



# Leading the conversation on migrant and refugee women and gender diverse people's experiences of pain

A submission to the Victorian Government Inquiry into Women's Pain by the **Multicultural Centre for Women's Health**

## 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 research was undertaken. Aboriginal sovereignty was never ceded.

We recognise that as women of migrant and refugee backgrounds, 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.

We acknowledge that Aboriginal and Torres Strait Islander people have been active leaders in health promotion and advocacy and our work should be held accountable to the same aims.

## MCWH acknowledgements

MCWH welcomes the opportunity to make a submission to the Victorian Government's Inquiry into Women's Pain. Our submission directly addresses the scope outlined by the Victorian Government and is based on our work in promoting the health of migrant and refugee women and gender diverse people nationally and across Victoria.

The Research, Advocacy and Policy Department would like to thank everyone who contributed to this submission. Your generosity, knowledge, and willingness to share your personal experiences enabled us to better understand migrant and refugee women and gender diverse people's experiences of pain and healthcare access across Victoria.

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## Executive Summary

This submission has been developed by the Multicultural Centre for Women's Health (MCWH), a Victorian-based, national women's health service established in 1978 that works to promote the health and wellbeing of migrant and refugee women and gender diverse people across Australia. We do this work through research and publication, participation in advisory groups and committees, written submissions, delivering in-language health education, training and capacity building.

As the national voice for migrant and refugee women's health and wellbeing, this submission employs an intersectional approach to exploring issues related to women's and gender diverse people's experiences of pain. We recommend that reforms arising out of this Inquiry recognise and address the role of societal structures — at the intersections of age, class, ability, race, ethnicity, health and socio-economic status — in contributing to experiences of pain inequalities migrant and refugee women and gender diverse people experience.

This submission is informed by the lived and living experience of migrant and refugee women and gender diverse people. It draws upon a qualitative survey that we conducted focusing specifically on women's pain and distributed through our extensive networks, data from our in-language health education programs, interviews, focus groups and previous research projects. This submission centres the voices of migrant and refugee women and gender-diverse people as it outlines their unique experiences of pain across the domains of sexual and reproductive health, mental health and their experiences of dealing with workplace related pain and injury.

The evidence outlined in this submission confirms that for migrant and refugee women and gender diverse people, the prevalence of pain is difficult to ignore, and systemic barriers can and do prevent people from accessing care in a timely manner. Pain is more than a health issue and the notion of women's pain in particular, needs to be viewed as an issue of equity that is shaped and compounded by intersecting forms of discrimination and structural barriers to accessing healthcare. Therefore, paying attention to the social determinants of pain is crucial to realising a more just, equitable and healthy society.

MCWH acknowledges recent efforts from both the Federal Government and Victorian Government to address the gender pain gap. The Inquiry into Women's Pain is an important first step in responding to this public health and human rights issue.

## Key recommendations:

Our recommendations focus on creating equitable healthcare systems, strengthening social services, and implementing intersectional policies and programs for migrant and refugee women and communities across all levels of healthcare including prevention, early intervention, and treatment.

### 1. Addressing the multiple forms of structural inequalities that limit migrant and refugee women's and gender diverse peoples' access to healthcare by:

- i. Extending all Victorian healthcare and support services to include all migrants and refugees regardless of visa status. Including costs associated with diagnosis, treatment, mental health support, and integrative care related to migrant and refugee women and gender diverse people's experiences of pain.
- ii. Advocating to the Federal Government to implement Recommendation 30 (4.111) of the Senate Inquiry into Universal Access to Reproductive Healthcare: 'The committee recommends that the Australian government, in consultation with state and territory governments, consider options for ensuring the provision of reproductive health to all people living in Australia, irrespective of their visa status.'
- iii. Advocating to abolish waiting periods and visa restrictions for all migrants, including in relation to temporary migrants on the Pacific Australia Labour Mobility (PALM) scheme, and Overseas Student Health Cover (OSHC) Deed (ensuring the Deed recognises labour or termination of pregnancy as conditions of 'emergency care' that require urgent attention).
- iv. Re-instating the Sick Pay Guarantee program for disadvantaged migrant and refugee women and gender diverse people who are casually employed and ensure that leave options for the treatment and management of pain, including "reproductive leave," extends across all industries and employment types: casual, contract, part-time, and full-time workers.
- v. Investing in strategies that prevent gender and race discrimination in workplaces and healthcare services.

**2. Investing in the expansion of MCWH's services to deliver a comprehensive statewide, specialist, multicultural preventative women's health program, that provides:**

- i. Multilingual and culturally appropriate health and wellbeing education (including information about work safety and rights) and support programs across Victoria, including in rural and regional areas. Education programs are co-designed, targeted and tailored, and delivered by expert bilingual health educators through active outreach and consultation and considers the specific needs of different population groups, such as young migrant and refugee women and gender diverse people, international students, and newly arrived migrants.
- ii. Specialist secondary consultations, capacity building and training to ensure the newly established women's health clinics are culturally safe and accessible.
- iii. Support for the existing models of perinatal health screening and assessment to improve early identification and intervention at the primary care level for birthing migrant and refugee people.
- iv. Transparent and standardised referral pathways for migrant and refugee women and gender diverse people to access healthcare services, including the promotion of healthcare services that are available to migrant and refugee women and gender-diverse people, such as Mental Health and Wellbeing Locals.
- v. Specialist advice and expertise to antenatal care providers through formal partnership, to increase access to antenatal care in the first trimester for migrant women and gender diverse people, improve perinatal health outcomes, and reduce stillbirth and neonatal death.
- vi. Community-based initiatives to promote social cohesion and the development of social networks within migrant and refugee communities.

### 3. Building the evidence base on migrant and refugee women and gender diverse people's experiences of pain and program evaluation capacity by:

- i. Investing in intersectional policy development, analysis and evaluation to ensure that Victorian government policy impacts positively on migrant and refugee women and gender diverse people's health. For example, analysis and evaluation of the health system and service delivery options should address the multiple forms of disadvantage and barriers to accessing services experienced by migrant and refugee families (including racism and discrimination in service delivery, and language barriers).
- ii. Commissioning new community-led research through equitable research partnerships with migrant and refugee women's organisations to investigate the impacts of various gynaecological conditions on migrant and refugee women and gender-diverse people's health in particular, economic consequences, access to healthcare services, treatments, and information (including digital health technologies). Research should be intersectional and inclusive of different population groups, such as young people.
- iii. Funding research into mental health (specifically suicide and self-harm) that is inclusive of migrant and refugee women and gender diverse people to ensure prevention initiatives can be tailored to their specific needs.
- iv. Developing a framework for collecting disaggregated health data (by gender, sex, ethnicity, disability, place of birth and visa status) and outcomes data relevant to migrant and refugee populations, and ensure medical research reflects the principles of racial and gender equity.

