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Barriers and enablers influencing access to services among migrant and culturally and linguistically diverse women living in Australia: An Integrative Review

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Systematic Review

Keywords: migrant women, culturally and linguistically diverse (CALD) women, sexual and reproductive health (SRH), access, enablers

Posted Date: June 16th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-10036289/v1

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Additional Declarations: The authors declare no competing interests.

Abstract

Australia's cultural diversity includes a large migrant population, yet culturally and linguistically diverse (CALD) women continue to face significant barriers to sexual and reproductive health (SRH) care. Multiple individual-to-systemic factors often hinder early health care engagement, and cultural and religious influences further shape trust in services. These challenges reflect global patterns of restricted SRH access among migrant women, despite known enablers such as bilingual resources and culturally sensitive care. This integrated review critically synthesises evidence on the barriers and enablers influencing access to SRH services among migrant and CALD women living in Australia. This review was conducted on 19 primary studies from the Australian context, published in English between January 2015 and August 2025. The databases searched were MEDLINE, CINAHL, Web of Science, Scopus, PsycINFO, ERIC, ProQuest, and Google Scholar. Nineteen studies underwent thematic synthesis, identifying five overarching themes: communication and sociocultural factors; access, financial constraints, and systemic complexity; knowledge and resource gaps; support networks and community engagement; and quality of care and health workforce. Migrant and CALD women in Australia face multifaceted barriers from individual to systemic levels when accessing SRH services. Enablers, including multilingual educational resources, culturally safe care and female health providers, are essential to improving SRH engagement. Further research is needed to gain an understanding of rapidly growing migrant groups such as Indian women in Australia.

1. Introduction

Australia is a highly diverse country and is home to one of the most culturally diverse populations in the world. Nearly 31.5% (8.6 million) of its population was born overseas [1]. In Australia, the majority of overseas-born migrants come from England, India, China, New Zealand, Philippines, Vietnam, South Africa, Nepal, Malaysia and Shri Lanka, shaping the country's demographic landscape [2].

Despite this diversity, the migrant and CALD women continue to face unique challenges in accessing SRH services after arriving in Australia. After migrating, a familiar support network is suddenly distant or absent. Evidence shows that shame, silence, social stigma, fear of judgment and discrimination, language difficulties, and unawareness of SRH services often shape early encounters of these women [3–6], while their cultural and religious beliefs can contribute to the mistrust of Australian health care settings [7].

Globally, these challenges reflect a broader pattern of complex factors affecting SRH outcomes. In 2020, the number of international migrants reached 281 million, with women accounting for nearly half of this total [8]. The Guttmacher-Lancet Commission's reports (2018) on sexual and reproductive health and rights (SRHR) revealed that 4.3 billion people of reproductive age lack access to adequate SRHR services globally [9]. Migrant and CALD women experience multilevel barriers such as limited information about SRH services, cultural taboos, difficulties in navigating the health care system and discriminatory administrative policies related to their visa status [10–13]. However, several enablers of access to and use of SRHs have been identified. These include bilingual resources, extended consultation times, non-judgmental approaches, peer support, and community engagement interventions [12].

Existing evidence remains fragmented on how these barriers and enablers influence SRH outcomes and the effectiveness of strategies to address them. Few studies have adopted an intersectional perspective to analyse how these barriers and enablers interplay to affect these outcomes. Using an intersectional lens, this integrated review will provide a clear picture of barriers and enablers that influence access to and utilisation of SRH services.

Identifying any existing factors at the individual, interpersonal, community, and systemic levels will improve understanding of this topic. Analysis of these multilayered factors will provide insight for policymakers, protocol developers, and health workforce leaders to develop culturally appropriate care strategies to improve SRH outcomes. Ultimately, this critical analysis will support more equitable and effective SRH interventions, reducing inequities and fostering enablers to improve SRH outcomes among migrant and CALD women living in Australia.

2. Material and Methods

A five-stage integrative literature review process was used, as described by Whittemore and Knafl [14] and complemented by the Joanna Briggs Institute (JBI) guidance for scoping and integrated review [15, 16]. This review includes five steps: problem identification, literature search strategies, data evaluation, data analysis using critical review, and presentation of findings [14]. This review, drawing on Australian literature, is guided by four aims:

1) To identify and synthesise existing evidence on barriers faced by migrant and CALD women in accessing SRH services.

2) To explore the enablers that facilitate access to SRH services among migrant and CALD women

3) To highlight gaps in the current literature and propose recommendations for improving equitable access to SRH services for migrant and CALD women.

4) To provide an integrated understanding of the interplay between barriers and enablers, informing policy and practice for culturally responsive health care delivery.

The protocol for this integrated review of literature is published in the Open Science Framework

Kaur, G. (2026, February 14). Barriers and enablers influencing access to sexual and reproductive health care services among migrant and culturally and linguistically diverse women living in Australia: Integrated Review of Literature. https://doi.org/10.17605/OSF.IO/PVSX8

2.1 Search strategy

An initial search was undertaken to identify key terms and phrases using foundational papers as starting points, providing insight into access to and utilisation of SRH services and identifying keywords and concepts to support the development of search strategies. The research strategy was devised using the PCC framework for subject headings and keywords, as recommended by the Joanna Briggs Institute scoping reviews and integrated review, especially when the question is broad and includes multiple study designs [15, 16]. This PCC framework (Table 1) helped to define: 1) Population (migrant and CALD women), 2) Concept (Barriers and enablers to access Services) and 3) Context (Sexual and Reproductive Health Services in Australia). The search strategy was designed with input from an expert librarian to select MeSH headings, field codes, exploded terms, and descriptors unique to the database used. The used keywords were; Migrants women, CALD Women, Access, Barriers, Enablers, Reproductive Health and Sexual Health (Table 1). The first search was undertaken in July 2026 and August 2026 (*supplementary file 1).*

Table 1
PCC Framework

Search concepts **Using** **a search framework such as PCC**	**Population: Immigrant/Migrant and CALD Women**	**Concept: Barriers and Enablers to Access Services**	**Context: Women's Reproductive and Sexual Health Services**
Subject headings	**Subject Headings**: **Medline** (MH "Immigrants+") **CINAHL** (MH "Immigrants+") **APA PsycInfo** (DE "Immigrants+") **MeSH Terms**: Emigrants Immigrants	**Subject Headings**: **Medline** ("Barriers and enablers+") **CINAHL** ("Barriers and enablers+") **APA PsycInfo** ("Barriers and enablers+") **MeSH terms**: Challenges Enablers Difficulties	**Subject Headings**: **Medline** (MH "Women's Sexual and Reproductive Health+") **CINAHL** (MH "Women's Sexual and Reproductive Health+") **APA PsycInfo** (DE "Women's Sexual and Reproductive Health+") **MeSH terms**: Reproductive Health Women's Health Services Sexual Health
Keywords	Migrants OR Immigrants OR Emigrants OR "South Asian Women" OR "Culturally and Linguistically Diverse Women" OR CALD Women	Access OR Accessibility OR Barriers OR Obstacles OR Challenges OR Enablers OR Utilization OR Use OR "Health Service Utilization" OR Health-seeking behavior OR "Health Service Barriers"	"Reproductive Health" OR "Sexual Health" OR "Maternal Health" OR "Women's Health Services" OR "Family Planning Services" OR "Sexual and Reproductive Health Services" OR SRH OR Contraceptive Services OR "Antenatal Care"
Filters	English Language Year 2015–2025	English Language Year 2015–2025	English Language Year 2015–2025

