



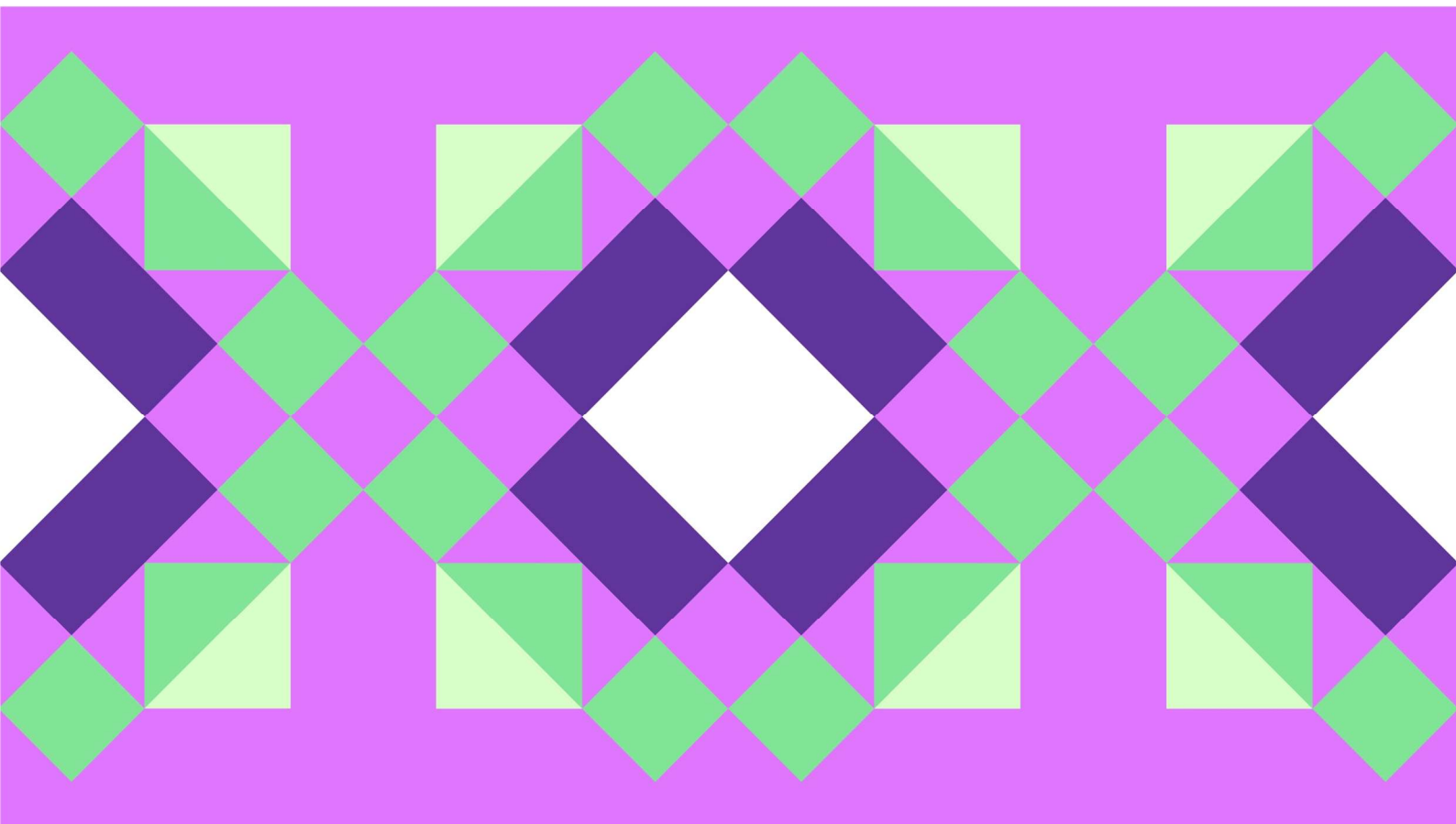
Australian
Multicultural
Women's
Alliance



Australian
Multicultural
Health
Collaborative

Submission to the Select Committee on Women's Health

October 2026



Background

About AMWA

The Australian Multicultural Women's Alliance (AMWA) is led by the Federation of Ethnic Communities' Councils of Australia (FECCA), the national peak body representing Australians from culturally and linguistically diverse backgrounds, in partnership with Settlement Services International (SSI) and Media Diversity Australia (MDA).

AMWA is one of five National Women's Alliances funded by the Australian Government through the Office for Women. The National Women's Alliances provide an important mechanism for ensuring that the experiences and expertise of diverse groups of women inform national gender equality policy.

AMWA is the national voice for multicultural women. We advocate for gender equity, representation and inclusion across all facets of Australian society. Our work is informed by lived experience, community insights and evidence-based research to ensure systemic barriers are addressed and opportunities are unlocked. As an intersectional alliance, we seek to ensure that women from all multicultural backgrounds can thrive and contribute fully to Australia's social and economic life.

About the Collaborative

The Australian Multicultural Health Collaborative (AMHC or the Collaborative) is the national multicultural health peak body. Our vision is to ensure that our health and social care system is committed to health equity and works proactively towards sustained improvement in the physical, mental and spiritual health and wellbeing of our multicultural communities.

The Collaborative is an initiative of the Federation of Ethnic Communities' Councils of Australia (FECCA). We provide a national voice, leadership and advice on policy, research, data, and practice to improve access and equity, address systemic racism, and achieve better health and wellbeing outcomes for Australians from multicultural backgrounds. The Collaborative is representative, and membership based. Members include consumers and carers; health services and wellbeing/social care services; practitioners; and researchers. The Collaborative also welcomes as affiliates other national health peak organisations.