**4. Supporting the healthcare workforce, across the health system, to build their capacity to deliver a culturally responsive and safe service to migrant and refugee women and gender diverse people by:**

i. Working in partnership with specialist migrant and refugee organisations to implement best practice and trauma-informed service provision, encompassing person-centred approaches that promote continuity-of-care and cultural safety from the beginning of migrant and refugee people’s engagement with the healthcare system.

ii. Supporting ongoing capacity building and professional development for healthcare professionals and the interpreting workforce in gendered, cross-cultural awareness and provide training for early detection of signs of domestic violence and reproductive coercion, through the funding of programs and partnerships between healthcare providers and migrant and refugee-led organisations.

iii. Resourcing, upskilling and embedding bilingual workers across mental health and sexual and reproductive healthcare services.

iv. Investing in and actively prioritising a culturally and linguistically diverse healthcare workforce and increasing employment and leadership opportunities for migrant and refugee health professionals. This includes addressing the barriers for recognising the qualifications of overseas-trained healthcare professionals.

v. Ensuring accessibility to translation and interpreting services by investing in a secure, well-paid translation and interpreting workforce with expertise in cultural safety, women’s health and gendered violence.

## Background

The gender pain gap is a public health crisis and a human rights issue. The pain experienced by women and gender diverse people is disproportionately under-researched, ignored, or misdiagnosed. This submission employs a gendered, intersectional lens which underscores the need to treat migrant and refugee populations as a heterogeneous group at a policy and programming level. Future policy reforms and programs arising out of this Inquiry need to be tailored and intersectional in their design and implementation, for the state's healthcare system to be more equitable and culturally responsive to the needs of migrant and refugee women and gender diverse people.

In this submission, 'women and gender diverse people' is used to include cisgender women, transgender women and non-binary and gender diverse people. Unless specified, where literature is cited, we have used the term 'women' as most research does not clarify authors' identifications of gender. MCWH recognises this approach is limiting and not always inclusive of non-binary and gender diverse people, who may experience significant barriers to accessing support for their health and wellbeing.

In preparing this submission, we heard from migrant and refugee women and gender diverse people on how their experiences of pain were compounded by socio-cultural factors and systemic inequalities, including racial and gender discrimination, lack of culturally and linguistically responsive services, inadequate in-language and interpreting services, long waiting times and costly services.

We captured migrant and refugee women's and gender diverse peoples' experiences of pain and accessing care through a variety of methods, including:

- Qualitative data from previous research projects we conducted between 2020-2024 into migrant and refugee women's mental health, sexual and reproductive health and experiences of violence (in this submission we refer to this data as 'previous research')
- Literature review to understand the experiences of pain among migrant and refugee women and gender-diverse people, and to identify gaps in research
- Data from our state-wide bilingual health education sessions between 2019-2022
- A purposefully designed qualitative survey that was distributed to a select group of migrant and refugee women and gender diverse people (including international students, farm workers and casual employees). We received 17 responses which provided valuable insights about the impact of systemic barriers on women's pain
- Three follow up in-depth interviews with survey respondents and healthcare professionals
- Engagements with key organisations, including Centre for Multicultural Youth (CMY)



## **Experiences of pain and seeking care**

In this submission, the issue of pain is defined based on the 'social determinants of health' lens as it considers migrant and refugee women and gender diverse people's unique experiences, and the political and socio-economic realities in which they live their lives. In our consultations, we found that the physical, emotional, psychological and social experiences of pain are interlinked and exacerbated by systemic barriers to accessing healthcare. The literature confirms our findings that rates of seeking support for pain relating to mental and physical health among migrant and refugee communities are generally lower than that of the general population (Guo et al., 2020; Khatri et al., 2022), which is related to systemic barriers, such as the complex nature of healthcare systems in Australia and the lack of culturally and linguistically responsive services (Fauk et al., 2021; Moss et al., 2019; Radhamony et al., 2023; Shafiei et al., 2018).

The experiences highlighted in this submission underpin the importance of moving beyond biomedical understandings of pain, to one which is intersectional and responsive to everyone's needs. This requires improving service delivery, so that the health system is less fragmented and integrating models of care that connects primary and specialist health services. As shown in this submission, the fragmentation of the current system not only causes difficulties for service providers and the health workforce, but has flow-on effects to consumers, carers, and families.

In the following section, we present the voices of migrant and refugee women and gender diverse people's access to healthcare for their pain. Their perspectives on pain provide a way forward to better understand how Victoria's healthcare system can be made more just, equitable, and culturally responsive.

## **Racial and gender discrimination**

Racism and discrimination in healthcare settings is a common occurrence for migrant and refugee women and gender diverse people seeking help for their pain. For this submission, people shared stories of the discriminatory practice they had experienced from healthcare professionals. Their perspectives were consistent with studies, which highlighted how migrant and refugee women were often ignored, dismissed, silenced, misinterpreted or discredited by clinicians (Filler et al., 2020; Entwistle et al., 2023). For instance, in the survey responses, some women shared their stories of being treated poorly by healthcare professionals, because of assumptions made about their cultural background, visa status, and/or English proficiency:

*"I have had many...experiences where my pain was dismissed. Most of these instances were by hospital staff who would assume I don't speak or understand English well and would say or behave in very questionable manner... I felt extremely disrespected to say the least because my severe experience of the pain was sexualised... I was alone and the hospital staff, knowing and seeing that I'm under heavy sedation, did not ask how I'm going to get myself home or if I needed any help arranging transport home. ... made me feel very disrespected, discriminated against and not cared for properly, just because of my cultural background or status as an international student/temporary migrant woman."*

Similarly, another migrant woman in the survey explained that:

*"I was treated discriminately several times by English-speaking health professionals due to my international student visas, Asian-background, and non-English speaking abilities... I live in the Northern suburbs, I found it harder to seek health professionals who can speak my first language."*

We found that the experience of not being taken seriously or being dismissed was also a persistent issue that cut across all types of pain and was a significant barrier for migrant and refugee people seeking help. One participant of our health education sessions shared that she had spent over ten years living with menstrual pain, only to be told by her GP that it was "normal period pain." Similarly, another woman who participated in our research project last year (Tran et al., 2023) shared:

*"My English is not bad at all, I can fully understand what they say and speak English fluently, but still ...I remember that I had pain in my shoulder and my neck, I went to my GP, and he said you are too young to have problems with your neck and shoulder. He just gave me painkillers and he did not refer me to further treatment. I gave up seeing GP from that experience... It has been so many years I have not gone to see a GP here."*

As a result of not being taken seriously or having their pain dismissed, many migrant and refugee women told us about having to change health professionals on multiple occasions until they found someone who would listen to their concerns and provide a diagnosis. The experience of having to repeatedly express how debilitating the pain was resulted in self-advocacy fatigue for many migrant women. As one survey respondent put it:

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

Experiences of being invalidated by health professionals can lead to exacerbations of health problems due to patients' avoidance and delayed seeking care (DiGiacomo et al., 2015). Therefore, there is a need to recognise and address systemic racial and gender discrimination within the healthcare system so that it delivers care that is equitable, fair and respectful to the needs of migrant and refugee women and gender diverse people.