2.2 Eligibility criteria

For the screening process, to ensure rigour, the researchers followed the Preferred Reporting Items for Systematic Reviews and Meta-analyses 2020 (PRISMA) guidelines (Fig. 1) and pre-defined eligibility criteria to identify articles that discussed barriers and facilitators to accessing and utilising SRH services by migrant and CALD women in Australia [17]. A total of 2906 articles retrieved from databases were imported into Covidence [18], and 933 duplicates were removed automatically. The remaining articles, 1973, were screened independently by three researchers using titles and abstracts to assess eligibility against the inclusion and exclusion criteria (Table 2), to ensure trustworthiness, reduce bias, and support transparency and reproducibility for the review [19]. Irrelevant studies were removed, leaving 129 articles for retrieval. These articles were independently reviewed in full text by each researcher, and a total of 110 studies were excluded, leaving 19 for data extraction (Fig. 1). The discrepancies between the reviewers were resolved through meetings and consensus.

Table 2
Inclusion and Exclusion Criteria

		Inclusion Criteria	Exclusion Criteria
Population	**Migrant and CALD Women**	**Migrant Women living in Australia** **Culturally and Linguistically Diverse (CALD) Women** **Individuals who identify as women**	**Exclusively focused on male participants** **Non-migrant population** **Non-CALD population** **Focused on only the health care professionals' views**
Context	Country	Australia	Outside Australia
Outcomes	Barriers and enablers to access Services Reproductive and Sexual Health Services	Identification of migrant and CALD women Assessment of SRH needs of migrant and CALD women Exploring perceptions of migrant and CALD women in accessing SRH services Investigation of the lived experiences of migrant and CALD women in accessing SRH services Examination of existing enablers influencing migrant and CALD women's access to SRH services Analysis of existing barriers influencing migrant and CALD women's access to SRH services Identification of community-specific priorities related to SRH and research gaps Variations in access to SRH across Australia Community-specific insights for sub-groups Culturally specific strategies needed	Outcomes not including SRH-related services, Outcomes not focusing on migrant women's SRH Outcomes not focusing on CALD women's SRH Non-empirical or anecdotal sources (e.g., opinion pieces without evidence or analysis) Studies exclusively focused on male participants Non-migrant population Non-CALD population Views of health care professionals Articles not discussing barriers or enablers related to SRH Studies not addressing sexual and reproductive health (SRH). Studies focusing on general health, mental health, or non-SRH services. Articles discussing health care access without linking to SRH services.
Research Design	Primary research articles	2015 to the present Publications in the English language Full texts that are accessible or retrievable Full Text matching the Objectives of the research questions	Studies published before 2015 Studies written in languages other than English Full texts that are inaccessible or not retrievable Full texts not matching the Objectives of the research questions Discussion papers, synthesised review articles

2.3 Quality appraisal

To enhance the validity and reliability of the evidence and support robust synthesis [20], the final 19 articles were appraised using the Critical Appraisal Skills Programme (CASP), the Joanna Briggs Institute (JBI) checklists and the Mixed Method Appraisal Tool (MMAT). Three reviewers independently appraised each article to evaluate methodological rigour and identify potential sources of bias in study design, conduct and analysis. The quality assessment scores for each selected article are provided in the final column in Table 3.

2.4 Data extraction

For this review, a manual tabulation method was used, with the following items: author/year, aim, design and method, sample, health care service-SRH, findings-barriers, findings-enablers, and quality appraisal tool. Extracted results from each article are summarised in Tables 3, 4**and** Fig. 2. The findings on barriers and enablers to accessing and using SRH services among migrant and CALD women are presented in Table 3, and the extraction process is presented using the PRISMA flow diagram [17], see Fig. 1.

Table 3
Results for Enablers and Barriers, including Standard Quality Assessment Criteria

Author(s)/ Year	Aim	Design and Method	Sample (Population Characteristics)	Health Care Service-SRH	Findings- Barriers	Findings - Enablers	Quality Appraisal Tool
Alam et al., 2022	To explore the reasons and barriers for low cervical screening participation among South Asian immigrant women in Australia through qualitative interviews.	Qualitative (semi-structured interviews)	20 South Asian migrant women aged 26–50 years	Cervical Cancer Screening	Lack of Awareness about cervical cancer screening and misconceptions about it. Language barriers. Cultural beliefs causing misconceptions and cervical screening tests Dependency on the male gender for decision-making, financial support and transport. Lack of GP engagement, poor reminders for appointments and time constraints.	Self-sampling is viewed positively Culturally tailored interventions are essential. Information in native languages to improve participation is essential.	**CASP Qualitative Checklist Scores 18/20**
Brammall et al., 2025	To describe the formation of a Consumer and Community Involvement (CCI) reference group using the HiPPP Alliance framework and explore antenatal health care experiences of CALD women to identify opportunities for improvement.	Qualitative (2 focus group interviews using a videoconferencing platform)	18 migrant women (from diverse countries of China, India, Indonesia, Iraq, Libya, Myanmar, Somalia, UAE) aged 18–50	Antenatal care	Lack of culturally tailored health information. Limited cultural competency of health care providers. Isolation due to migration, Stigma around mental health limited help-seeking behaviours.	Need to provide culturally sensitive dietary advice for managing gestational diabetes. Peer networks and social support networks are helpful. Need for culturally competent health care providers to increase their trust in the system. Need to integrate mental health support in antenatal care.	**CASP Qualitative Checklist Scores 16/20**
dos Santos, 2023	To explore migrant mothers' and health professionals' experiences and views of the Australian perinatal health care system, particularly its impact on mental health and perinatal depression (PD).	Qualitative (in-depth interviews, face-to-face and over the telephone with health professionals, and direct migrant women participant observations)	17 migrant women (7 from Hamilton, 10 from Canberra), 13 health professionals and 1 key informant, age groups not provided	Perinatal care	Lack of continuity of care. Language barriers and the underutilization of interpreting services. Reliance on husbands for translation. Time constraints for booking interpreters by health providers. Cultural misunderstandings and the lack of culturally appropriate services not meeting needs. Limited screening for PD. Social isolation and lack of a	Need for continuity of care in improving perinatal care services. Need for culturally sensitive care Peer support networks help reduce isolation. Need for supportive midwives and community programmes. Support networks.	**CASP Qualitative Checklist Scores 18/20**