About This Submission

This submission responds to the Terms of Reference of the Senate Select Committee on Women's Health, with particular attention to the experiences of multicultural women in accessing and navigating reproductive healthcare.

The submission draws on a combination of community consultation, professional expertise, lived experience, research and engagement with multicultural organisations and health practitioners. These include:

- the AMWA Health Thematic Working Group consultation held in May 2026, involving approximately 50 community health workers, bicultural workers, researchers, midwives, allied health professionals, advocates and community members; and AMWA's community consultations through Ethnic Communities Councils of Western Australia (ECCWA), May 2026;
- insights from the Australian Multicultural Health Collaborative's work on women's health, including community engagement relating to cervical screening and women's health information;
- Consultations with multicultural women, including through Fairfield Women's Health Service and community-led health education initiatives;

- Insights from the Ethnic Communities Council of Queensland (ECCQ), informed by its previous consultation processes with multicultural communities on women's health, health equity and access to services.
- stakeholder insights from midwives and other maternal health professionals; and
- relevant evidence and policy analysis developed through the National Women's Alliances.

A consistent message across these consultations is that multicultural women's health inequities should not be understood as individual deficits or a lack of willingness to engage with healthcare. Rather, they frequently reflect structural barriers in how health systems are designed, communicated and delivered, compounding whatever condition-specific issue a woman is presenting with.

Introduction

AMWA and AMHC welcome the opportunity to contribute to the Senate Select Committee on Women's Health. The establishment of the Committee recognises that women's health requires sustained national attention across the life course. Its Terms of Reference appropriately extend beyond individual conditions to consider the systems through which women access care, including the cost and accessibility of postpartum healthcare, reproductive health education, healthcare workforce training, chronic and long-lasting pain, fertility and assisted reproduction, medical devices, and health data and research.

For multicultural women, access to pregnancy, postpartum, reproductive and pain care is shaped by multiple factors including migration pathway and visa status, language, cultural and religious background, socioeconomic circumstances, disability, geography and caring responsibilities. A research study of six Australian hospitals, surveying 48,240 women, found that women who had migrated within the previous five years were 70 per cent less likely to receive midwife continuity of care than Australian-born women, while women who had migrated five or more years earlier were 49 per cent less likely.¹ A Victorian population-based study similarly found that women from refugee backgrounds experienced higher odds of several adverse maternal and neonatal outcomes, including stillbirth, neonatal death, postpartum haemorrhage, perineal tear and maternal intensive-care admission, with limited evidence that these gaps were closing over time.²

Through a community snapshot 80 migrant women, the Multicultural Centre for Respectful Maternity Care also found that 52 per cent of women did not know what help was available after birth and 24 per cent reported that their postnatal pain was not taken seriously.³ While this snapshot is not representative of migrant women nationally, it illustrates the kinds of access and continuity gaps that can remain invisible when service availability is measured without examining multicultural women's experiences.

These issues are particularly important in the postpartum period, which can become the weakest point in the continuum of care. Women require ongoing support for pain and physical recovery, pelvic-floor health, feeding, mental health and contraception after discharge, yet multicultural women may face additional barriers to accessing and navigating these services.

¹ Sarah J. Melov et al., "Do Migrant Women Have Equity of Access to Midwife Continuity of Care?," *Women and Birth* 38, no. 4 (2025): 101918, <https://doi.org/10.1016/j.wombi.2025.101918>.

² Yordanos Gizachew Yeshitila et al., "Trends and Disparities in Perinatal Health Outcomes among Women from Refugee Backgrounds in Victoria, Australia: A Population-Based Study," *Midwifery* 132 (2024): 103980, <https://doi.org/10.1016/j.midw.2024.103980>.

³ Multicultural Centre for Respectful Maternity Care, *Pregnancy, Birth and the Year After — Migrant, Refugee and Culturally and Linguistically Diverse Women and Families*, submission to the Senate Select Committee on Women's Health, September 2026.

The Committee's consideration of chronic and long-lasting pain is also relevant across this continuum. Pain during pregnancy, birth and postpartum recovery can intersect with longer-term conditions such as pelvic pain and endometriosis, while communication barriers and racialised assumptions can affect whether women's pain is recognised and appropriately treated.

The distinction between service availability and meaningful access is therefore central to our submission.

AMHC's work on cervical screening has shown that awareness does not necessarily translate into participation, with women identifying unanswered questions and misconceptions alongside structural barriers including cost, Medicare access, availability of female healthcare providers, and navigation difficulties. To increase participation, community-led approaches using bilingual and bicultural workers, trusted organisations, and female providers can help women ask questions, address concerns and build confidence to access care. The evidence suggests that these are not optional additions: a community-based Refugee Midwifery Group Practice in Brisbane was associated with improved perinatal outcomes compared with standard care, including lower rates of preterm birth and higher rates of spontaneous onset of labour and normal birth.⁴

The same principle applies to reproductive health education, fertility and assisted reproduction. Meaningful access for multicultural women rests on three interconnected pillars: **cultural responsiveness, community models, and structural reform**. Cultural responsiveness requires professional interpreting, privacy, informed decision-making and respectful engagement with cultural, religious and family contexts, alongside action on gendered racism, medical misogyny and discrimination. Community models—including multicultural organisations, culturally matched peer support and community health navigators—provide trusted pathways to understand information, navigate complex systems, connect with appropriate services and strengthen continuity of care. Structural reform requires addressing visa and Medicare barriers, fragmented referral pathways, workforce and interpreter capacity, and gaps in data and evidence, so that health systems respond to these barriers rather than placing the burden of navigation on individual women.