### **Under-resourced in-language and interpreting services**

The use of interpreters is often featured in health policies relating to migrants and refugees as a strategy to address linguistic barriers, with healthcare providers having around-the-clock access to the Commonwealth Government's Translating and Interpreting Service (TIS). However, patients and providers have reported specific issues with TIS, such as poor telephone connection or interpreters being preoccupied with other tasks (Olcon et al., 2023). As a participant of our previous research on mental health explained:

*"For some people who could not speak English, if they need to go to the hospital or clinic, they need interpreter to clearly describe their suffer inside the bodies. No more interpreter available in [name of hospital] more than one and half years already. Sometimes, some interpreters especially in telephone interpreting do not be patient and allow to speak a lot. Additionally, we could not hear clearly because there is not clear in telephone line, I would like to request the interpreters to be patient and understand the patients."*

In preparing this submission, we heard about how the availability of interpreting services greatly differed between healthcare providers and sites, with a survey respondent explaining how the inconsistent availability of interpreters in her area meant she had "to wait until [she] can speak English enough to seek further help for pain." It has also been well-documented in literature that service providers based in regional areas have even less access to onsite interpreters and more difficulty locating interpreters for some languages, particularly those spoken by new and emerging refugee communities (Vaughan et al., 2016; Sullivan et al., 2023). Moreover, in instances where interpreters were not reached or were late, some women missed appointments they had waited a long time for. Overall, the limited access to interpreters particularly in remote or regional areas continues to place

migrant and refugee people with low English language proficiency at further risk of experiencing pain for longer periods of time.

The concerns highlighted above regarding access to interpreters, reflect broader structural issues related to resourcing and workforce development. Interpreters need to be recognised as an integral part of the provision of healthcare and supported to upgrade their skills on an ongoing basis.

### **Lack of culturally and linguistically responsive services**

In addition to racial and gender discrimination in healthcare settings, another systemic barrier that actively prevents migrant and refugee women and gender diverse people from accessing help for their pain is the lack of culturally and linguistically responsive services. For instance, one survey respondent spoke about how the lack of in-language services and information meant she had limited options in seeking further help for her pain:

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

Providing ongoing capacity building and professional development for healthcare professionals and the interpreting workforce in gendered, cross-cultural awareness is crucial for responding to migrant and refugee women and gender diverse people's needs.

### **Lack of meaningful support for young migrant and refugee women and gender diverse people**

In our consultation with the Centre for Multicultural Youth (CMY), a non-profit organisation based in Victoria, we heard that young people from migrant and refugee backgrounds often faced barriers to accessing support services. Young migrant and refugee people experience a range of challenges relating to 'settling in a new country, disrupted support networks, developing a new sense of self-identity, racism and discrimination' (Orygen & CMY 2020, p.4). We note that these challenges impact migrant and refugee women's and gender diverse people's health and experiences of pain. For instance, research shows that migrant and refugee youth in Australia experience poorer sexual and reproductive health outcomes, lower service engagement and have difficulties navigating the healthcare system (Napier-Raman et al., 2022). Overall, we found that there is a lack of culturally responsive and tailored healthcare services that meet the needs of young migrant and refugee women and gender diverse people. For instance, CMY has noted that mental health services are often based on 'Western-clinical models of treatment and recovery and are frequently perceived

or experienced as being at odds with culturally informed perspectives’ (Orygen & CMY, 2020, p.5).

Considering these barriers and the lack of tailored, culturally and linguistically responsive programs for migrant and refugee youth, MCWH is uniquely positioned to partner with organisations like CMY to deliver health education programs on a range of topics, such as sexual and reproductive health, respectful relationships, and mental health. In order for these programs to be tailored and meaningful, they need to be co-designed with young migrant and refugee women and gender diverse people. In preparing this submission, we found that overall migrant and refugee women and gender diverse people are not provided meaningful opportunities to be involved in active decision making regarding their health and wellbeing. Therefore, it is crucial to invest in community-led research to better understand the unique challenges young migrant and refugee women and gender diverse people face and their solutions for an equitable healthcare system.

### Long waiting times and costly services

Many women we engaged with cited extended waiting periods and costly services as barriers to accessing adequate support to manage their pain. These barriers are symptomatic of an inadequate healthcare system that has not kept up with the needs of Victorians and has inadvertently run the risk of harming patients. In our research project into mental health experience (Tran et al., 2023), many women told us that they had to travel back to their country of origin to manage their pain. For those who are living in regional Victoria, many of them often had to wait at least three months for a medical appointment. As said by the following participant:

*“I always use online consultations from doctors in [country of origin] for other health issues as I have to wait so long to see the specialist doctors, and the price are so expensive. I have to see doctor online and even go back to [country of origin]. Much cheaper and much quicker. When I go back to see doctor in [country of origin], I feel like I’m their first priority while when I book and see doctor here, still feel sense of discrimination.”*

On the issue of cost, several spoke about the unaffordability of mental health services. One survey respondent mentioned how high costs intersected with the lack of LGBTQIA+ responsive services. Their perspective is aligned with current evidence on some of the barriers LGBTQIA+ communities face when seeking mental health care and sexual and reproductive health care, which include less continuity in general practitioner care and lower levels of satisfaction with mental healthcare services (Bowler et al., 2023). As a migrant individual from the LGBTQIA+ community expressed:

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

For those who are on temporary visas, seeking support for pain – whether it be physical and/or mental health related – is made more difficult due to ineligibility for Medicare. In this regard, we heard mainly from international students. One survey respondent shared her experiences of pain from a work-related injury:

***“With regard to the work-related injury, I was an international student so I did not have access to Medicare which meant I couldn't get the support I needed myself either--because of the cost.”***

As a visa condition, international students in Australia are required to purchase Overseas Student Health Cover (OSHC) for themselves and their dependents to cover medical costs for the duration of their stay in Australia. Under the OSHC, international students are covered for basic medical treatment similar to that which Australian citizens and permanent residents are covered for under Medicare. This is not to imply, however, that international students are guaranteed equal health protection once OSHC is purchased (Poljski et al., 2014). In research that we have conducted in partnership with the University of Melbourne, Deakin University and Monash University examining the help-seeking experiences of international students after sexual violence and intimate partner violence in Australia (Tran et al., 2024), one participant shared her experiences of seeking mental health care in Victoria:

***“It's extremely expensive, like one appointment is \$500. It is just the initial appointment and if I don't have any Medicare and then I just have a student health insurance, so how I can afford it? [Insurance] just covers for some accidental injuries... It's very challenging for [international] students like us”***

The following quote is from another participant of the same study who experienced sexual assault and wanted to seek mental health care support (Tran et al., 2024). She shared how common it was for international students to forgo timely care and support due to long waiting times and exorbitant costs, thus indicating a critical need for improved accessibility and affordability in healthcare services:

*"I have overseas health insurance I pay \$150 a month for, but still, you have to pay \$200 [for mental healthcare]. I've just seen so many of my friends just be like, "I can't afford it, I'm not going to go." So, they're just suffering because it's too expensive or because the waiting list is up to a year..."*

Overwhelmingly we have found that unaffordability and cost is a significant factor for migrant and refugee people, in terms of their capacity to access health services. Especially in relation to temporary migrants, welfare restrictions, such as ineligibility for Medicare and social security payments, contributes to economic and health insecurity. Many temporary migrants face prohibitive costs for services, leading to delayed treatment and exacerbation of physical and mental health conditions. Addressing affordability issues is essential for prevention and early intervention measures aimed at reducing both the burden of pain and secondary healthcare costs for the patient and the healthcare system.