Author(s)/ Year	Aim	Design and Method	Sample (Population Characteristics)	Health Care Service-SRH	Findings- Barriers	Findings - Enablers	Quality Appraisal Tool
					support network. Financial and visa-related stress. Rushed appointments by health professionals.		
Henning Cruickshank et al., 2019	To describe women's awareness of maternity service options, explore the barriers to participating in pregnancy care, and identify possible enablers to improved uptake of services	Qualitative descriptive approach (focus group discussions)	33 migrant women (from diverse countries of Maori, Samoan, Tongan, Fijian, PNG, Cook Islander) aged 19–45	Maternity care	Limited awareness of formal service options. Language barrier and discomfort with communication from male clinicians. Financial barrier affecting out-of-pocket treatment costs. Systematic barriers: long wait times and a rigid appointment system. Experiences of discomfort with racial judgment and stigma from health care providers.	Culturally sensitive care models to continue midwifery care. Need for community-based services. Need for female health care professionals to support care. Need for digital resources to support improving appointment booking, access and engagement with text reminders.	**CASP Qualitative Checklist Scores 18/20**
Jean Hailes for Women's Health, 2025	To understand the experiences of Arabic-, Punjabi- and Vietnamese-speaking women in relation to contraception and women's health care, including preferences around health care providers, knowledge about contraception methods, and barriers to accessing and using contraception.	Qualitative (6 focus group discussions)	54 women (from diverse languages speaking Arabic, Punjabi and Vietnamese) aged 18–50	Contraception	Complexity of health care systems. Transportation issues. Treatment cost. Language barriers. Unawareness of contraceptive services. Cultural taboos and religious influence on childbearing and contraception use. Fear of side effects of contraception influences decision-making. Family pressure influences decision-making.	Need for culturally sensitive care. Need for culturally appropriate education at the community level. Need to provide female health care professionals. Need to provide GPs from similar cultural backgrounds.	**CASP Qualitative Checklist Scores 16/20**
Inoue et al., 2016	To explore the contraceptive understandings, experiences, and preferences of Japanese women living in Australia.	Qualitative (open-ended interviews)	7 Japanese migrant women aged over 18 years	Contraceptives	Language barriers are hindering access to contraceptives. Cultural norms discourage the discussion of sexual health-related topics. Embarrassment in consulting GPs and fear of confidentiality.	Migrant women preferred contraceptive methods, such as withdrawal and condoms and the use of emergency pills. Need for a culturally tailored approach by health care providers.	**CASP Qualitative Checklist Scores 16/20**

Author(s)/ Year	Aim	Design and Method	Sample (Population Characteristics)	Health Care Service-SRH	Findings- Barriers	Findings - Enablers	Quality Appraisal Tool
					Lack of awareness about different methods of contraceptive use. Limited awareness of STIs.	Needs strategies to enhance confidentiality.	
Lang et al., 2020	To explore pregnancy planning, preconception lifestyles, awareness, experiences and health care needs of migrant women in Australia.	Qualitative (semi-structured interviews with focused groups)	25 migrant women, aged 18 and above, from diverse cultural backgrounds.	preconception	Limited awareness of preconception health. Cultural barriers discourage open discussions about SRH topics. Lack of SRH education and unplanned pregnancies. Language barriers. Difficult navigation with the health care system. Family dependency for decision-making and isolation. Financial strains. Cultural norms influence women's preferences, prioritising stability in family and finances over health-related aspects.	Need to deliver culturally tailored education on SRH. Need to provide culturally sensitive treatment by health professionals. Need to provide culturally sensitive information via schools, community programmes and media to support pregnancy planning and navigate preconception care needs.	**CASP Qualitative Checklist Scores 18/20**
Maheen et al., 2025	To develop an understanding of young African migrants' knowledge of existing sexual health services in Australia and explore their perceptions of youth-friendly SRH services for optimal engagement.	Qualitative (2 participatory workshops)	30 participants (24 females, 6 males), aged 18–24 years	SRH services	Lack of awareness of SRH services. Cultural taboos and stigma about not discussing SRH with the support network, including family. Mistrust of treating GPs and concerns about confidentiality. School-based sex education lacks practical information on SRH services.	Need to provide youth-friendly SRH services. Need for culturally tailored care and respectful communication. Need for female and younger health care providers. Need to provide clear communication and respectful attitudes from health care providers. Need to provide clear information on health care system navigation and access guidance.	**CASP Qualitative Checklist Scores 20/20**
Mander & Miller, 2016	To determine whether identifying as CALD was associated with the perceived safety, quality and cultural competency of maternity care from a	Retrospective cross-sectional (Survey responses)	4704 women (655 CALD and 4049 non-CALD) with no specific age group	Maternity care	Language barriers and lack of interpreter access. Lack of female gender as a care provider. Culturally inappropriate	Need for culturally competent care. Need for continuity of care with the same health care providers. Allowing support persons during	**JBI Analytical Cross-Sectional Checklist scores 16/16**

Author(s)/ Year	Aim	Design and Method	Sample (Population Characteristics)	Health Care Service-SRH	Findings- Barriers	Findings - Enablers	Quality Appraisal Tool
	consumer perspective, and to identify specific needs and preferences of CALD maternity care consumers				services not meeting needs. Mistrust in public health models.	labour and postnatal care to enhance cultural safety. Need to provide female gender health care professionals to meet cultural sensitivity needs.	
Mohale et al., 2017	To examine the maternity experiences of Sub-Saharan African women who had given birth in both Sub-Saharan Africa and Australia	Qualitative (Semi-structured face-to-face interviews)	14 Sub-Saharan African women aged above 18	Maternity care	Navigation difficulties within the Australian health care system due to the distance of facilities and logistical issues. Language barriers. Health literacy gaps. Culturally inappropriate education. Long waiting times. Rushed appointments.	Need to increase family support during labour to meet cultural needs. Need for respectful and culturally appropriate communication strategies. Need for continuity of care. Need to provide information on pain relief resources. Need for culturally effective communication.	**CASP Qualitative Checklist Scores 18/20**
Owens et al., 2016	To explore the perceptions of pregnancy care among refugees and CALD backgrounds who used a community-based antenatal service, and whether this model enhanced their pregnancy experience	Qualitative (semi-structured interviews)	12 women aged 23–44 years, many from refugee backgrounds	Antenatal care	Language barriers including the lack of interpreter services. Transport and logistical challenges. Limited social networks and isolation. Cultural differences and lack of cultural safety.	Need to provide continuity of care with the same health care workers. Need to provide female health care workers to meet cultural needs. Need for longer and more flexible appointments. Need to provide access to social and community services. Need to organise support for psychosocial issues. Need to increase family mediation to increase trust in the system.	**CASP Qualitative Checklist Scores 18/20**
Palani et al., 2025	To derive a deeper understanding of the needs and barriers of CALD women in accessing antenatal educational resources, and to explore the cultural appropriateness of existing resources	Qualitative (semi-structured interviews with two focus groups)	10 CALD women (from 8 different countries: Kurdistan, Vietnam, Zimbabwe, Burundi, Liberia, Iraq, Iran, Turkey).	Antenatal care	Lack of health literacy awareness. Language barriers. Overwhelming and culturally inappropriate educational resources. Navigation difficulties with maternity health care models. Isolation.	Need for using visual aids/infographics for low literacy groups. Need to provide culturally tailored resources and multilingual educational resources. Group education is preferred.	**CASP Qualitative Checklist Scores 20/20**