Together, these pillars provide a framework for addressing both the specific health issues identified in the Committee's Terms of Reference and the cross-cutting barriers shaping multicultural women's experiences across the health system.

Note: National Recommendations, Local Implementation

While our recommendations are national in scope, their implementation must account for differences in state and local health systems, service availability and community needs. The consultations and insights informing this submission—including those from Ethnic Communities Councils in Queensland and Western Australia, Fairfield Women's Health Service, and multicultural women and health professionals—show how women's access can be shaped by local availability of maternity, reproductive and postpartum services; and the capacity to provide professional interpreting, including in newer and less commonly supported languages. Practical factors such as transport, appointment scheduling, digital systems, costs and eligibility, and access to childcare can also affect whether women are able to use services. National recommendations should therefore set consistent expectations for equitable, culturally safe access while allowing states, territories and local services to work with multicultural women and organisations to develop approaches suited to local circumstances. This should include resourcing local partnerships and monitoring whether services are reaching women who face the greatest barriers.

⁴ Mpho Dube et al., "Effect of an Australian Community-Based Caseload Midwifery Group Practice Service on Maternal and Neonatal Outcomes for Women from a Refugee Background," *Women and Birth* 36, no. 3 (2023): e353–e360, <https://doi.org/10.1016/j.wombi.2022.10.004>

Executive Summary of Recommendations

Cultural Responsiveness

1. Cultural Safety in Health Information, Help-Seeking and Care

- 1.1. Require women's health services to provide culturally safe communication and help-seeking practices**, including private consultations and culturally appropriate information, with workforce capability on how culture, religion, family expectations, stigma and gender norms can influence disclosure, help-seeking and reproductive decision-making.
- 1.2. Develop protocols for respectfully negotiating cultural and religious practices** relating to birth, newborn care, reproductive healthcare, serious illness, death and dying, including culturally appropriate alternatives where a practice cannot be safely accommodated.
- 1.3. Ensure women have safe opportunities to disclose sensitive concerns**, such as infertility, reproductive coercion, psychological and emotional abuse without requiring disclosure in front of partners or family members.

2. Interpretation and Language Barriers

- 2.1. Require women's health services to provide culturally safe communication and help-seeking practices**, including private consultations and culturally appropriate information, with workforce capability on how culture, religion, family expectations, stigma and gender norms can influence disclosure, help-seeking and reproductive decision-making.
- 2.2. Develop protocols for respectfully negotiating cultural and religious practices** relating to birth, newborn care, reproductive healthcare, serious illness, death and dying, including culturally appropriate alternatives where a practice cannot be safely accommodated.
- 2.3. Ensure women have safe opportunities to disclose sensitive concerns**, such as infertility, reproductive coercion, psychological and emotional abuse without requiring disclosure in front of partners or family members.

3. Address Gendered Racism and Medical Misogyny

- 3.1. Embed integrated capability**: Require health services to provide training that addresses medical misogyny, anti-racism and gender bias together, including how these forms of bias can compound in clinical practice.
- 3.2. Build accountability for women's experiences**: Establish culturally accessible mechanisms to collect and respond to multicultural women's experiences of medical misogyny, racism and discrimination, with findings informing service improvement, clinical guidelines and workforce practice.

Community Models

4. Expand Continuity of Care Across Pregnancy, Antenatal and Postpartum Care

- 4.1. Build on the multidisciplinary and connected-care model of the Endometriosis and Pelvic Pain Clinics by developing integrated reproductive health pathways** spanning primary care, pregnancy, antenatal, postpartum and specialist services.
- 4.2. Strengthen primary-care entry points**, including affordable access to female GPs, and provide GPs with guidance and referral pathways to identify and connect multicultural women with appropriate maternity, reproductive and specialist services early in pregnancy.

4.3. Establish integrated referral and navigation pathways linking GPs, midwives, maternity and reproductive health services, allied health providers and trusted multicultural organisations, with professional interpreting available throughout the pathway.

5. Recognise Multicultural Organisations as Essential Health Infrastructure

5.1. Establish multi-year funding for multicultural organisations to deliver and co-design culturally and linguistically responsive health literacy and community engagement initiatives, and to employ or host culturally matched peer supporters and community health navigators.

5.2. Include multicultural organisations in the design, implementation and evaluation of publicly funded women's health programs from the outset, recognising their community expertise, reach and relationships as essential infrastructure.

5.3. Establish formal partnerships between multicultural organisations and mainstream health services so that community-based support is connected to clinical and specialist care.

6. Invest in Culturally Matched Peer Support

6.1. Fund culturally matched, paid peer support programs for multicultural women, particularly during pregnancy and postpartum, including postpartum mental health services.

6.2. Develop peer support models that recognise extended-family and community caring structures and the diverse ways women understand and experience motherhood.

7. Establish Community Health Navigation as Permanent Infrastructure

7.1. Resource community health navigator and bicultural liaison models as permanent, paid infrastructure with formal referral and partnership pathways across health services and adjacent sectors.

7.2. Prioritise navigation at key life stages and points of increased vulnerability, including pregnancy and postpartum care, reproductive healthcare, chronic illness and pain, mental health and family violence.

7.3. Ensure navigators can support women to understand and act on practical requirements, including eligibility, costs, appointments, referrals, screening pathways, rights and entitlements, while ensuring professional interpreting is used where required.