### **Implications of lack of access to healthcare**

Across all the different types of pain, a recurring theme was the lengthy amount of time migrant and refugee women and gender diverse people had lived in pain due to lack of access to healthcare. Most of these experiences could potentially be identified as chronic pain given this is defined as 'persistent or recurrent pain lasting longer than three months'. (Treede et al. 2015, p. 1004). In preparing this submission, many migrant and refugee women and gender diverse people told us that they experienced pain from one year to as long as 17 years before gaining a diagnosis. One survey respondent shared her story of chronic pain, illustrating how physical and mental health and wellbeing are inextricably linked:

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

Chronic pain is often poorly recognised and inadequately managed in the general population. However, the burden of pain is far greater for those who face cultural, financial, and/or geographical barriers to healthcare (Craig et al., 2020; Altun et al., 2022a). Populations that are systemically disadvantaged are also more likely to live with chronic pain and greater pain severity due to disparities in pain care, such as the persistence of racial and ethnic discrimination in healthcare settings (Wallace et al., 2021; Altun et al.,

2022b; Anderson et al., 2009). In Australia, evidence consistently shows communities who are already disadvantaged are more likely to have their pain underestimated, under-investigated, and undertreated. For example, research into pain management of First Nations people illustrates how discriminatory practice from health care providers is an active barrier that prevents many from seeking care for their pain (Bernardes et al., 2022; Strong et al., 2015). Research indicates the same issues persist for migrant and refugee women (Altun et al., 2023).

Chronic pain is not just a health issue, it is a social justice matter. Social inequities and disparities in care play a significant role in shaping people's experiences of pain. Individuals and communities who have been excluded from societal power structures and decision-making processes face additional challenges when accessing resources and opportunities for effective pain management (Altun et al. 2023). Any person experiencing pain should be able to access safe, free or low-cost, and culturally appropriate healthcare in a timely manner to reduce the likelihood of the pain becoming chronic or to ensure it can be managed effectively.

## **Types of pain across three domains**

As outlined earlier, socio-cultural factors and systemic inequalities play a significant role in contributing to pain and the pain-related disparities migrant and refugee women and gender diverse people experience. Identifying how pain is experienced by migrant and refugee people is essential in order to provide culturally responsive healthcare, health education and health promotion, and to increase the capacity of women and gender diverse people to access appropriate services. As such, in this section, we present the voices of migrant and refugee women and gender diverse people on their experiences of pain relating to:

1. Sexual and reproductive health
2. Mental health and wellbeing
3. Workplace-related injuries and pain

### **1. Sexual and reproductive health related pain**

Sexual and reproductive health encompasses a range of health and wellbeing, issues and rights, including efforts to eliminate preventable maternal and neonatal mortality and morbidity; ensuring quality and appropriate services for everyone, including contraceptive services; and addressing sexually transmitted infections and cervical cancer, violence against women and girls, and equitable and respectful relationships. While universal access to sexual and reproductive health is essential to achieving health and gender equity, there are significant health disparities among different population groups in Australia, contributing to the gender and racial pain gap.



In order to reduce the gender and racial pain gap, it is imperative that our healthcare system is better set up to understand and respond to the needs of migrant refugee communities. There are a variety of issues that specifically impact migrant and refugee women and gender diverse people, such as experiences of FGM/C, and efforts to address the needs of affected communities need to be led by the community and specialist migrant and refugee women's organisations with specific expertise in the area, such as MCWH.

### **Gynaecological conditions**

In preparing this submission, we heard from migrant and refugee women and gender diverse people on their debilitating experiences of pain, as it related to gynaecological conditions, such as endometriosis. In Australia, more than 11% of women, girls, and people assigned female at birth suffer from endometriosis. This condition can significantly impact individuals' overall quality of life, as symptoms may include pelvic and abdominal pain, cramping, heavy and painful menstruation, bloating, fatigue, bowel and bladder dysfunction, and pain during sexual intercourse (MCWH, 2021). Currently there is very little research on the nature and impact of endometriosis on migrant and refugee women and gender diverse people, however, 26% of endometriosis-related hospitalisations between 2021-22 were among females born outside of Australia (AIHW, 2023b). Given the many barriers migrant and refugee women and gender diverse people experience in accessing diagnosis, we suspect this number to be even higher.

Gynaecological and pelvic-pain related conditions, such as endometriosis has racialised and gendered roots. In a systemic review of literature, Bougie et al. (2022) found that endometriosis was historically viewed and understood by doctors to be a condition of White women only, an inaccurate association that persists in treatment today. For women and gender diverse people, medical misogyny has meant that pelvic pain is often dismissed or normalised by healthcare professionals. However, for migrant and refugee women and gender diverse people, gendered factors underpinning underdiagnosis are compounded by stereotypes based on race, class and sexuality. As an LGBTQIA+ migrant individual who responded to our survey described:

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

Evidence indicates that people who have endometriosis experience both difficulties and delays in receiving diagnosis and subsequent treatment. For example, one paper found that it takes doctors an average of 6.4 years to recognise symptoms as endometriosis (Nnoaham et al., 2011). However, migrant and refugee women and gender diverse people face additional barriers when it comes to accessing help for their sexual and reproductive health, which often result in even longer delays in diagnosis and treatment of pelvic-pain related

conditions. One migrant woman shared in her survey response that she had been living with pain for 22 years. Another woman shared:

*"...it took 17 years to be diagnosed with Polycystic ovary syndrome (PCOS)."*

Another survey respondent explained she was initially misdiagnosed with another condition, and it took many years until she was given the right diagnosis:

*"...it took 14 years for me to get a diagnosis with adenomyosis and endometriosis after being referred to a private ultrasound clinic. When I was younger, I was told the pain was normal for my age and it will get better, but it never did."*

Currently, laparoscopy is the only way to obtain a definitive diagnosis of endometriosis. The surgical procedure is covered by Medicare but is classified as a low-priority elective surgery, meaning there could be long wait times and late diagnoses in public health settings. Between 2021-22, endometriosis-related hospitalisations were more likely to be partly or fully funded by private health insurance, self-funded, or occur in a private hospital (AIHW, 2023b). Notably, the costs of hospitalisations and treatments for endometriosis can run into the thousands, especially for migrants on temporary visas, who are excluded from Medicare coverage and whose health insurance may not cover all health treatments. On managing pain from endometriosis, one survey participant said:

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

We recognise there have been efforts by Government at both Commonwealth and state and territory levels to reduce inequities in sexual and reproductive health. In particular, the Senate Inquiry into Universal Access to Reproductive Healthcare has been a necessary first step. There is now an opportunity for government to implement the recommendations put forward by the Committee in the Senate Committee Report entitled 'Ending the Postcode Lottery'. While all 36 recommendations apply to migrant and refugee women and gender diverse people, the specific Recommendation 30 4.111 (which will be discussed below) is crucial to ensuring equitable access to services, irrespective of visa type or migration status.

We also welcome the Federal Government's establishment of endometriosis and pelvic pain clinics across the country and the announcement of two new items to the Medicare Benefits Schedule that will enable extended consultation times and increased rebates. These initiatives have much potential to reduce diagnosis timeframes and offer better pain

management for those experiencing complex gynaecological conditions. However, these changes are only likely to benefit Medicare holders and will not make sexual and reproductive healthcare more equitable for migrant women and gender diverse people on temporary visas. More specifically, even when temporary visa holders have private health insurance, not all gynaecological care is covered. For instance, private health insurance does not cover all pregnancy-related costs including specialist consultations with obstetricians, total hospital fees and paediatrician visits (Australian Government, 2022; Shannon, 2021). This forces many migrant women and gender diverse people to pay out-of-pocket costs for their reproductive healthcare or prevents them from being able to access the care they need.