Author(s)/ Year	Aim	Design and Method	Sample (Population Characteristics)	Health Care Service-SRH	Findings- Barriers	Findings - Enablers	Quality Appraisal Tool
					Lack of continuity of care.	Need for continuity of care with the same health providers. Need to promote guidance on navigation services.	
Power et al., 2022	To evaluate the feasibility, acceptability, implementation and effectiveness of co-designed, culturally tailored cervical screening health promotion forums with migrant and refugee women in Western Sydney, Australia	non-randomised feasibility study (semi-structured interviews with 7 focus groups)	71 CALD women aged 18–74 from African and Middle Eastern backgrounds	Cervical screening	Cultural stigma. Unawareness of health needs. Fear and embarrassment in utilizing SRH services. Language barriers. Logistical challenges Culturally inappropriate information.	Need to involve community health care workers. Need to provide culturally tailored information. Need for flexible delivery formats. (online and face-to-face) to overcome logistical barriers. Need to include broader health topics and develop peer support.	**MMAT appraisal Scores 12/14 (mixed methods)**
Rambaldini-Gooding et al., 2024	To explore how to improve maternal health care experiences of refugee and migrant women through the lens of cultural humility, and to co-design training approaches with health care providers and communities	Qualitative (2 online sessions and 2 group interviews of migrant women)	41 participants, comprising 20 refugee and migrant women from a diverse range of cultures; 5 maternal health care providers; 7 multicultural health care providers; 1 community-based birth educator; 7 in group interviews (Arabic, Burmese, Karenni women).	Maternity care	Language and communication barriers. Stereotyping and cultural insensitivity. Lack of trauma-informed care to continue support. Insufficient support pre- and postnatally. Limited awareness of available maternal health care options.	Need to improve and deliver co-designed training with multicultural communities. Need to provide culturally sensitive education. Need to focus on women's stories, cultural nuances in pregnancy and birth. Need to provide trauma-informed care. Need to provide effective cross-cultural communication to improve maternity care. Provision of emotional support. The provision of interpreter services.	**CASP Qualitative appraisal Tool Scores 20/20**
Robbers et al., 2024	To explore the views and experiences of young women from migrant and/or refugee backgrounds regarding the contraceptive implant and related decision-making	Qualitative study (Semi-structured interviews)	33 migrant and CALD women aged 15–24	Contraceptives	Cultural taboos and stigma limited open discussion. Lack of SRH education and awareness. Language barriers. Financial strains and costs of services. Fear of side effects of contraceptives.	Peer support supports key decision-making. Availability of online resources supported key decision-making. Need of culturally sensitive and tailored care. Needs strategies to enhance confidentiality and trust in	**CASP Qualitative appraisal Tool Scores 18/20**

Author(s)/ Year	Aim	Design and Method	Sample (Population Characteristics)	Health Care Service-SRH	Findings- Barriers	Findings - Enablers	Quality Appraisal Tool
						healthcare providers outside their communities. Government financial support, e.g., access to Medicare	
Rogers & Earnest, 2015	To investigate and document the experiences and knowledge of sexual and reproductive health and contraception among Sudanese and Eritrean women in Brisbane and explore their views on sexuality and relationships education within the family environment.	Qualitative (in-depth interviews)	13 women (8 older women aged 35–55, 5 younger women aged 18–35)	SRH and Sexual reproductive education	Cultural taboos around SRH limit open discussions. Male gender dynamism negatively affects decision-making. A lack of older women's interest in SRH services is linked to generational differences, negatively impacting decision-making. Language barriers. Parental refusals for school-based SRH education. Limited contraceptive knowledge leads to adolescent pregnancies. Lack of culturally appropriate SRH education.	Need for culturally competent educators to deliver SRH education. Need to encourage community engagement and parental support for SRH.	**CASP Qualitative appraisal Tool Scores 20/20**
Vazquez Corona et al., 2025	To explore the expectations and experiences of migrant women (including international students) in using maternity care services and identify factors affecting access and use	Qualitative (photo-elicitation workshops and semi-structured interviews with 4 groups)	21 migrant women aged 29–38 (Indonesian, Vietnamese, and international students from multiple countries).	Maternity care	Financial constraints including Insurance complexities and high costs. Language barriers. Rushed consultations. Limited continuity of care from familiar healthcare providers. Culturally inappropriate care. Poor health information sharing among these population groups. Navigation difficulties with the healthcare system.	Need to increase opportunities for social and partner support. Need for woman-centred and respectful care. Need to provide language-concordant providers, reducing communication barriers. Need to provide information on health insurance and waivers. Need to increase transport access. Needs provision of hospital apps for scheduling appointments to meet flexibility.	**CASP Qualitative appraisal Tool Scores 20/20**
Vizheh et al., 2023	To understand how immigration and settlement context shape Iranian immigrants' agency in accessing and using reproductive	Qualitative (open-ended surveys)	21 Iranian migrant women aged 18–49	Reproductive healthcare	Language barriers, including the underutilization of interpreter services. Navigation difficulties with the health system.	Financial independence for women increases autonomy and negotiating power. Social media and online platforms help women to	**CASP Qualitative appraisal Tool Scores 20/20**

Author(s)/ Year	Aim	Design and Method	Sample (Population Characteristics)	Health Care Service-SRH	Findings- Barriers	Findings - Enablers	Quality Appraisal Tool
	healthcare services.				Financial constraints, including health insurance complexities. Long waiting times. Cultural taboos with shame and stigma around SRH discussions. Male gender dynamism is negatively impacting decision-making. Systematic complexity in accessing specialists. Culturally inappropriate resources.	share experiences and find suitable information. Culturally and linguistically appropriate services from their community providers. The Australian socio-cultural context supports open discussion on SRH topics, influencing some immigrant women positively. Increasing awareness of SRHR motivates the autonomy of women in decision-making despite pressure from traditional norms.	
Yelland et al., 2015	To explore Afghan families' experiences of language support during pregnancy, labour and birth, and health professionals' experiences of communicating with clients with refugee backgrounds with low English proficiency in Australian maternity care.	Qualitative (interviews and focus groups)	30 Afghan participants with 16 women and 14 men aged above 18, 34 health professionals: 10 midwives, 5 medical practitioners, 19 community-based health workers	Maternity care	Language barriers, including the underutilization of interpreter services Navigation difficulties. Cultural norms for not using male interpreters for women clients. Rushed appointments discouraged professionals from using interpreter services. Fear of a confidentiality breach with their own community service providers. Husbands played the role of interpreters and controlled the flow of information.	Availability of free professional interpreters, though underutilised, telephone interpreter services offered anonymity for some women. Policy framework mandates the use of interpreters for low-English-speaking women. Health professionals' awareness actively encouraged the use of interpreter services. Bicultural health workers bridge communication gaps	**CASP Qualitative appraisal Tool Scores 20/20**

2.5 Data analysis

A descriptive approach was employed for data analysis. Table 4 illustrates the frequency of the emerged themes and subthemes from the selected 19 articles.

