**

This finding is confirmed by another literature review conducted by Sullivan et. al in 2020, which shows that migrants from non-English speaking backgrounds are particularly at risk of experiencing perinatal depression and anxiety. Additionally, pregnant refugee women have also reported higher rates of major depressive disorder (32.5%) in the antenatal period compared with pregnant-Australian-born women (14.5%) (Rees et. al 2019).

Both reviews identify a range of key risk factors for perinatal mental health conditions for migrant and refugee women. These include shorter length of residency, social isolation, and socioeconomic or financial insecurity, which can be compounded by migration-related stressors including immigration status and family separation. In addition, trauma and family violence also appear to be associated with perinatal mental-ill health among migrant and refugee women (Shafiei et. al 2018; Sullivan et. al 2020).

In their review, Shafiei et. al found that migrant and refugee women tend not to seek help for perinatal mental health issues. The barriers to seeking assistance include social stigma, complexity of the health system, limited transport options, communication barriers, and the high cost of services, particularly for women on temporary visas who are not eligible for Medicare. However, the study found that the most significant barrier to service access for migrant and refugee women is the lack of culturally relevant or appropriate services.

## Endometriosis and pelvic pain

Endometriosis is a chronic, disabling condition that affects approximately 1 in 10 people in Australia. While symptoms of endometriosis can vary between people, it can include pelvic and abdominal pain, cramping, heavy and painful menstruation, bloating, fatigue, bowel and bladder dysfunction, and pain during sexual intercourse.

A systematic review and synthesis of qualitative research found that endometriosis significantly impacts women's mental health and reduces their quality of life (Young et. al 2015).

While there is very little (if any) research on the nature, prevalence and impact of endometriosis on migrant and refugee women, given the population of migrant and refugee women in Australia, migrant and refugee women account for 30% of people impacted by endometriosis.

There is growing evidence that women who have endometriosis experience both difficulties and delays in receiving a diagnosis and subsequent treatment. The evidence shows that migrant and refugee women face significant barriers to accessing sexual and reproductive healthcare, which may result in even longer delays in diagnosis and treatment of endometriosis.



## Female genital mutilation/cutting (FGM/C)

FGM/C is the deliberate cutting or altering of the external female genital organs for non-medical reasons. In all cases it is of no health benefit to girls or women. Health complications can include: bleeding (which can be fatal) and extreme pain, infection and inability to pass urine and psychological trauma. There are also common and long-term health complications which can include:

- menstrual problems;
- recurrent urinary and kidney infections;
- difficulties having sexual intercourse including extreme pain and sexual dysfunction;
- infertility;
- difficulties around labour and birth (Caesarean birth is common);
- recurrent cysts and abscesses that can lead to chronic pelvic inflammation and long-term pain;
- incontinence, prolapses and fistulas
- difficulty in using some contraceptive methods;
- long-term psychological effects including depression, loss of sleep, nightmares and post-traumatic stress (NETFA 2021).

It is estimated that FGM/C affects the lives and health of more than 200 million girls and women in the countries where it is prevalent. FGM/C has been documented in 28 countries in Africa and several countries in Asia and the Middle East. In some multicultural countries such as Australia, New Zealand, Canada, UK, USA and across Europe, some girls in migrant communities may be at risk of FGM/C (NETFA 2021).

Due to ethical considerations and lack of data, it is difficult to speculate on the prevalence of FGM/C in Australia. However, the AIHW estimates that 53,000 girls and women born elsewhere but living in Australia in 2017 had undergone FGM/C during their lifetime. They sourced their data from population health surveys in 29 countries where FGM/C is concentrated and data are available, to the estimated number of girls and women living in Australia who are born in these countries (AIHW 2019b).<sup>4</sup>

Available evidence suggests that the occurrence of FGM/C anywhere in Australia is rare (Moeed and Grover 2012). Research conducted by the University of Melbourne indicates the practice has been declining in the home countries of migrant communities now living in both rural areas and the inner metropolitan areas of Victoria (Vaughan et. al 2014a; Vaughan et. al 2014b).

The *Best Practice Guide for Working with Communities Affected by FGM/C* suggests that “to ensure that women who have experienced FGM/C are properly supported and that FGM/C is not being practiced in communities once they migrate to Australia, it is essential that effective and comprehensive health promotion programs and community education initiatives are in place” (Chen and Quiazon 2014).

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<sup>4</sup> The report offers a detailed explanation of limitations and assumptions.