Structural Reform

8. Address Healthcare Barriers Arising from Visa Status

8.1. Extend Medicare-funded postpartum care (beyond the standard six-week review) to visa categories currently excluded, so recently arrived mothers are not the most vulnerable and the least covered

8.2. Exempt women on temporary visas and women seeking asylum who have experienced domestic, family and sexual violence from meeting residency requirements, so they can fully access Centrelink and Medicare while their visa is being processed.

8.3. Enable Medicare access to roll over, rather than requiring repeated applications which can disrupt access to care and medical treatments mid-treatment cycles.⁵

8.4. Ensure publicly funded women's health programs consider visa status and Medicare eligibility when assessing access barriers and designing services.

⁵ Ibid.

9. Embed Gender-Based Violence Capability Across Healthcare

- 9.1. Ensure healthcare settings provide private opportunities for women to disclose violence and access professional interpreting** where required and establish safeguards so that women can disclose sensitive health concerns without fear that doing so will adversely affect their migration circumstances.
- 9.2. Develop clear referral pathways** between healthcare, specialist gender-based violence, legal, housing, financial and community services, with sustained cross-sector infrastructure to support coordination.
- 9.3. Support health education that promotes women's health autonomy, privacy and decision-making**, including approaches that engage families and communities in understanding women's rights to confidential healthcare.

10. Address Data and Evidence Gaps

- 10.1. Improve data collection and reporting:** Require national women's health datasets to collect and report relevant information on multicultural women, including ethnicity where appropriate and self-identified, alongside country of birth, language, time since migration, visa status, and interpreter need and provision. Require interpreter need and interpreter provision to be recorded as separate, comparable national data fields, so gaps in language access are visible and measurable.
- 10.2. Measure women's experiences of care:** Mandate multilingual, multi-format maternity experience surveys that capture cultural safety, communication, experiences of discrimination and continuity of care.
- 10.3. Embed lived experience and migrant-led expertise:** Ensure migrant and refugee women with lived experience are represented in the design, guideline development and evaluation structures of national maternity, postpartum and women's health strategies, and resource consumer-led migrant and refugee organisations as partners in health education, data and research.

Recommendations:

Cultural Responsiveness

1. Cultural safety in health information, help-seeking and care in relation to reproductive health, infant loss and fertility.

Core recommendation:

The Australian Government should embed cultural safety in how health information is provided, how help-seeking is supported, and how healthcare professionals work with women and families to navigate cultural, religious and family practices relating to birth, reproductive health, illness, and infant loss.

The AMWA Health Thematic Working Group identified culture as shaping help-seeking practices, trust, disclosure, and experiences of healthcare, and emphasised the importance of culturally safe communication and trauma-informed care.⁶ Cultural safety requires more than translated information or cultural awareness training. For multicultural women, the way information is communicated can influence whether women understand their options, feel safe to ask questions, disclose health concerns and make informed decisions about their care.

This is particularly important in reproductive and maternal healthcare, where women may need to discuss sensitive issues including infertility, pregnancy loss, contraception, sexual health and reproductive coercion. For instance, ECCQ consultations highlighted culturally unsafe maternity care, including practitioners' uncertainty when caring for women with FGM (female genital mutilation) and breaches of privacy around student attendance of patient appointments.⁷ These experiences underscore the need for practitioner capability, dignity, privacy and informed consent. Services should provide safe opportunities for women to raise these concerns privately, including where psychological or emotional abuse may be connected to fertility or reproductive expectations.

Cultural and religious practices relating to birth and newborn care should also be approached through respectful negotiation. Where a practice is clinically safe, services should seek to accommodate it; where there are clinical risks, providers should explain these respectfully and work with women and families to identify culturally appropriate alternatives.

Family privacy dynamics also shape what reproductive health information is shared, and with whom. Women may also be culturally expected to cope with postpartum and women's health issues privately, whilst shouldering caring responsibilities. This leaves them without support networks at the point when they need them most. Services should recognise these dynamics while ensuring that women retain privacy, autonomy and safe opportunities to make informed decisions about their own healthcare.

The same principle applies to death, dying and bereavement. Cultural and religious practices can shape who is involved in decision-making, how the body is cared for, the timing and nature of rituals, and the role of spirituality and community. Culturally safe care should provide opportunities for women and families to communicate

⁶ Australian Multicultural Health Collaborative, *Women's Health Key Messages & Insights* (September 2026); AMWA Health Thematic Working Group, "Health Thematic Working Group," May 11, 2026.

⁷ Consultation insights from Ethnic Communities Councils of Queensland.

these preferences and, wherever clinically and legally possible, incorporate them into end-of-life, bereavement and infant-loss care.³

Specific recommendations:

1.1. Require women's health services to provide culturally safe communication and help-seeking

practices, including private consultations and culturally appropriate information, with workforce capability on how culture, religion, family expectations, stigma and gender norms can influence disclosure, help-seeking and reproductive decision-making.

1.2. Develop protocols for respectfully negotiating cultural and religious practices relating to birth, newborn care, reproductive healthcare, serious illness, death and dying, including culturally appropriate alternatives where a practice cannot be safely accommodated.

1.3. Ensure women have safe opportunities to disclose sensitive concerns, such as infertility, reproductive coercion, psychological and emotional abuse without requiring disclosure in front of partners or family members.

2. Interpretation and Language Barriers

Core recommendation:

The Australian Government should ensure that multicultural women can access professional interpreting, alongside accessible, diverse and navigable health information. This is particularly important where communication is essential to informed consent, diagnosis, treatment, safety and continuity of care.