Table 4
Themes and Subthemes Classification with Frequencies

Main Theme	Subtheme	Nature	Number of studies/ Frequency	References
Communication and sociocultural factors	Communication & language barriers	Barriers	18	Robbers et al., 2024., Z. Alam et al., 2022., Brammall et al., 2025., Henning Cruickshank et al., 201., Inoue et al., 2016., Jean Hailes for Women's Health, 2025., Lang et al., 2020., Maheen et al., 2025., Mander & Miller, 2016., Mohale et al., 2017., Owens et al., 2016., Palani, Fereday, et al., 2025., R. Power et al., 2022., Rambaldini-Gooding et al., 2024., Vazquez Corona et al., 2025., Vizheh et al., 2023., Yelland et al., 2015.
	Influence of culture and safety concerns	Mixed Subtheme with barriers and enablers	14	Z. Alam et al., 2022., Brammall et al., 2025., dos Santos, 2023., Henning Cruickshank et al., 2019., Inoue et al., 2016., Lang et al., 2020., Maheen et al., 2025., Mander & Miller, 2016., Owens et al., 2016., R. Power et al., 2022., Robbers et al.,2024., Rogers & Earnest, 2015.
	Cultural expectations and gender dynamics	Barriers	9	Z. Alam et al., 2022., Brammall et al., 2025., Henning Cruickshank et al., 201., Jean Hailes for Women's Health, 2025., Lang et al., 2020., Maheen et al., 2025., Mander & Miller, 2016., Mohale et al., 2017., R. Power et al., 2022.
Access, financial constraints and systematic complexity	Barriers related to service access and navigation of the health system	Barriers	11	Z. Alam et al., 2022., Henning Cruickshank et al., 201., Jean Hailes for Women's Health, 2025., Lang et al., 2020., Maheen et al., 2025., Mohale et al., 2017., Owens et al., 2016., R. Power et al., 2022., Vazquez Corona et al., 2025., Vizheh et al., 2023., Yelland et al., 2015.
	Financial constraints & complexities associated with health insurance	Mixed with barriers and enablers	9	Z. Alam et al., 2022., dos Santos, 2023., Henning Cruickshank et al., 201., Jean Hailes for Women's Health, 2025., Lang et al., 2020., Robbers et al., 2024., Mander & Miller, 2016., Vazquez Corona et al., 2025., Vizheh et al., 2023.
Knowledge & Resources gaps	limited sexual health awareness	Mixed with barriers and enablers	10	Z. Alam et al., 2022., Henning Cruickshank et al., 2019., Jean Hailes for Women's Health, 2025., Inoue et al., 2016., Lang et al., 2020., Mohale et al., 2017., Palani, Fereday, et al., 2025., R. Power et al., 2022., Rogers & Earnest, 2015.
	Culturally inappropriate education and misconceptions	Mixed with barriers and enablers	9	Z. Alam et al., 2022., Jean Hailes for Women's Health, 2025., Lang et al., 2020., Palani, Fereday, et al., 2025., R. Power et al., 2022., Robbers et al.,2024., Rogers & Earnest, 2015., Rambaldini-Gooding et al., 2024., Vizheh et al., 2023.
Support network & community engagement	Support network & community engagement	Mixed with barriers and enablers	11	Brammall et al., 2025., dos Santos, 2023., Mander & Miller, 2016., Owens et al., 2016., Robbers et al.,2024., Rambaldini-Gooding et al., 2024., Mander & Miller, 2016., Palani, Fereday, et al., 2025., Vazquez Corona et al., 2025., Vizheh et al., 2023.
Quality care & health Workforce	Continuity & trust in care	Mixed with barriers and enablers	5	Henning Cruickshank et al., 2019., Owens et al., 2016., Robbers et al.,2024., Vizheh et al., 2023., Yelland et al., 2015.
	Provider's attitudes & training needs	Barrier	5	Z. Alam et al., 2022., Brammall et al., 2025., Jean Hailes for Women's Health, 2025., Mander & Miller, 2016., Vizheh et al., 2023.

3. Results

The selected 19 studies addressed various sub-fields of SRH service models for migrant and CALD women living in Australia. The most frequently covered area was maternity care (n = 6), followed by antenatal care (n = 3), contraception(n = 3) and cervical screening (n = 2). Other areas included perinatal care, SRH education, and general SRH services. The predominant focus was placed on maternal health, with limited attention to preventive and educational SRH services for these population groups, as shown in Fig. 2.

Most Studies used qualitative methods to explore the lived experiences and social contexts of migrant and CALD populations. The common approaches included in-depth interviews, semi-structured interviews, and focus groups [21–32]. Three studies incorporated workshops and photo-elicitation techniques within participatory frameworks, integrating co-design and community engagement processes [33–35]. One study employed a phenomenological approach to capture lived experiences [28], while two other studies used integrated mixed methods designs or feasibility study approaches [21, 36]. Quantitative elements appeared in population-level cross-sectional analyses in one article that used survey data [37]. Across 17 articles, thematic analysis was the predominant analytic method used to ensure a systematic interpretation of narratives [21, 23, 25, 27–40]. Collectively, these methodological choices reflect a commitment to culturally responsive, participatory and theory-informed inquiry in SRH research.

Across the 19 included studies in this review, a total of 1,084 migrant and CALD women participated in research exploring their experiences with SRH services. Sample sizes varied considerably, ranging from 7 to 655 participants, reflecting the diversity of study designs and populations. Reported ages spanned from 15 to 74 years, with most studies focusing on women aged 18–50 years. Where age distributions were provided, the mean age across studies fell within early to mid-30s, and the mode age group was consistently 18–24 years, largely due to studies involving young migrant and refugee women. The participants represented a broad range of cultural and linguistic backgrounds, including women from South Asia, the Middle East, East and South-East Asia, Africa and the Pacific Islands.

The authors synthesised the selected studies to identify recurring themes that illuminated both the challenges and opportunities experienced by migrant and CALD women accessing and engaging with SRH care in Australia. Five overarching themes and nine subthemes were identified through an analytic grouping process represented in Table 4 and detailed below.

3.1 Communication and sociocultural factors

Data from the studies indicate that cross-cultural communication barriers, socio-cultural norms, and opportunities influence the decision-making capacities of migrant women accessing SRH services in Australia.

3.1.1 Communication barriers and gender dynamics

Communication barriers were consistently identified as predominant factors affecting SRH outcomes. In several studies, language difficulties emerged as a prominent challenge, often limiting women's engagement with SRH information [21, 23–25, 27, 28, 30–41]. These barriers were also compounded by restricted access to interpreter services [28, 37] and misaligned linguistic needs in educational resources [27, 32]. The inconsistency of interpreter services, along with their underutilisation by the health professionals, further restricted the flow of information across SRH settings [32]. It was noted that due to a lack of proficiency in the English language, women were required to rely on their male partners for translations, which restricted the flow of information. This also controlled women's autonomy in decision-making capacities for SRH treatment [31, 32, 38, 40]. Similarly, concerns about safe communications and privacy were evident, specifically when interpreters or health professionals were male [32]. Another reason for this occurrence was that there were limited options for women to choose from when selecting female interpreters, further restricting their communications on SRH discussions [33].

3.1.2 Influence of culture and safety concerns

Women reported limited opportunities to discuss SRH needs when health information appeared culturally inappropriate or misaligned with their cultural expectations during their antenatal, labour and post-natal needs. Cultural misunderstanding between the health providers and women influenced SRH outcomes [22, 23]. Restricted options to access female health providers often required women to rely on male clinicians, which raises concerns about personal safety, privacy and cultural sensitivity. This discomfort was frequently compounded by social stigma and racial judgment, which led women to feel ashamed while engaging with health care providers of the opposite gender. As a result, open discussions on their SRH needs and issues were restricted [24, 28, 37]. Additionally, their partners and family members experienced perceived risk to the privacy and safety of their women during these consultations, which did not meet cultural norms when they consulted male health care providers [30, 31, 39, 40].