In responding to this structural barrier to access, the Senate Committee put forward the Recommendation 30 4.111 which recommends ‘that the Australian Government, in consultation with state and territory governments, consider options for ensuring the provision of reproductive health and pregnancy care services to all people living in Australia, irrespective of their visa status.’ The implementation of this recommendation is important for international students or partners of international students who do not currently have access to pregnancy-related care if they fall pregnant within the first 12 months of migration. Since July 2011 under the OSHC Deed, insurers have been allowed to set a 12-month waiting period for non-emergency pregnancy-related services as outlined in Schedule 4d. In other words, an OSHC insurer is not required to pay benefits for the treatment of pregnancy-related conditions to international students and their dependents in the first 12 months of arrival in Australia, unless emergency care is required. This means international students who have an unplanned pregnancy within their first 12 months of being in Australia are faced with limited reproductive choices and may be forced to pay out-of-pocket costs for their reproductive healthcare. This is another example of how migration related policies impact reproductive choice and contribute to experiences of pain.

At a state level, MCWH welcomes the Victorian Government’s 20 planned women’s health clinics that will deliver free comprehensive healthcare and support to women and gender diverse people across the state. These clinics, in conjunction with the sexual and reproductive health hubs, have significant potential to improve migrant and refugee people’s access to sexual and reproductive healthcare and ultimately equalise outcomes. However, there is a need to systemically embed equitable access from the beginning and ensure that clinics deliver culturally and linguistically responsive and safe care for migrant and refugee women and gender diverse people in Victoria. This can only be delivered through partnership and collaboration with expert migrant women’s health organisations like MCWH, who are well placed to provide in-language information to the community about the clinics and their role in addressing women’s pain, as well as advice on strategy, policy development and capacity building to the clinics themselves.

## Maternal health and pregnancy complications

Women's pain during pregnancy, particularly when unrecognised or inadequately treated, can impact maternal health outcomes. Timely and regular access to antenatal care is key to ensuring maternal and pregnancy associated pain and complications can be prevented and managed at an earlier point. However, currently only 70% of women born in non-English speaking countries access antenatal care in the first trimester, compared with 77% among non-migrant women (AIHW, 2020). Victorian antenatal care rates are lower than national rates, with some geographical areas showing persistently low rates over time. In Northwest Melbourne, where there are high numbers of migrant communities, the antenatal care rate has ranged from 46.6% to 61.8% from 2014-2019, well below national figures (Safer Care Victoria, 2021). There are several factors driving the low uptake of antenatal care, such as unfamiliarity with the healthcare system, pre-migration trauma, social inequality and financial constraints, social isolation and limited transport options, visa constraints, and lack of culturally and linguistically appropriate services (Mengesha et al. 2016; Penman et al., 2023).

Research also shows that some migrant women are at higher risk of experiencing pregnancy related complications, such as gestational diabetes and pre-eclampsia, which if left undetected and untreated, can exacerbate both physical and mental pain and result in serious complications during birth. Ethnicity has been identified as a known risk factor for having gestational diabetes (Yuen and Wong, 2015; AIHW, 2024; MCWH, 2021). Women born in Southern and Central Asia, South-east Asia, North Africa and the Middle East and North-East Asia were between 1.6 and 2.3 times likely to be diagnosed (AIHW 2023a). This highlights the importance of tailored programs for screening and assessment to improve early identification and intervention at the primary care level for birthing migrant and refugee people.

Pre-eclampsia is another serious condition that can lead to maternal morbidity and mortality and is associated with complications including pre-term birth, foetal growth restriction, perinatal death and adult long-term health problems in offspring. In 2019, postpartum haemorrhage and pre-eclampsia made up almost half of clinical reasons for ICU admissions of birthing mothers in Victoria and migrant women made up almost 40% of mothers admitted (Safer Care Victoria, 2021). Early detection and management of birthing complications and postpartum haemorrhage risks through routine antenatal care can reduce the burden of pain experienced by birthing migrant and refugee individuals and prevent serious medical emergencies during birth.

In preparing this submission, we found that birthing complications, also prevented migrants and refugees from obtaining continuity of care that is culturally responsive to their needs (Bradford et al., 2024). One migrant woman who participated in our mental health research project (Tran et al., 2023) spoke about her experiences of having to “negotiate” for her preferred methods of care after being diagnosed with gestational diabetes:

*"I was pregnant and diagnosed with gestational diabetes and the system straight away sent me to an obstetrician. I was a midwife, my background, myself. And I did say, I'm confident that this gestational diabetes doesn't mean I need to go to an obstetrician-led care... I had to do the negotiation at the higher level to keep me in midwife-led care, because I was really threatened by obstetrician-led care cause my emotional safety and mental health... the midwife gave me that emotional safety as well as cultural safety in a way how I wanted to have my baby. So in the end what I had to do was taking my own physical risk into my own responsibility...I don't care if I die but I don't want to be in the obstetrician's care and I don't need a c section. I just had to make my own life call."*

The participant shared with us the mental toll and pain of self-advocacy in a healthcare system that is not setup to deliver culturally responsive and safe care to migrant and refugee women and gender diverse people. As such, when it comes to addressing women's pain, trauma-informed service provision and person-centred approaches that promote continuity of care and cultural safety are key.

Another important pregnancy related issue concerning migrant and refugee women and gender diverse people is trauma and pain associated with increased rates of birthing interventions during their pregnancy and birth. Among migrant women, emergency caesareans tended to be more prevalent than planned (or elective) caesareans, with one of the most common indications for an emergency caesarean section being foetal distress (Merry et al., 2016). The unplanned nature of an emergency caesarean can be distressing, and for some, may result in birth trauma and depression (Merry et al., 2016). A prevention approach to maternal health through routine antenatal care needs to be adopted to ensure such interventions are timely and necessary, and birthing migrant and refugee parents are well-supported throughout pregnancy and childbirth.

### **Maternal mortality**

The lack of access to timely and culturally responsive care during the perinatal period contributes to the burden of pain but can also tragically result in maternal death. Although there is little data on maternal death in migrant and refugee populations in Australia, mandatory state reporting on maternal mortality and morbidity tells a clear story. For example, reporting of Severe Acute Maternal Morbidity (SAMM) cases is an important mechanism to assess the quality of obstetric care in Victoria. Between 2019-2021, the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) reported 259 women were admitted to an ICU with SAMM, of which 39.9% (95 women) were born overseas (Safer Care Victoria, 2021).

The CCOPMM found that complex social circumstances, mental health issues and lacking or fragmented access to care was a commonality across reported SAMM cases, thus highlighting an area of need for birthing migrant and refugee women and gender diverse

people. As such, integration of care between primary carers, hospitals and support services during and following pregnancy in women and gender diverse people at risk, and in a manner that is culturally responsive and appropriate, is vital to addressing all forms of physical and mental health related pain experienced during the perinatal period.

### **Violence and sexual and reproductive health**

When it comes to addressing women's pain within the domains of sexual and reproductive health, the impacts of violence need to be considered. In Australia, the prevalence of violence against women is unacceptably high – 2 in 5 women have experienced violence since the age of 15 (ABS, 2021-2022). For migrant and refugee women, evidence indicates that violence is more severe and prolonged (Moon et al., 2016). Our research elsewhere found that factors, such as migration 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 (Vaughan et al., 2016).