## HIV

In 2018, there were 833 HIV notifications in Australia, down from 1,081 in 2014 (a reduction of 23%). Based on newly diagnosed cases in 2017 (963), the main route to transmission in Australia continues to be sexual contact between men, which accounted for 63% of HIV notifications in 2017. There has not been a decline in HIV notifications in people who acquired HIV from heterosexual sex: in 2017, there was an increase in individuals who are more likely to be diagnosed late (48%), including those born overseas (53%), indicating the importance of initiatives to raise awareness about HIV

testing among migrant communities (The Kirby Institute 2018).

Of the 238 HIV notifications in 2017 that were attributed to heterosexual sex, 61% were in males, and 45% were in people born in Australia. 15% were in people born in Sub-Saharan Africa, and 13% in people born in Asia. Over the past five years (2013-2017), the proportion with late diagnosis was higher in people born in Central America (56%), Sub-Saharan Africa (47%) and Southeast Asia (42%) (The Kirby Institute 2018).

## Hepatitis B

**In 2018, the estimated chronic hepatitis B prevalence in Australia was:**

**6.7%** among people who were born in Northeast Asia

**5.1%** among people who were born in Southeast Asia

(The Kirby Institute 2020)

Hepatitis B leads to chronic liver conditions, including liver cancer. The estimated prevalence of chronic hepatitis B infection among people born in Australia is 1%.

In 2018, there were 6,045 hepatitis B notifications, down from 6,516 in 2014. Of the estimated 226,566 people living with chronic hepatitis B in Australia in 2018, an estimated 157,927 (70%) were born overseas (The Kirby Institute 2020).

Primary prevention strategies to protect people from acquiring hepatitis B infection include vaccination, use of clean needles and condom use. Testing and treatment are secondary prevention strategies.

**Women should be targeted for education because hepatitis B can be transmitted via sexual contact. Hepatitis B can also be transmitted from mother to baby, either in the uterus or around the time of birth.**



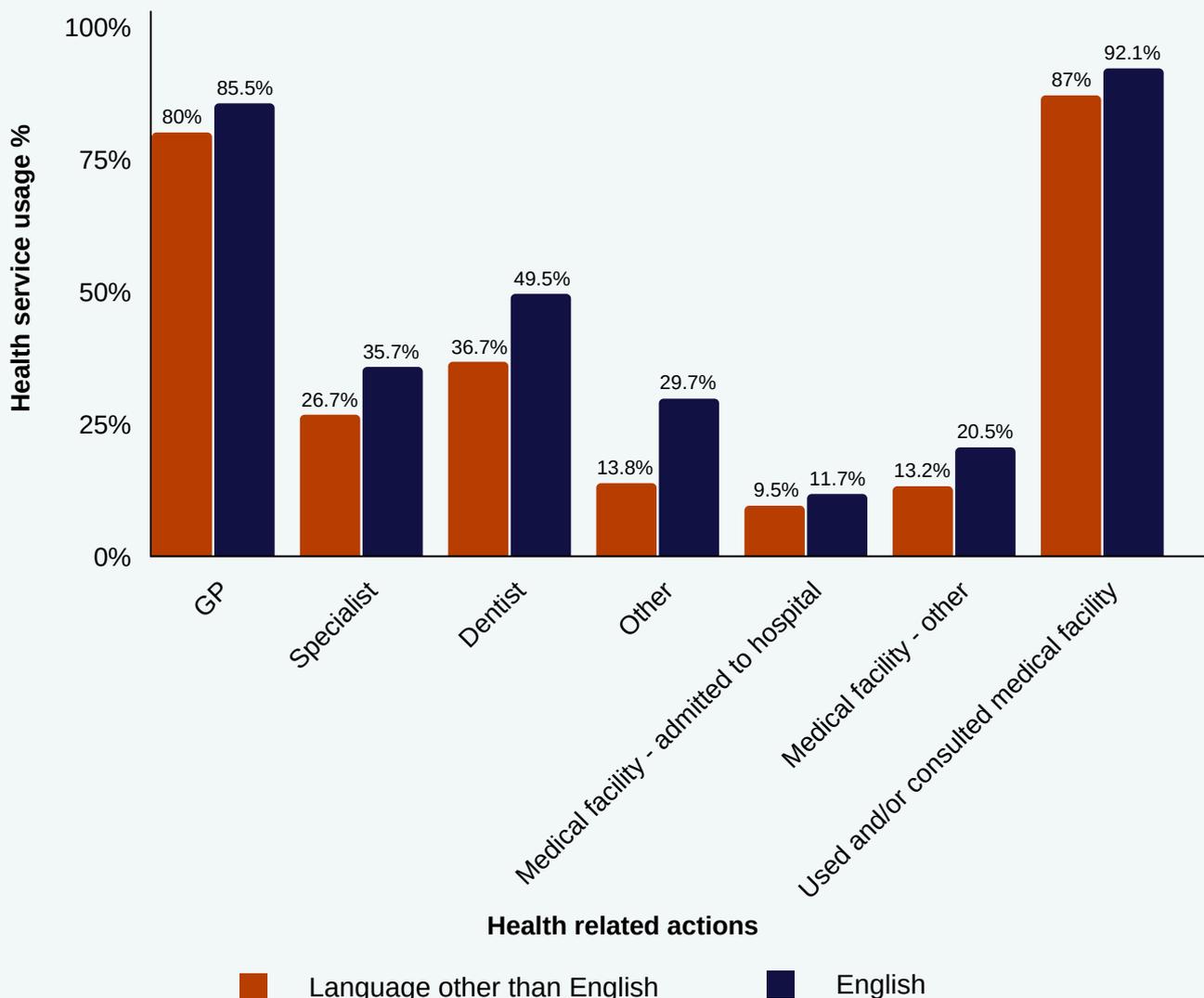
## Health literacy and health service usage