AMWA and AMHC call for cultural safety in women's health services as a relational and negotiated practice, requiring sufficient time for communication, professional interpreting and the meaningful involvement of multicultural women and organisations in the design of information and care models.⁸

The experience of multicultural women seeking pain care demonstrates the potential consequences of these barriers. In the Victorian Women's Pain Inquiry, 71 per cent of respondents, speaking language other than English, felt ignored or dismissed in reporting their pain, while delayed diagnosis and misdiagnosis were reported by 53 per cent and 43 per cent respectively.⁹ These findings reinforce that cultural safety requires health systems to recognise that women may access and understand health information in different ways, and to provide information that is accessible, relevant and responsive to their cultural and linguistic contexts.

The AMWA Health Thematic Working Group further identified overstretched interpreter services, gaps for newer and less commonly supported languages, and the underuse of bilingual staff. Time-pressured consultations routinely failed to accommodate interpreter use or a full clinical work-up. Sensitive disclosures were often made to ancillary staff who shared a woman's language but did not have the authority to respond to or act on the information. Scheduling failures, no-shows and instances of interpreters leaving during appointments made interpreter access ineffective even where a service was technically available.

Professional interpreting must therefore be treated as a core component of safe and effective care, rather than an additional service provided when resources permit. This requires clear requirements for when professional

⁸ Australian Multicultural Women's Alliance (AMWA) and Australian Multicultural Health Collaborative (AMHC), *Women's Health Consultation Insights*; AMWA Health Thematic Working Group, 2026.

⁹ Victorian Department of Health, *Bridging the Gender Pain Gap: The Inquiry into Women's Pain 2025* (Melbourne: Victorian Government, 2025).

interpreting is necessary, supported by sustainable funding, workforce capacity and monitoring of whether interpreting is available throughout the full clinical encounter.

Specific recommendations:

- 2.1. Establish mechanisms to monitor interpreter access and identify gaps in provision**, including by language, service and geographic location with adequate support for newer, less commonly spoken and emerging community languages.
- 2.2. Require health services to monitor interpreter scheduling failures, no-shows and incomplete appointments**, including by language, service and geographic location, and implement measures to ensure continuity of interpreting throughout appointments.
- 2.3. Mandate interpreter involvement at hospital discharge for postpartum patients**, specifically covering medication instructions, warning signs and follow-up care.
- 2.4. Ensure antenatal and postpartum education is available in accessible formats** (including translated video, visual and easy-read resources and community-based and social media communication, alongside translated written information); and the education covers fetal movements, warning signs, labour, pain relief, informed consent, infant feeding and postpartum care.

3. Address gendered racism and medical misogyny in women's healthcare

Core recommendation:

The Australian Government should recognise gendered racism and medical misogyny as intersecting determinants of multicultural women's health and embed anti-racist and gender-responsive practice across healthcare.

AMWA and AMHC consultations highlight how racialised and gendered assumptions persist in the provision of women's healthcare, including in relation to chronic and pelvic pain, menopause and reproductive health. Screening rates for women are lower across most cancer types, and cultural taboos around menopause, sexuality and pelvic pain mean symptoms are frequently normalised rather than investigated.¹⁰

Medical misogyny can compound these experiences, particularly where assumptions about women's pain, bodies, sexuality or reproductive health intersect with racialised assumptions about multicultural women.¹¹ At Fairfield Women's Health Service, Vietnamese women described menopause symptoms (depression, anxiety, sleep disruption, pain) and chronic pelvic pain as an unavoidable part of ageing - something to tolerate rather than something to raise with a clinician.¹²

Time-pressured consultations and communication barriers can further limit women's ability to explain complex or sensitive health concerns. Cultural safety and gender-responsive practice should therefore be addressed together rather than treated as separate areas of clinical capability.

¹⁰ Southwestern Sydney Primary Health Network (2022). *Multicultural Health Week: Cancer Screening*.

¹¹ Jasmine Therese Arcilla et al., "Racialized Migrant Women's Discrimination in Maternal Care: A Scoping Review," *International Journal for Equity in Health* 24 (2025).

¹² Australian Multicultural Health Collaborative (AMHC), *Women's Health Key Messages & Insights*, 2026,

Specific recommendations:

3.3. Embed integrated capability: Require health services to provide training that addresses medical misogyny, anti-racism and gender bias together, including how these forms of bias can compound in clinical practice.

3.4. Build accountability for women's experiences: Establish culturally accessible mechanisms to collect and respond to multicultural women's experiences of medical misogyny, racism and discrimination, with findings informing service improvement, clinical guidelines and workforce practice.

Community Models

4. Expand continuity of care across pregnancy, antenatal and postpartum care

Core recommendation:

The Australian Government should build on its investment in multidisciplinary women's health services by expanding connected, continuous models of care across pregnancy, antenatal and postpartum care. This should include dedicated pathways for multicultural women, early referral from primary care, bilingual and bicultural care and accessible antenatal and postpartum education.

The 2026–27 Federal Budget increased investment in the Endometriosis and Pelvic Pain Clinics to \$39.9 million, supporting a national network of 33 clinics. The clinics provide multidisciplinary care and strengthened diagnostic, treatment and referral pathways, with additional practice staff such as nurse navigators and connections to local providers.¹³ This investment provides an important model for addressing fragmented women's healthcare through services that are accessible, connected to primary care and able to support women to navigate the system.

A similar approach is needed across pregnancy, antenatal and postpartum care. Continuity of care is a best-practice model of pregnancy care, but access remains limited and inequitable across public maternity services. Services that were once distributed across community settings (baby health clinics, women's health checks) have consolidated into GP land, creating a single point of failure for women who already struggle to access a female General Practitioner (GP). AMWA and AMHC consultations further reveal that multicultural women may be unaware of which services are available or best suited to their needs, or do not receive information and referral early enough in pregnancy. General practitioners (GP) are often an important first point of contact, and should be supported to identify eligible women, explain available models of care and make timely referrals.