The Royal Commission into Family Violence found that 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. 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 (Safer Care Victoria, 2021). A national study found 1 in 4 migrant mothers who participated had experienced intimate partner abuse in the first 12 months postpartum (Navodani et al., 2019). Therefore, the impact of violence against women as one of the main contributing factors to women's pain should not be neglected in provision of sexual and reproductive healthcare.

Furthermore, reproductive coercion is a form of violence against women that contributes to women's pain as it interferes with a person's reproductive autonomy and decision-making. It can encompass threats or coercion to force a person to become or remain pregnant; force a person to have an abortion, or interfere with a person's decision-making about fertility, family planning use and contraceptive use. It also encompasses actions which sabotage a person's contraceptive use; and the use of violence with the intent to cause miscarriage. While the data on reproductive coercion in Australia is scarce, emerging research indicates that it is an issue that affects women from migrant and refugee communities. In addition to interpersonal actions, literature shows that reproductive coercion is also facilitated at a structural level, where perpetrators can exploit the threat of deportation and visa restrictions to stop migrant women from accessing contraception, maternal, and abortion services (Marie Stopes, 2020; Tarzia et al. 2022; Suha et al., 2022; Graham et al., 2023). These factors contribute to women's pain by preventing them from accessing health information and care in a timely manner (MCWH, 2023). Therefore, healthcare providers need to have ongoing training in detecting early signs of domestic violence and reproductive coercion and interpreters need to be properly trained in providing services to migrant and refugee women who have experienced violence.

## 2. Mental health related pain

The migrant and refugee women and gender diverse people who responded to our survey and participated in our in-language health education programs identified mental health issues as a form of pain that was linked to structural, institutional, and interpersonal forms of disadvantage.

In preparing this submission, we heard from migrant and refugee women and gender diverse people on how their experiences of pain were manifested through anxiety, prolonged stress, depression, post-traumatic stress disorder (PTSD), perinatal depression, and suicidality. It was also clear that their mental health related pain was sometimes associated with their experiences of poorer physical health. This health disparity has also been documented in the literature, which has indicated migrant and refugee women experiencing poorer health outcomes, compared to Australian-born women (Outram et al., 2004; Sullivan et al., 2020). As a result of limited access to culturally responsive and trauma-informed mental health care that considers the unique lived and living experiences of migrant and refugee women and gender diverse people, participants and respondents shared that they often had to endure poor mental health for many years and were forced to manage pain alone without any formal support.

### Impacts of migration-related trauma

Migration-related stressors are one of the significant risk factors leading to mental health illness amongst migrants and refugees (Delara, 2016). Traumatic experiences of violence and war, displacement, family separation, imprisonment and immigration detention have resulted in increased and ongoing psychological distress for many migrant and refugee women and gender diverse people (Sullivan et al., 2020; Reesp, 2003; Hamrah et al., 2021)

In preparing this submission, many migrant and refugee women spoke about the long-lasting impacts of trauma and how pain was often exacerbated by challenges in the settlement journey. For example, one migrant women in our mental health research project (Tran et al., 2023) shared that her mum had been living with PTSD for decades. Due to the lack of mental healthcare infrastructure in regional Victoria, her mother's mental health worsened:

*'My mum suffered from mental health issues since she was in the refugee camp... She was diagnosed with PTSD when she arrived in Australia. That was thirteen years ago... I'm now her carer. I have to be around her all the time and I am unable to work... No psychiatrist is available in ... (name of her area). My mum needs regular psychiatrist consultations for her assessment and medication adjustment. Though long waiting for the appointment, only telephone appointment is available. Even interpreter via the telephone is not easy to get, face-to-face interpreter is more far away...I am tired of it now.'*

This participant's experience not only tells us of the burden of pain associated with trauma, but also the stress experienced by migrant and refugee women who disproportionately shoulder the responsibility of unpaid and informal carer work. In our research elsewhere, we found migrant and refugee women who were carers were at higher risk of experiencing poorer physical and mental health outcomes, particularly when they were undertaking caring roles with low levels of family, community, and formal support (Aryal, 2017). Migrant and refugee seniors and carers have smaller family networks and lower rates of service use compared to the Australian-born population, potentially placing strain on carers and leaving complex health needs unmet (Aryal, 2017). The mental health related pain associated with the burden of caring duties and precarious work was also highlighted in our survey when one migrant woman said:

*'I have also experienced poor mental health, including stress, anxiety and depression for at least 5 years. I have received support from clinical psychologists and counsellors on a number of therapies to address my anxiety, PTSD and depression. Some of this pain was developed by unpaid caring duties and paid work due to workload stress, instability of short-term contracts, financial strain and experiencing burnout'*

### **Stress experienced associated with resettlement**

In our work with migrant and refugee communities, we have consistently heard about the stress and anxiety caused by resettlement challenges and Australia's migration system. The time following migration is recognised in Australian literature as a stressful time of adjustment, with concerns around housing, employment, and financial stress contributing to the mental health burden experienced by migrant and refugee women and gender diverse people (Hamrah et al., 2021; Sullivan et al., 2020). As one woman who participated in our previous research expressed:

*"As a migrant woman, we have to deal with everything to survive and start our new life in Australia without support from our family. So many things we have to deal with, and I found my health outcome decreased after many years deal with things in Australia."*

In our previous research on mental health, we note that migration-related stressors such as social isolation, loneliness, acculturation, separation from family, conflict in their country of origin, experiences of racism and insecure employment contribute to the stress experienced across the settlement journey (Tran et al., 2023). Australia's migration system also plays a key role in contributing to the burden of physical and mental health related pain



experienced by migrant women and gender diverse people, especially those on temporary visas. As one bilingual health educator noted:

*“This [mental health session] was very important to speak about with the women as it was extremely requested by the majority of the ladies. Since they were all mostly on their bridging visas they constantly stressed and worried that they might be deported back to their country without their kids or relatives.”*

This observation illustrates how visa status is a risk factor that actively prevents many migrant and refugee women from seeking support for their health and safety when experiencing domestic violence. Uncertainty around visas coupled with the fear of deportation and potential impacts on children have resulted in women staying in abusive relationships and enduring years of violence on end (Satyen et al., 2018; Vaughan et al., 2016). Domestic violence impacts mental health and wellbeing, with many migrant and refugee women reporting isolation, depression, guilt and self-blame, low self-esteem, loss of confidence and suicidality (Vaughan et al., 2016). In our recently published research on the help-seeking behaviours of international students in Australia (Tran et al., 2024), one student who had experienced intimate partner violence, shared her experience of pain, which led to suicidal thoughts:

*“I felt a lot of time that I was left alone on my own and I didn’t have anyone to talk to. I struggled a lot. I was suicidal... Because I have nobody here. I could have been murdered by now and my family probably wouldn’t be able to reach me.... it’s painful to think that I could have brought that much pain to my family.”*

### **Perinatal mental health**

Available evidence in Australia shows migrant and refugee women experience higher rates of depressive symptoms and anxiety during the perinatal period, compared to Australian-born women. In particular, pregnant refugee women have reported higher rates of major depressive disorders (32.5%) in the antenatal period compared to pregnant Australian-born women (14.5%) (Rees et al., 2019).