Health literacy relates to how people understand, access, and use health information to promote and maintain good health.

There is evidence to suggest that people who speak a language other than English at home participate less in health services than those who speak English (ABS 2017b).

A higher proportion of people who spoke English in the home strongly agreed they felt understood and supported by health care providers (30%) than those who did not speak English in the home (20%). In addition, those who spoke English in the home were more likely to always find it easy to actively engage with health care providers (34%) than those who spoke a language other than English in the home (26%) (AIHW 2020e).

Health service usage and health related actions 2014-2015 by main language spoken at home



## Breast and cervical screening

People who speak a language other than English at home typically have lower screening rates in BreastScreen Australia than those who only speak English at home (45% compared with those who speak English only at 56% in 2017-2018) (AIHW 2020f).

In 2020, due to COVID-19, all states and territories experienced their lowest number of screening mammograms performed per month in April and May. The data shows that women who speak a language other than English showed a slower return to screening following the April lockdown, compared with women who speak only English at home (AIHW 2021c).

The cervical screening program changed from 2-yearly Pap tests to 5-yearly Cervical Screening Tests from December 2017. While there were fewer screening HPV tests in 2020 compared with 2019, the impact of COVID-19 cannot be quantified without further years of data (as 2020 is the first year impacted by the change to 5-yearly screening) (AIHW 2021).

Research by Aminisani et. al showed that SRH services are underutilised among women from migrant and refugee backgrounds, with migrants from the Middle East and Asia less likely to utilise cervical screening services at the recommended interval, when compared with Australian-born women (Aminisani et. al 2012a; Aminisani et. al 2012b).





## Experiences of accessing sexual and reproductive healthcare

Migrant and refugee women experience a range of barriers and facilitators to accessing sexual and reproductive healthcare in Australia (Hach 2012; Mengesha et. al 2017). Systematic reviews of studies that focus on the views and experiences of migrant and refugee women in accessing SRH care in Australia (Mengesha et. al 2016; Rogers et. al 2020) have found the following:

### Barriers

- Both spoken and written language, including issues relating to interpreters;
- Health professionals' lack of knowledge regarding cultural norms;
- Systemic barriers relating the health care system and difficulty navigating the system;
- Transport difficulties;
- Cost of services;
- Lower levels of health literacy;
- Discrimination.

### Facilitators

- Provision of interpreters and bilingual health professionals;
- Multilingual resources;
- Appointment reminding services;
- Flexible and accessible services, including home visits;
- Provision of health professionals who are women;
- Health professionals using their time to listen to concerns, answer questions and explain treatment options;
- Continuity of care and culturally responsive care.

A study by Rogers et. al found that a model of care in NSW which employs Cross Cultural Workers (bilingual women with lived experience of migration) to work alongside maternal and child health services, improved the provision of culturally responsive care within maternity and child health settings. The study showed that Cross Cultural Workers helped migrant women and their families navigate maternity child and family health services and helped them engage with service providers across the continuum of pregnancy and the transition to child and family health services. Overall, the program resulted in reduced barriers to access for migrant women and their families, improved the healthcare experience for women, and potentially improved perinatal outcomes (Rogers et. al 2021).