Some studies emphasised the importance of culturally responsive care models and culturally competent care to meet cultural expectations of women by providing female health care professionals [24, 27.] Researchers noted that the following enablers improved maternity and SRH care experiences for these women: firstly, acknowledging cultural nuances in pregnancy and birth; secondly, incorporating trauma-informed approaches; and thirdly, fostering culturally appropriate communication [24, 35]. The delivery of culturally and linguistically appropriate services by health care providers was suggested to facilitate open discussions about SRH, controlling perceived risk of safety and confidentiality among women [37]. Further, when bilingual health providers and female health providers are provided, it will be possible to meet both their cultural safety and linguistic needs [39].

3.1.3 Cultural expectations and family dynamics

Cultural expectations were emphasised in maintaining family cohesion, bearing children, and prioritising husbands' well-being to ensure family stability for these women after marriage [25]. These factors influenced health-seeking behaviour and delayed SRH treatments [40]. Additionally, patriarchal cultural practices delayed SRH services utilisation when decision-makers were elderly family members or male partners [25, 32]. However, in one study, generational differences were evident, with younger women demonstrating greater openness to SRH education and engagement compared to older women [42].

3.2 Access, financial constraints and systematic complexity

Some of the factors, such as those related to access challenges, financial difficulties and systemic complexity across SRH, also played a complex role for migrant and CALD women in accessing SRH. A total of 11 articles highlighted access barriers, and nine articles highlighted financial insecurities faced by migrant and CALD women.

3.2.1 Barriers related to services and navigation of the health system

Accessing SRH services was often constrained by multiple, overlapping barriers that limited migrant and CALD women's ability to engage with these services. Transport dependence, particularly reliance on husbands for travel, combined with various logistical challenges, made attending appointments difficult for these women [24, 28, 31, 36, 43]. These practical barriers were compounded by communication difficulties, post-migration settlement stress,

cultural differences and unfamiliarity with Australian health care models, all of which reduced women's confidence and capacity to navigate SRH pathways [21, 24, 25, 27, 32, 34, 38, 40, 41]. System-level barriers further restricted access. These included long wait times, short and rushed consultations, distant or hard-to-reach health care facilities, inflexible scheduling systems, and competing work commitments, making it challenging for women to attend appointments and maintain continuity of care [27, 32]. Additionally, rigid online booking systems and inadequate appointment reminder processes created further obstacles, particularly for women with limited digital literacy or competing settlement demands [21, 24]. Despite these challenges, several studies highlighted that proactive guidance from health care providers, such as explaining service pathways, assisting with system navigation, and offering practical support, can help to mitigate access barriers and improve women's utilisation of SRH services [41].

3.2.2 Financial constraints & complexities associated with health insurance

Financial pressures emerged as a substantial barrier to accessing SRH services for migrant and CALD women, particularly because a large proportion of migrants in Australia reside on study visas, which often limit employment opportunities and income security. Post-migration financial stress made it difficult for women to meet the direct and indirect costs associated with SRH care, including out-of-pocket fees to pay for treatment, transportation, and parking [24, 25, 30, 34, 38, 40]. These challenges were compounded by broader settlement issues linked to visa status, such as uncertainty about residency, the cost of extending study visas, partially covered medical expenses, and restricted working conditions [23]. Cultural factors also affect women's financial dependence. In some communities, traditional gender roles position men as income earners while women undertake childcare and domestic responsibilities, leaving women with limited control over financial resources. This dependency on husbands for managing finances often delayed timely access to SRH services [21]. Limited understanding of complex health insurance arrangements and, for many, ineligibility for Medicare, Australia's free medical care system, also created barriers to accessing appropriate care [38]. Despite these constraints, several studies identified potential enablers. Providing health insurance navigation support, such as information sessions explaining coverage, eligibility and claims processes, as well as waiving out-of-pocket fees for certain services, was suggested as a strategy to facilitate access and improve utilisation of SRH services [34]. Financial independence was shown to enhance women's autonomy in making SRH treatment decisions, enabling earlier engagement with care and improved outcomes [38]. For example, migrant women who were financially stable reported higher satisfaction levels when able to choose private specialists, highlighting how economic stability can expand care options beyond those available in the public health sector [37]. Overall, these findings indicate that improving financial literacy, expanding insurance supports and fostering women's financial independence may play a critical role in reducing inequities and enhancing SRH access for migrant and CALD women.

3.3 Knowledge and resource gaps

Following migration, many women face challenges in understanding the Australian health system and were often unaware of the SRH services available to them. Although these gaps in awareness initially hindered service utilisation, several studies identified enablers that helped women become more familiar with the health care system.

3.3.1 Limited sexual health awareness

A few researchers highlighted existing gaps in knowledge and awareness about contraceptive and SRH options in migrant and CALD women in Australia [25, 39]. These included poor access to preconception health treatment [40], antenatal educational resources [41], cervical cancer screening [21], and contraceptive methods [24]. Each of which negatively influenced SRH outcomes. Limited health literacy further complicated women's ability to understand and navigate available support services [36]. For some women, unfamiliarity with medical procedures and consent processes created additional barriers to engaging with care [32]. Difficulties in understanding maternity care models [41], ineffectively utilising maternal health care and trauma-informed care services, restricted women's confidence and participation in SRH care [35]. Cultural beliefs further shaped these experiences, as SRH education was sometimes viewed as inappropriate or unwelcome, particularly for young, unmarried women. In some families, parents actively excluded their daughters from school-based SRH education to avoid culturally sensitive topics, limiting their contraceptive knowledge and contributing to higher rates of adolescent pregnancy [31]. Despite these challenges, several enablers were identified. Access to multilingual resources and culturally tailored information was shown to improve women's understanding of SRH options and support more effective engagement with services [41]. Generational differences also played a role, with younger migrant and CALD women generally more open to learning about SRH than older women, suggesting a gradual shift in attitudes as women adapted to the Australian context.

3.3.2 Culturally inappropriate education and misconceptions

The misconceptions related to unawareness and a lack of culturally sensitive education discouraged women from accessing SRH services. Culturally inappropriate SRH education disadvantaged these women in overcoming misconceptions [31]. For instance, some migrant and CALD women preferred natural methods for safety concerns, believing contraceptives could cause infertility [25, 30]. Similarly, misbeliefs about cervical screening delayed treatment, as they believed it was only for diagnosing cancer and with limited knowledge that it also serves as a preventive tool for early-stage cancer treatment. Delayed cervical screening was further compounded by the social stigma factor, as a confirmed cancer diagnosis would diminish women's value within the family and impact the family's reputation [21, 36]. Despite these challenges, when culturally tailored interventions were implemented, SRH outcomes improved, including increased uptake of cervical screening through self-sampling [21, 36]. Conversely, when culturally appropriate information was provided in their native languages [25] via schools, community-based programmes and social media, it was shown to improve their engagement [21, 38]. Similarly, the education delivery in their native language engaged them in early preconception care [40]. The group-based education sessions were suggested to meet the learning needs of low-literacy women. These sessions should include visual aids and infographics, with flexible delivery formats such as online and face-to-face [36]. In addition, co-designing and co-delivering SRH educational programs were recommended to foster cultural humility [35].