In preparing this submission, we heard from birthing migrant and refugee people who shared their experiences with depression, anxiety, self-harm, and suicidal thoughts when they gave birth in Australia, often with limited support from their families and social network. In our previous research (Tran et al., 2023), one participant shared her experiences of having no support during the COVID-19 lockdowns and having her mental health condition dismissed by a GP:

*"I was alone here and struggling with my baby, there were no one else to help and it was lockdown and even I can't call my friends to come to help me. I remember I go to GP every month... I used to feel so scared of everything and consistently I feel that something is going to harm me and my baby... I thought it was depression and went to see the GP five times and asking her to that I have depression symptoms but every time she kept saying it was not depression."*

For many migrant and refugee birthing people in Victoria, social isolation is compounded by the complexity of the healthcare system, limited transport options, and the lack of culturally responsive services. There is a critical need for equitable support of migrant and refugee women during the perinatal period, however, as noted by Shafei et al. (2018), current perinatal health services do little to address the complex needs of migrant women.

To address this gap, MCWH acknowledges that initiatives designed to respond to the perinatal needs of migrant and refugee birthing people have been implemented across the state. For example, at Monash Health, the creation of a dedicated refugee antenatal clinic that employs bicultural workers and refugee health nurse liaisons from community-based refugee health and wellbeing services is a step in the right direction. As part of the antenatal clinic, perinatal mental health screening has also been codesigned with maternal health service stakeholders, and an evaluation published from the perspective of clinicians found the initiative to be acceptable and feasible (Willey et al., 2020).

Perinatal mental health screening, as identified in national guidelines and literature, is crucial for detecting depression and anxiety in all birthing people and is essential for early management of symptoms (Willey et al., 2020; Willey et al. 2024). As such, we recommend the Victorian government build upon the findings and evaluations of existing initiatives in developing state-wide perinatal mental health screening guidelines. Additionally, these guidelines should be co-designed with community-based migrant and refugee-led organisations who have expertise in women's health and wellbeing to ensure they are culturally meaningful and responsive.

### **Mental health services and initiatives**

MCWH also welcomes the state-wide reforms around mental health brought about by the Royal Commission into Victoria's Mental Health System. In particular, the introduction of Mental Health and Wellbeing Locals is an important initiative in making mental health care more accessible and equitable for Victorians, especially for those on temporary visas who do not have Medicare.

Whilst the Mental Health and Wellbeing Locals are widely open to the public, they are not well-equipped to respond to the complex needs of migrant and refugee women and gender diverse people due to limited training in delivering culturally responsive care. As one practitioner in our previous research stated: *"we talk about culture awareness, that's it."*

Additionally, at the time of interview, the practitioner mentioned that there was not enough promotion of Mental Health and Wellbeing Locals within migrant and refugee communities:

*“I think Victorian government is providing them [migrant and refugee communities] multi-language information if you want to read, but only on websites. If you are from overseas and you don’t even know what website exists, how do you go there and read?... One challenge is that we are a brand-new service... clients from migrant and refugee background, they did not know about us. And again, if you don’t know, you can’t seek support... and how can you show up?”*

This further highlights the importance of engaging with community-led organisations who can support the promotion of services across communities and provide ongoing capacity building and professional development for healthcare professionals in gendered, cross-cultural awareness.

In preparing this submission, the Mental Health Care Plan was also cited by migrant and refugee women and gender diverse people as an important mechanism for making mental healthcare support more accessible and affordable. In particular, the provision of an additional ten rebated psychology sessions under the Mental Health Care Plan during the height of COVID-19 was an important policy response to the mental health impacts of the pandemic. However, the revert to the original ten rebated sessions per calendar year has deliberately barred many from seeking support for their mental health and wellbeing. As reported by the following survey participant:

*“At the time, cost and wait times was an issue. In the beginning, I was really hesitant to go for help because I really didn’t know where to start. Setting up a mental health plan seemed tedious and not sure why it was necessary. I was taken serious about my mental health issue especially because this was just after the lockdowns and there was more awareness and support for mental health of people. But I feel like if I sought out the same support I did back then, now that it would be harder to put together mental health plan and more costly, because the support that the government gave back then is no longer there and that actually stops me from going to a mental health specialist now.”*

It should be noted that certain migrant and refugee groups, such as temporary visa holders and international students, are not eligible to receive subsidised mental health treatment through Medicare. This means that not all migrant and refugees are in a position to access the care they need for their mental health and wellbeing in a timely manner.

### 3. Workplace related pain and injuries

Migrant and refugee women and gender diverse people disproportionately occupy underpaid, precarious, and essential frontline roles that often place them more at risk of injuries and pain. There are numerous barriers that ‘push’ migrant and refugee women and gender diverse people into occupying insecure work. They include visa status, low English language proficiency, lack of qualifications or recognition of overseas qualifications, discrimination, limited social networks, a lack of referees, and no local work experience (Ziersch et al., 2022; Ziersch et al., 2021).

Considering how work, income and employment conditions are important social determinants of health (Benach et al., 2010; Delara, 2016), this section outlines migrant and refugee women and gender diverse people’s experiences of pain in the workplace. More specifically, we heard from migrant women who were or are currently employed as casual workers in farms and factories across northern Victoria. They explained how poor working conditions, such as long working hours, and repetitive actions impacted their physical health. One survey respondent who used to work as a harvester on a mushroom farm reflected:

*“I used to suffer lots of physical health issues including hands wrists, shoulders, legs, and digestion during my 9 years of working as a mushroom picker in the mushroom factory in...Victoria while I held my international student visas for my MA and PhD journey.”*

This woman’s experience reflects the physically demanding nature of horticultural work and the harsh environment in which work was undertaken. Unfortunately, her experience of physical pain was a common one. Challenges such as environmental hazards (heat stress, sunburn, cold, thunderstorms), long exposure to chemicals, manual handling, exposure to poisonous animal baits have been well-documented in Australian literature on horticultural work (Ziersch et al., 2023; Underhill & Rimmer, 2015). The nature of piecemeal work and the additional pressure to work quickly and continuously without breaks often meant workers were working in pain.

Although women attributed their pain to work, many did not have the choice to leave their work on farms and in factories. For example, one woman shared in her survey response how she was hesitant to change jobs, even though she knew doing so would resolve her pain:

*“My right hand got sore, and it was happening for over a year. I went to see my GP a couple of times, but they could not help much and they recommended to find another job. However, I was not confident to find another job due to my level of English and it might not be easy to get any... I were afraid that I would lost the job if I report this.”*

The reality is that migrant and refugee workers are often faced with limited employment options. As such, this puts them at risk of enduring pain for a longer time as they are unable to leave their current places of employment. Faced with language barriers, migrant and refugee workers are also more prone to workplace exploitation and face barriers to reporting, due to fear of losing employment and concerns about visa status (Salmen-Navarro, 2022; Ziersch et al., 2021). As one survey respondent expressed:

*“I had experienced a mental pain when I was working at [name of factory]. I did not get a respect from my supervisors and co-workers. It’s happened for almost 5 years...One of the most important reason I think that’s the language. When you are not perfect in communication in English you can’t argue to protect yourself, can’t explain properly when something wrong happened. You look unconfident and easy to be bullied.”*

When it comes to managing pain at work, we found the lack of accessible, in-language information on work rights and limited options for leave were some of the key issues facing migrant and refugee women and gender diverse people. The following example comes from an MCWH bilingual health educator who delivered a session on workplace safety to her community:

*“One lady shared her story about her back pain after a few months when she started working and she didn’t know that she could talk to her manager about that because she thought it was normal to have back pain because sometimes, she does lift some boxes at work. She even didn’t know that it was her right to report that.”*

The lack of accessible information on workers’ rights is a factor that influences whether employees can advocate for their health and safety, and this is particularly significant for women, who may endure prolonged periods of pain in the workplace without adequate support or accommodations. Also, workplaces might be one of the few places where migrant and refugee women have access to the information and resources they need to advocate for their health and wellbeing.