AMWA and AMHC therefore call for continuity of care that extends beyond the clinical encounter to the information and support women need to participate in their care. For multicultural women, continuity needs to encompass more than seeing the same provider. It requires connected pathways between GPs, maternity services, specialist and allied health care, community organisations and postpartum support, with professional interpreting and culturally responsive information embedded throughout. It must also include meaningful access to female GPs, particularly where women need to discuss intimate, reproductive or culturally sensitive health concerns. This would reduce the need for women to repeatedly explain their circumstances, navigate disconnected referral pathways or rely on family members to interpret complex health information.

¹³ AMWA Health Thematic Working Group, "Health Thematic Working Group," May 11, 2026.

Specific recommendations:

4.4. Build on the multidisciplinary and connected-care model of the Endometriosis and Pelvic Pain Clinics by developing integrated reproductive health pathways spanning primary care, pregnancy, antenatal, postpartum and specialist services.

4.5. Strengthen primary-care entry points, including affordable access to female GPs, and provide GPs with guidance and referral pathways to identify and connect multicultural women with appropriate maternity, reproductive and specialist services early in pregnancy.

4.6. Establish integrated referral and navigation pathways linking GPs, midwives, maternity and reproductive health services, allied health providers and trusted multicultural organisations, with professional interpreting available throughout the pathway.

5. Recognise multicultural organisations as essential health infrastructure for women's health

Core recommendation:

The Australian Government should provide sustainable, multi-year funding for multicultural organisations to serve as essential health infrastructure, supporting culturally and linguistically responsive health literacy, prevention, community engagement, peer support and navigation, and involving these organisations in the design and evaluation of women's health programs.

Health literacy cannot be addressed through information provision alone. The *Own It* campaign demonstrated that receiving information does not necessarily translate into understanding or action: women could still have unanswered questions or misconceptions about when screening was needed, how self-collection worked and what results might mean. ECCQ consultations also highlighted the value of trusted, local settings for women's health education, including organisations such as joint Refuge Health, CentacareFNQ and BreastScreen Queensland morning tea offering bicultural support, screening information and opportunities to participate in breast screening.¹⁴

AMHC consultations with Vietnamese women similarly identified information gaps relating to menopause and hormone replacement therapy, HPV and cervical screening, endometriosis and pelvic pain. Women also reported difficulties navigating eligibility, costs, online systems and support pathways, including being unaware that they could request an interpreter.¹⁵

These experiences demonstrate why multicultural organisations should be understood as part of the health system's infrastructure rather than as supplementary providers of outreach. Their value lies not only in delivering information, but in their sustained relationships with communities, understanding of cultural and linguistic contexts, ability to identify emerging needs, and capacity to connect women with appropriate services. With sustainable investment, multicultural organisations can provide the community infrastructure through which health literacy and prevention initiatives are co-designed and delivered.

¹⁴ Consultation insights from Ethnic Communities Councils of Queensland.

¹⁵ Australian Multicultural Health Collaborative (AMHC), *Women's Health Key Messages & Insights*, 2026.

Multicultural organisations can also provide trusted settings for recruiting, training, and sustaining peer and navigation workforces, while formal partnerships with health services can ensure that community-based support is connected to clinical care (see recommendations 6 & 7).¹⁶

Specific recommendations:

5.4. Establish multi-year funding for multicultural organisations to deliver and co-design culturally and linguistically responsive health literacy and community engagement initiatives, and to employ or host culturally matched peer supporters and community health navigators.

5.5. Include multicultural organisations in the design, implementation and evaluation of publicly funded women's health programs from the outset, recognising their community expertise, reach and relationships as essential infrastructure.

5.6. Establish formal partnerships between multicultural organisations and mainstream health services so that community-based support is connected to clinical and specialist care.

6. Invest in culturally matched peer support for multicultural women

Core recommendation:

The Australian Government should fund culturally matched, paid peer support programs for multicultural women across key stages of reproductive and women's health, particularly pregnancy and postpartum care, and integrate peer support alongside clinical services rather than treating it as an adjunct.

For multicultural women, peer connection can provide a form of culturally familiar support that mainstream services may not provide. Connection with women from similar cultural backgrounds can reduce social isolation and provide an opportunity to share experiences of pregnancy, birth, postpartum recovery and motherhood in ways that recognise cultural and family contexts.¹⁷ This is particularly important for women who may be away from established family and community networks, or who experience barriers to accessing mainstream postpartum mental health support.

There is currently limited publicly funded postpartum mental health support designed specifically for multicultural women, while generic services may be delivered primarily in English and rely on interpreting rather than culturally matched models of support. Peer support should therefore complement, rather than replace, clinical mental health care, providing an accessible and trusted connection to women who may otherwise experience isolation or difficulty engaging with services.

Postpartum care should also recognise the diverse ways women organise family and community support. Models should not assume a single-partner or nuclear-family structure but should recognise extended-family and community caring arrangements where these are important to women's wellbeing and recovery.

The experience of AMHC's *Own It* cervical screening campaign demonstrates the value of trusted, culturally relevant community-based approaches. Bilingual and bicultural workers, trusted community organisations and female healthcare providers created opportunities for women to ask questions, address concerns and build

¹⁶ Australian Multicultural Women's Alliance (AMWA), Submission to the Second Action Plan to End Violence against Women and Children 2022–2032 (Canberra: AMWA)

¹⁷ "Refugee Mothers' Mental Health and Social Support Needs: A Systematic Review of Interventions for Refugee Mothers" (2022).

confidence to participate in screening.¹⁸ Similar principles should inform peer support across pregnancy, postpartum and other areas of women's health.