3.4 Support network & Community engagement

Post-migration, some women experienced psychological vulnerability during their maternity needs due to social stigma, isolation and a limited family support network [22, 23, 28, 40, 41]. Additionally, these women experienced insufficient support from the health sector for their antenatal, intrapartum and postnatal care [35]. However, several researchers suggested that enablers, such as strong peer networks and support from family members, could help in reducing isolation and increasing women's engagement and trust in SRH services [22, 23, 27, 30]. The Australian socio-cultural context supports their freedom to have open discussions around SRH [38]. It is suggested that multicultural health policies can improve SRH outcomes when male partners engage in treatment processes during their partner's maternity needs [34, 35, 37]. The involvement of families and communities of the women further fosters their engagement in SRH services.

3.5 Quality care and health workforce

Ensuring high-quality care for migrant and CALD women relies heavily on a culturally competent and responsive health workforce. Trust, safety, and respect were central to women's willingness to access and continue using SRH services, with researchers consistently emphasising the importance of non-judgmental, culturally sensitive care.

3.5.1 Continuity and trust in SRH services

Continuity of care and trust in the health care system were closely linked to the health care providers' cultural competency, communication style and gender. Limited availability of female clinicians created challenges for migrant and CALD women, disrupting continuity of care and reducing their comfort in disclosing sensitive SRH concerns [24]. These restricted options also undermined women's trust and satisfaction with the health care system [21, 25, 37]. Lack of cultural competency among health care providers further contributed to discontinuity of care, with two studies showing that women disengaged when services did not align with their cultural expectations or when communication felt dismissive, rushed or culturally insensitive [32, 34]. In addition, one study revealed that women from close-knit community groups were particularly concerned about breaches of confidentiality when treated by health care professionals from their own cultural background, further reducing trust in the system. Discomfort with male clinicians was another commonly reported barrier [32]. Many women expressed reluctance to discuss intimate SRH issues with male providers, which affected their willingness to attend follow-up appointments or remain engaged in ongoing care [24]. To address these challenges, researchers recommended recruiting more female health care providers and implementing practical strategies to maintain confidentiality, which would foster trust and confidence of women in accessing SRH services [28, 30].

3.5.2 Providers' attitudes and training Needs

Judgmental approaches and stereotyping attitudes among health care providers significantly influence migrant and CALD women's engagement with SRH services. When care is delivered in ways that reflect racial bias or cultural insensitivity, women often disengage from services, resulting in poorer SRH outcomes [22]. Strengthening the cultural competence of health care providers through targeted training has been shown to improve trust in the Australian SRH system and enhance women's willingness to seek care [37]. Culturally respectful communication and behaviour also play a critical role in fostering feelings of safety and satisfaction during SRH encounters [22, 25, 38]. When health care providers demonstrate an understanding of cultural norms, including expectations related to diet, modesty or gender dynamics, women are more likely to participate in care. For example, providing dietary advice that aligns with women's cultural preferences can improve engagement in the management of conditions such as gestational diabetes [22]. Similarly, encouraging family support during labour time will increase the satisfaction level of women and their trust in health care providers. Overall, cultural competence training and an awareness of community-specific expectations help reduce cultural misunderstandings, promote trust, and sustain ongoing engagement with SRH services among migrant and CALD women.

4. Discussion

This review identified a range of interconnected barriers and enablers that influence migrant and CALD women's access to, and utilisation of SRH services in Australia. The most prominent barrier was communication and language difficulty, which aligns with findings from broader international research [6, 29, 44–49]. Limited English and inconsistent use of interpreter services often force women to rely on informal translators, restricting their autonomy in SRH decision-making [12, 50]. Gendered power dynamics further amplified this issue when husbands acted as interpreters, as they often controlled the flow of information, sidelining women from decisions about their own health [4, 12, 13, 50, 51]. These communication barriers significantly compromised timely engagement with SRH services.

Cultural beliefs also strongly influenced attitudes of women towards SRH. Women's understanding of menstruation, fertility control and sexual health was influenced by inherited cultural norms, creating tension between sociocultural expectations and biomedical care [4, 5, 7, 12, 13, 29, 44, 50]. This evidence shows that health care providers from migrant and CALD communities also carry influence and sometimes discourage women's access to SRH settings. For example, when unmarried women were denied contraceptives by health care providers of their familiar cultural backgrounds, their trust in the health care system of Australia was undermined [6]. Shame and discomfort when discussing SRH topics, and fear of judgment or confidentiality breaches further limited women's willingness to engage with services [11]. Collectively, these findings demonstrate how sociocultural norms can override medical advice and delay access to SRH services.

Several enablers were highlighted in the research, offering promising pathways for improvement in accessing SRH services for migrant and CALD women. These included culturally respectful communications, bicultural health professionals and trained interpreters to enhance women's comfort and

engagement [13, 29, 44, 45, 52]. Training health care providers in cross-cultural communication, low literacy consent processes and non-judgmental practice were also identified as facilitators to overcome social stigma and racial bias [7]. Additional enablers included access to female health care providers from familiar cultural backgrounds, culturally tailored education resources and communication approaches aligned with cultural and religious boundaries [12, 13, 44]. Researchers also recommended embedding cultural considerations into national policies and service design [13, 45, 53]. Family dynamics and intergenerational influences also affect women's engagement and access to SRH services. Parental gatekeeping, particularly in conservative cultural groups, restricted young women's access to SRH education and contributed to misconceptions and reduced autonomy [54]. More research is needed to understand how these dynamics influence SRH outcomes.

Structural barriers further restricted women's access to care, including inflexible employment conditions, travel time to distant services, complex health system navigation, uncertain visa status and competing work and family responsibilities. These constraints discouraged consistent engagement in SRH services. These constraints discouraged consistent engagement and echoed findings from other researchers [6, 55]. SRH programs designed for mainstream populations often overlooked the unique needs of migrant groups, contributing to inequitable outcomes [56].

Financial constraints compounded these barriers. The high cost of contraceptives, abortions service, consultations and ineligibility for Medicare limited women's ability to access timely SRH care [4, 6, 55, 57]. Suggested facilitators included free or low-cost contraceptive and STI services and the involvement of migrant communities in SRHR policy development and service design [5, 58].

Limited literacy and poor awareness of SRH resources also contributed to suboptimal outcomes. Women often lacked understanding of contraception, infertility services, cervical self-screening, HPV vaccination, and STI prevention, echoing patterns reported in international migrant health research [5, 58]. Linguistically and culturally misaligned SRH educational material further impeded women's comprehension [56]. Studies identified effective enablers, such as peer support, group-based education and flexible delivery methods, that improve women's SRH awareness when tailored to their cultural and linguistic needs [6, 29, 44, 46]. Additionally, these approaches would be more effective when resources are culturally inclusive and tailored education, making participants feel respected [4, 12, 48, 59]. For example, it is reported by a few researchers that culturally inclusive antenatal SRH education was found to reduce stillbirths, and rapid self-testing methods supported timely STI prevention [13, 57]. Moreover, providing SRH education options to various age groups is effective, such as youth migrants who have opportunities to attend sexual health education in schools [5], and other groups through community settings [57], which fosters their awareness in Australia.