Another issue preventing migrant and refugee workers from managing their pain is the lack of leave options. In the survey responses, we heard about how difficult it was for migrant and refugee women and gender diverse people to seek treatment for their pain due to limited leave options:

*"I was low income for many years. It is difficult to get leave from work to attend medical appointments. The quality of services was very low in the area I lived (often losing my medical history records)."*

*"It took 15 years of back and forth with the medical system to receive a diagnosis of endometriosis, I've missed studies and work due to this. I have also worked while in severe pain as I haven't been sure if my workplace will be understanding/ or provide me with leave for this."*

For those who faced financial hardship, concerns about income and the prospect of losing employment were added challenges for taking leave to manage pain. These examples reflect some of the prolonged issues associated with leave options, especially for casual employees who do not have access to sick, parental and annual leave. Although casual employees can request flexible working arrangements to take unpaid leave, no one should have to choose between a day's pay and their health.

MCWH acknowledges that the Victorian Government's Sick Pay Guarantee Pilot was the first of its kind across Australia to support casual and contract workers – many of whom are migrant and refugee women and gender diverse people – by extending sick pay entitlements. The pilot program has been a safety net for many casual workers facing illness or injury who need to take sick leave to manage their health and wellbeing. It is disappointing to hear the program came to its early end in June 2024.

## **Healthcare professionals' experiences**

In this section, we present the voices of healthcare professionals on working within the healthcare system and as providers of care to migrant and refugee women and gender diverse people. Their perspectives on pain provide a way forward to better understanding how Victoria's healthcare system can be made more equitable and culturally responsive.

### **Persistent microaggressions and stereotypes within the healthcare system**

We heard from migrant and refugee health professionals about their experiences with racial and gender stereotypes in the healthcare system. Particularly concerning is how migrant

and refugee people's pain is often conceptualised. As one health professional from a migrant background stated:

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

The persistent microaggressions that migrant and refugee women and gender diverse people experience across healthcare settings when seeking support for their pain should be seen as racial and gender discrimination. All forms of discrimination including racism, sexism, ableism, homophobia and transphobia need to be addressed across all levels of the healthcare system: structural, organisational and individual.

### **Difficulties navigating the healthcare system**

In preparing this submission, we heard from a range of health professionals and health workers, including our bilingual health educators who deliver tailored, in-language, culturally responsive, accessible health education sessions across communities. They are an integral part to the provision of healthcare for migrant and refugee women and gender diverse people. They have also been crucial in identifying current gaps in the healthcare system and in supporting communities' needs around their experiences of pain. As one bilingual health educator expressed:

*"People from the community...stay in pain until their situation is very bad and then they go to the emergency. The issue is that in our country emergency services are totally different to Australia as when you go there you will be admitted straight away. But here, you will have to wait for hours and it depends on how serious your situation is, so that's why the community they prefer to stay in pain and wait to the next day to get an appointment with their GP."*

This quote tells us that emergency services are not properly resourced to respond to the needs of the general public, and that bilingual health educators can play a pivotal role in supporting migrant and refugee women and gender diverse people's to better navigate and access the health system. This approach is also supported by current literature which highlights the vital role of bilingual health educators in improving access to healthcare

services and easing navigation of clinical health systems (Henderson and Kendall, 2011; Mengesha et al., 2016).

## Healthcare professionals' experiences of burnout

In relation to the lack of resourcing, we also heard from migrant and refugee health professionals who described their experiences of burnout due to the increased demand for mental healthcare following the COVID-19 pandemic. The increased need coupled with the limited number of health professionals trained in culturally responsive care, have forced many migrant and refugee health professionals to fill this service gap, despite the limited resources. One psychologist explained that there has been no consideration to adequately resource migrant and refugee healthcare professionals:

*"...from a burnout perspective, there has been very little interest around the wellbeing of mental healthcare providers post pandemic. We have not been exempt from the experiences of pandemic but... [there has been] an increase in the expectation of our ability to provide services with very limited consideration of how we are doing. So in terms of resourcing therapists in general, it is been pretty lacking and then even worse if you are a therapist of colour, therapist with lived experience and therapist with lots of intersections of your own identity... in that sense I am very critical of the fact that there has not been any support that I have seen."*

There is a need to address the barriers to recognising overseas qualifications in the state's healthcare service, not only to meet the shortage of migrant and refugee health professionals in the sector, but to ensure that the workforce adequately reflects the diversity of the Australian community.

## Healthcare professionals not supported to deliver culturally responsive care

Healthcare professionals are expected to deliver culturally responsive services, however they are inadequately supported and insufficiently resourced to do so (Olcoñ & Gulbas, 2021; Olcoñ et al., 2023). In other words, there is an implementation gap between the way policy on culturally responsive care was envisioned and the way that it is currently being practised. In line with other research on the issue, we argue that structural violence and racism within healthcare systems must be recognised by organisations and policymakers as factors that undermine equitable access to healthcare (Grant & Guerin, 2018; Hamed et al., 2020).

The failure to recognise structural racism and the importance of intersectional approaches to policy and service delivery often results in 'cultural competency' training that reduces



'culture' to a skill that can be 'known' or mastered by clinicians. As one healthcare professional shared in our previous research (Tran et al., 2023), current forms of training are inadequate and do little to improve standards of care for those who are made most marginal by our systems and structures:

*"They study for 10 years and they get about 2 hours of culturally responsive training – and that covers literally like everyone from First Nations, to refugees, to migrants. It's completely inadequate support...Like even myself, in my Master's degree, I had a 2-hour unit about culturally responsive mental health..."*

Simplistic understandings of culture which rely on stereotypes and assumptions result in inadequate care for patients from migrant and refugee communities and has the potential to cause further harm. Healthcare professionals need to be adequately funded and supported to access ongoing training and professional development in gendered, cross-cultural awareness, delivered by specialist migrant and refugee health organisations.

## Conclusion

This submission centres the voices of migrant and refugee women and gender diverse people to understand their experiences of pain and access to healthcare services. From our consultations, it is clear that the concept of pain is not just a health issue but an issue of equity. Our intersectional understanding of pain, informed by the social determinants of health framework, illustrates how physical, emotional, psychological, and social experiences of pain are interlinked and exacerbated by systemic barriers that prevent migrant and refugee women and gender diverse people from accessing affordable and timely healthcare.

In this submission, we also heard from health professionals, who reinforced the notion that 'women's pain' transcends beyond the experiences of consumers of the healthcare system, and impacts those who importantly, administer care and support. Therefore, as part of this Inquiry, healthcare providers also need to be adequately supported to be able to create a more responsive and equitable healthcare system for everyone. Drawing on what we learned from listening to migrant and refugee women and gender diverse people's experiences of pain, we offer evidence-based recommendations that focus on creating equitable healthcare systems, strengthening social services, and implementing intersectional policies and programs.

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