Overall, the studies found that interactions with health care professionals were critical to migrant and refugee women's access to healthcare.

## International students

In 2018, there were 693,750 full-fee paying international students in Australia (Department of Education and Training 2019).

While there is scant literature about the sexual and reproductive health of female international students, available research shows that international students have varying levels of knowledge and understanding about SRH, and consent (Douglass et. al 2020; Parker et. al 2020). Some studies have found that international students have low rates of sexual literacy before arriving in Australia (Song et. al 2005; Simpson et. al 2015).

Research by MCWH (Poljski et. al 2014) has highlighted:

- the high rates of unplanned and unintended pregnancy in international student population;
- concerns about international students' rights in relation to informed choice in sexual and reproductive health;
- factors that impact upon students' lack of access to culturally appropriate health information and services, which include socio-economic status, intimate partner or other forms of violence, isolation and visa status entitlements.

In 2018, Women's Health In the North (WHIN) and La Trobe University conducted a project exploring the SRH of female international students. In their consultations with international students and service providers, they found that there is:

- Inadequate knowledge of Overseas Students Health Cover (OSHC) among international students;

- a need for increasing the capacity and capability of university staff to support international students;
- a persistent misunderstanding of informed consent among international students;
- a lack of knowledge about abortion laws and services;
- heterogeneity within the international student population;
- lack of access to women doctors;
- persistent stigma, fear and shame around accessing SRH services;
- persistent stigma, fear and shame around the topic of unintended pregnancy;
- value in information delivery to gender-specific groups and a need for targeted, impactful SRH strategies for international students.

Cost to international students has frequently been cited as a significant barrier to accessing sexual and reproductive services. International students on student (temporary) visas are not entitled to Medicare and must have Overseas Student Health Cover (OSHC) for the duration of their stay in Australia to cover medical costs for themselves and their families.

The minimum requirements and arrangements of OSHC are stipulated in the OSHC Deed (last updated April 2021). This Deed is a legal agreement between the Commonwealth of Australia, represented by the Department of Health and a registered private health insurer that provides OSHC. There are currently six private health insurers operating in Australia which offer OSHC: ahm OSHC (offered through Medibank Private), Allianz Global Assistance (Peoplecare Health), BUPA Australia, CBHS International Health, Medibank Private, and nib.



Since July 2011, under the OSHC Deed, insurers have been allowed to set a 12-month waiting period for non-emergency pregnancy-related services. This is despite data showing that more than 70% of all claims for pregnancy-related treatment for all international students occur within the first 12 months of cover, and between 33%-48% of claims for all hospital items relate to pregnancy (WHIN 2020).

**This means that an international student, or the partner of an international student, who experiences an unintended pregnancy within the first 12 months of arrival in Australia is faced with limited reproductive choices while simultaneously experiencing financial and/or settlement difficulties (MCWH 2013).**

On these terms, an OSHC insurer is not required to pay benefits for the treatment of pregnancy-related conditions to international students and their dependants in the first 12 months of their arrival in Australia, unless emergency care is required. Birth is not explicitly listed in the OSHC Deed as a health condition which constitutes 'emergency care'.

## Health education preference

Research shows (see below) that migrant and refugee women prefer to learn about sexual and reproductive health through group-based, same-sex, peer education.

This education should be in women's preferred language, and in settings that are culturally appropriate and accessible:

- A UK based study (Greenhalgh 2009) of a peer model of health education found that positive outcomes can be achieved through group participation (in addition to knowledge acquisition), as participants are able to negotiate meanings and make information meaningful for themselves.
- A Victorian study (McMichael 2008) conducted with resettled youth with refugee backgrounds in relation to the promotion of sexual health, found that gender-matched educators were the preferred method for learning about sexual health issues.

- Research conducted in Perth, Western Australia (Lee et. al 2013) into the topic preferences and means of access to health information among newly-arrived women, found that women's health ranked a top priority along with employment advice and mental health issues. Preferred methods for receiving information were interactive talks with written materials. In addition, it was found that non-threatening, participatory processes encouraged women to prioritise sensitive topics such as family violence and highlighted the need for such topics to be incorporated within general health information.
- An evaluation (Hurwath et. al 2003) of MCWH's group-based health education program found that the majority (70%) of migrant and refugee women who participated in the study expressed a preference for verbal delivery of information. The top three features and benefits cited by participants were: 'are offered only to women'; 'are offered in a preferred language'; and 'enabled learning'.



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