Specific recommendations:

6.3. Fund culturally matched, paid peer support programs for multicultural women, particularly during pregnancy and postpartum, including postpartum mental health services.

6.4. Develop peer support models that recognise extended-family and community caring structures and the diverse ways women understand and experience motherhood.

7. Establish community health navigation as permanent women's health infrastructure

Core recommendation:

The Australian Government should permanently fund community health navigator and bicultural liaison models to help multicultural women navigate complex and fragmented health systems, with priority given to key life stages and areas of increased vulnerability.

Community health navigation addresses a distinct barrier: the difficulty of translating a woman's need for care into successful access to the appropriate service. AMWA and AMHC consultations identified health-system navigation as a significant barrier for multicultural women, while ECCQ consultations also revealed how some women entered expensive private fertility pathways because they were unaware of options available through the public system.¹⁹ Appointment letters provided only in English, inflexible scheduling, transport constraints and caring responsibilities further prevented women from accessing appropriate services.

To address navigation hurdles, AMWA's Health Thematic Working Group highlighted community navigation as a practical model in which paid community members bridge women and the health system, particularly where women are unfamiliar with Australian healthcare pathways, have experienced negative interactions with services, or face multiple and overlapping barriers.²⁰ As indicated in AMWA's Second Action Plan, community navigation can be treated as essential workforce capability, with trusted multicultural organisations and specialist navigators strengthening culturally responsive pathways into support.²¹ AMWA's advocacy for the Second Action Plan also calls for community navigator and hub models that connect family violence, settlement, employment and childcare services, recognising that women's needs frequently span multiple systems.

Navigation is distinct from peer support. While a peer supporter provides culturally matched connection and shared experience, a navigator helps a woman successfully access and move between services.

Navigators can provide practical assistance to understand eligibility and entitlements, identify appropriate services, prepare for appointments, support referrals and follow-up, explain costs and available supports, and identify when professional interpreting or additional cultural support is required.

Navigation should also recognise that women's health needs do not sit neatly within the health system. Depending on their circumstances, women may need connected support across family and domestic violence services, legal assistance, housing, financial support, settlement services and social services. Community

¹⁸ Australian Multicultural Health Collaborative (AMHC), *Women's Health Key Messages & Insights*, 2026.

¹⁹ Consultation insights from Ethnic Communities Councils of Queensland.

²⁰ AMWA Health Thematic Working Group, 2026.

²¹ Australian Multicultural Women's Alliance (AMWA), *Submission to the Consultation on the Second Action Plan: National Plan to End Violence against Women and Children 2022–2032* (July 2026), Priority Area 5, Recommendation 5.2, "Building Community Navigation, Informal, Formal and Adjacent Sector Workforce Capability."

navigators can help establish these connections and reduce the risk that women are repeatedly referred between systems without receiving appropriate support (see Recommendation 9).

Community navigation should be understood as health infrastructure, not a supplementary function that multicultural organisations are expected to provide through unpaid labour or short-term grants. Sustainable funding is needed to maintain community relationships, develop trust and provide continuity, while mainstream health services remain responsible for delivering accessible and culturally safe care.

Specific recommendations:

7.4. Resource community health navigator and bicultural liaison models as permanent, paid infrastructure with formal referral and partnership pathways across health services and adjacent sectors.

7.5. Prioritise navigation at key life stages and points of increased vulnerability, including pregnancy and postpartum care, reproductive healthcare, chronic illness and pain, mental health and family violence.

7.6. Ensure navigators can support women to understand and act on practical requirements, including eligibility, costs, appointments, referrals, screening pathways, rights and entitlements, while ensuring professional interpreting is used where required.

Structural Reform

8. Address healthcare barriers arising from visa status

Core recommendation:

The Australian Government should remove visa-related barriers to equitable access to healthcare for migrant and refugee women, including gaps in Medicare eligibility, and ensure that immigration status does not prevent women from accessing timely and appropriate healthcare.

For some multicultural women, eligibility for healthcare is shaped not only by clinical need but by their migration status. The AMHC's *Own It* cervical screening campaign identified lack of Medicare, migration status and financial constraints as practical barriers to screening, even where women wanted to access care. Women on temporary or bridging visas also reported concerns about the potential implications of a positive diagnosis for their visa status, creating an additional deterrent to seeking care. These barriers can be particularly significant for reproductive and sexual health, where delayed care may result in more complex health needs and greater costs.

Visa-related barriers also intersect with other determinants of health, including financial insecurity, insecure housing, family violence and social isolation. A healthcare system that requires women to navigate eligibility rules while experiencing illness or vulnerability risks shifting responsibility for structural barriers onto individual women.²² Healthcare access should instead be based on health need, with clear and accessible pathways for women whose visa status currently limits Medicare access.

²² National Advocacy Group on Women on Temporary Visas Experiencing Violence. (2026). *National Blueprint for Reform: Securing safety for victims/survivors of domestic and family violence who are on temporary visas*. WESNET. <https://wesnet.org.au/ourwork/blueprint/>

Specific recommendations:

8.5. Extend Medicare-funded postpartum care (beyond the standard six-week review) to visa categories currently excluded, so recently arrived mothers are not the most vulnerable and the least covered.

8.6. Exempt women on temporary visas and women seeking asylum who have experienced domestic, family and sexual violence from meeting residency requirements, so they can fully access Centrelink and Medicare while their visa is being processed.