After migration, limited social networks increased isolation, which impacted women's continuity with SRH services. Migrant groups sustain engagement in SRH services when participation of both genders, elderly members and community-trusted leaders is valued in SRH educational delivery [4, 13, 45, 50, 56, 59]. Additionally, support from spouses for these women enhanced their utilisation of SRH services [46]. However, more evidence is needed on the effectiveness of family and community-inclusive approaches.

The quality of SRH care was closely linked to the cultural competence of the health workforce. Lack of cultural training, limited availability of female health care workers, and institutional biases undermined migrant and CALD women's trust and contributed to discontinuation of care in the Australian health care system [45, 54, 56]. System-level discrimination was reflected in limited SRH discussions initiated by GPs, a stereotypical attitude of GPs and a lack of proactive engagement towards these community women. In contrast, continuity of care, follow-up support, culturally tailored services, appointment reminders and recruitment of female and bicultural CALD health professionals were identified as key enablers to fostering trust and sustained SRH engagement [44, 45, 60].

Overall, this review illustrates how structural, cultural, interpersonal, and system-level barriers intersect to limit SRH access for migrant and CALD women, while also highlighting practical enablers that can improve outcomes. Many included studies relied on heterogeneous multicultural samples or mixed-gender groups [5, 45–52, 54, 55, 57, 61]. These findings limit the ability to draw subgroup-specific conclusions. Importantly, past research has disproportionately focused on maternity care, with limited attention to contraception, antenatal/postnatal care, preconception support, and psychological aspects of SRH. Significant gaps remain in evaluating culturally safe models of care, interpreter models, multilingual educational resources, continuity-of-care frameworks, peer-support interventions, family involvement, and confidentiality safeguards.

Methodological limitations are evident within the current literature, including a heavy reliance on qualitative study designs, small and culturally heterogeneous samples, limited comparisons across metropolitan, regional, and rural settings, and a scarcity of nationally representative studies. Notably, the rapidly growing population of Indian migrant women remains markedly underexplored, despite being one of the largest overseas-born groups in Australia, particularly in Victoria. Addressing this gap is essential to inform evidence-based SRH service models, culturally safe policy development, and equitable resource allocation at the national level. Nonetheless, there is also insufficient evidence on cross-cultural training for health professionals, evaluation of continuity-of-care models and strategies to avoid confidentiality breaches.

Overall, the demonstration of the interconnected complexity of barriers and enablers of SRH services for these populations significantly highlighted the need for future research to inform strategies that address factors at personal to systemic levels for improving SRH outcomes. Robust evidence is required on rapidly growing populations and in subgroup-specific findings, such as among Indian migrant women in Victoria, Australia.

4.1 Limitations

This literature review has its own limitations. This study is limited by its exclusive focus on research conducted in Australia. Consequently, relevant evidence, contextual differences, and insights from international settings were not examined, which may restrict the generalisability of the findings beyond the Australian context. Additionally, as this study focused on migrant and CALD women's perspectives, studies specific to health professionals'

perspectives were not considered. Finally, the exclusion of articles published in languages other than English may have limited the inclusion of valuable perspectives and experiences of CALD women.

5. Conclusion

This integrative review highlights the substantial barriers and facilitators faced by CALD and migrant women in accessing sexual and reproductive health (SRH) services in Australia. The barriers include communication difficulties, inappropriate cultural care, challenges in navigating the health care system, limited awareness about health care models, inadequate educational resources, culturally incompetent health providers, a lack of options to access female health providers, inconsistency in availability of interpreters, poor social support network, affordability constraints, and socio-cultural factors. However, numerous facilitators are suggested to improve SRH outcomes for these populations. These include providing culturally appropriate care aligning with their religious and cultural beliefs; educational resources aligning with their linguistic needs; bi-culturally trained health providers and bilingual educators; recruiting more female health providers to enhance options to access them and female interpreters with bilingual and bicultural competencies; and improving equitable policies for affordability to utilise SRH services regardless of their residential status. This review offers recommendations to address these barriers and foster enablers to improve access to and utilisation of SRH services.

Declarations

Data Availability

No datasets were generated or analysed during the current study.

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Figures

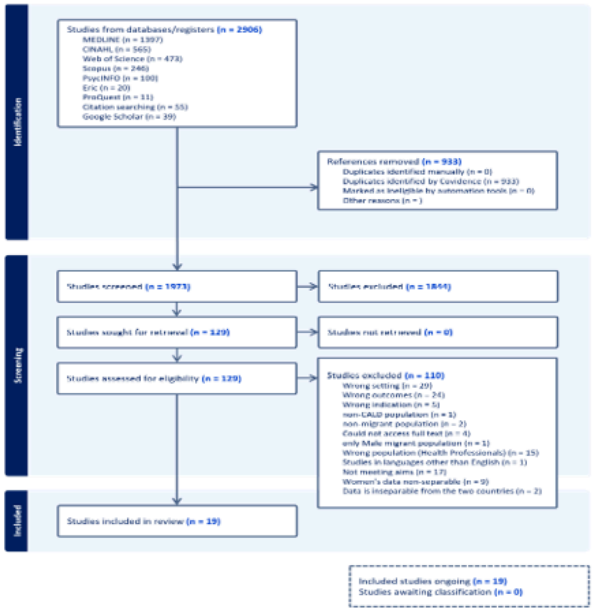


Figure 1. Flow Chart PRISMA 2020 Migrant and CALD Women's Access to SRH Services in Australia

Figure 1

PRISMA 2020 flow diagram illustrating the study selection process for research on migrant and culturally and linguistically diverse (CALD) women's access to sexual and reproductive health (SRH) services in Australia. A total of 2,906 records were identified across databases and registers, with 933

duplicates removed, resulting in 1,973 studies screened. Of these, 1,844 records were excluded at the screening stage. 129 full-text articles were assessed for eligibility, with 110 studies excluded for reasons including wrong setting (n = 29), wrong outcomes (n = 24), and not meeting study aims (n = 17). Ultimately, 19 studies were included in the final review.

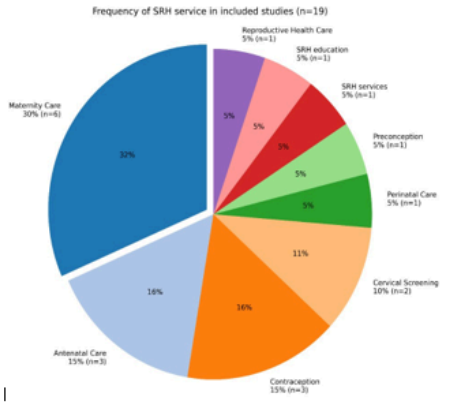


Figure 2. Frequency of SRH Service Topics Addressed in the Included Studies, Providing Insight into the Research Emphasis within the Australian Context

Figure 2

Frequency distribution of sexual and reproductive health (SRH) service topics across the 19 included studies. The figure presents the number and proportion of studies addressing specific SRH areas, highlighting dominant research themes and underrepresented topics within the Australian context. Variations in frequency indicate differing levels of research attention, with some SRH domains receiving greater emphasis, while others remain comparatively less explored.