8.7. Enable Medicare access to roll over, rather than requiring repeated applications which can disrupt access to care and medical treatments mid-treatment cycles.²³

8.8. Ensure publicly funded women's health programs consider visa status and Medicare eligibility when assessing access barriers and designing services.

9. Embed gender-based violence capability across healthcare, particularly around reproductive coercion.

Core recommendation:

The Australian Government should recognise healthcare as essential infrastructure for the prevention, early identification, response and recovery from gender-based violence, and invest in the capability of health services to provide culturally safe, trauma-informed and integrated support for multicultural women experiencing violence.

Gender-based violence is a significant determinant of women's health. Its impacts can include physical and psychological injury, chronic health conditions, financial stress, housing instability and longer-term health consequences.²⁴ Healthcare services are important universal touchpoints for victim-survivors before, during and after violence, creating opportunities for prevention, early intervention, response and recovery, that may not be well served by mainstream gender-based violence services.²⁵

Healthcare responses should also recognise that violence may affect women's engagement with health services over time. Psychological and emotional abuse, reproductive coercion and financial abuse may directly affect women's ability to make healthcare decisions, attend appointments or access treatment. A trauma-informed approach therefore requires more than screening for violence: it requires services to respond appropriately when violence is disclosed and to establish pathways into legal, housing, financial, social and specialist family and domestic violence support.

For multicultural women, this requires sustained partnerships between healthcare services, multicultural organisations and specialist gender-based violence services. As indicated in Recommendation 5, cross-sector partnerships with multicultural organisations can help ensure women are not required to navigate fragmented systems alone. This aligns with AMWA's advocacy in its Second Action Plan submission for greater recognition of the adjacent sectors and community touchpoints through which multicultural women may disclose violence,

²³ Ibid.

²⁴ Australian Institute of Health and Welfare, *Family, Domestic and Sexual Violence*, Australian Government, 2025.

²⁵ World Health Organization, *Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines* (Geneva: World Health Organization, 2013); World Health Organization, *Strengthening Health Systems for Women Who Experience Violence: A Guide for Health Managers* (Geneva: WHO, 2017)

seek assistance and be connected to safety and support, including sectors beyond the formal gender-based violence service system.²⁶

Specific recommendations:

9.4. Ensure healthcare settings provide private opportunities for women to disclose violence and access professional interpreting where required and establish safeguards so that women can disclose sensitive health concerns without fear that doing so will adversely affect their migration circumstances.

9.5. Develop clear referral pathways between healthcare, specialist gender-based violence, legal, housing, financial and community services, with sustained cross-sector infrastructure to support coordination.

9.6. Support health education that promotes women's health autonomy, privacy and decision-making, including approaches that engage families and communities in understanding women's rights to confidential healthcare.

10. Address data and evidence gaps affecting multicultural women

Core recommendation:

The Australian Government should address the systematic exclusion of multicultural women from health research, data and policy design, ensuring that migrant and refugee women are visible in the evidence base and decision-making structures that shape women's health services.

Multicultural communities can be excluded from the evidence base, and especially when research and evaluation are concentrated in populations or regions with limited migrant representation. This can mean that programs described as "evidence-based" do not adequately reflect the experiences, needs or barriers of migrant and refugee women.

There is currently no standardised, culturally appropriate approach to measuring women's experiences of maternity care. In many jurisdictions, maternity experience surveys are conducted by post, in English and months after birth, with limited measures of cultural safety beyond interpreter use. These approaches risk excluding women who face the greatest barriers to accessing and communicating with health services.

Better data and reporting are essential to making these gaps visible and ensuring that health systems can identify and respond to disparities. This is consistent with AMWA and AMHC's broader advocacy for data and evidence that makes the experiences of multicultural women visible and supports intersectional policy responses.

Specific recommendations:

10.4. Improve data collection and reporting: Require national women's health datasets to collect and report relevant information on multicultural women, including ethnicity where appropriate and self-identified, alongside country of birth, language, time since migration, visa status, and interpreter need and provision. Require interpreter need and interpreter provision to be recorded as separate, comparable national data fields, so gaps in language access are visible and measurable.

²⁶ Australian Multicultural Women's Alliance (AMWA), *Submission to the Consultation on the Second Action Plan: National Plan to End Violence against Women and Children 2022–2032* (July 2026), Priority Area 5, Recommendation 5.2, "Building Community Navigation, Informal, Formal and Adjacent Sector Workforce Capability."

10.5. Measure women’s experiences of care: Mandate multilingual, multi-format maternity experience surveys that capture cultural safety, communication, experiences of discrimination and continuity of care.

10.6. Embed lived experience and migrant-led expertise: Ensure migrant and refugee women with lived experience are represented in the design, guideline development and evaluation structures of national maternity, postpartum and women’s health strategies, and resource consumer-led migrant and refugee organisations as partners in health education, data and research.

Conclusion

AMWA and AMHC have highlighted that improving women’s health outcomes for multicultural women requires more than the availability of services: it requires meaningful, culturally responsive access across pregnancy, postpartum, reproductive health, pain care and the broader health system.

Our recommendations focus on addressing the structural, cultural, linguistic, and system-navigation barriers that can prevent multicultural women from accessing and benefiting from reproductive healthcare, while recognising the essential role of multicultural organisations, community-led expertise and culturally responsive models of care. While our recommendations are national in nature, implementation must also respond to state and local needs, with a consistent commitment to equitable access that allows for locally tailored approaches developed with multicultural communities and organisations.

AMWA and AMHC welcome the opportunity to continue engaging with the Committee and look forward to responding to its recommendations and providing further feedback and evidence as its work progresses

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