Journal of International Migration and Integration
https://doi.org/10.1007/s12134-025-01300-x

Healthcare Access and Utilisation among African Refugee and Immigrant Women in Australia: A Scoping Review

Alexis Harerimana[1,2] · **Julian David Pillay**[1] · **Gugu Mchunu**[1]

Accepted: 21 July 2025

Abstract

Background Access to healthcare is essential for the wellbeing and integration of refugee and immigrant women. In Australia, women of African descent—both refugees and immigrants—encounter substantial challenges in accessing healthcare services, despite the availability of free or subsidised programs such as breast and cervical cancer screenings. This study aims to map the existing literature on healthcare access and utilisation among African refugee and immigrant women in Australia.

Methodology A systematic scoping review was conducted using Levac et al.'s framework. Searches were performed in the CINAHL, Medline, Scopus, and Web of Science databases for studies published between 2014 and 2024. This process initially identified 842 records from the databases, along with eight manual entries. After removing duplicates, 471 articles were screened based on their titles and abstracts, excluding 428. Of the 43 full-text articles assessed, 20 met the inclusion criteria and were subjected to thematic analysis.

Results The findings indicate that refugee and immigrant women of African origin in Australia primarily seek healthcare for breast and cervical cancer screenings, contraceptives, antenatal care, maternity services and mental healthcare. Factors affecting access include inadequate health literacy, limited knowledge of sexual and reproductive health, contraceptive options, and cancer screenings, compounded by cultural and religious beliefs, gender norms, and misconceptions. Cultural insensitivity, stigmatisation and fear of medical interventions further inhibit access to healthcare services. Additionally, language barriers and unfamiliarity with the healthcare system delay diagnoses and worsen health outcomes. The preference for traditional medicine underscores the need for culturally sensitive healthcare solutions. Addressing these challenges requires culturally tailored interventions, community engagement, and enhanced health literacy, as well as improved access to healthcare.

Conclusion Women of African origin in Australia, including both refugees and immigrants, face various constraints that limit their access to healthcare services. Improved utilisation of healthcare among this population could lead to better sexual and reproductive health, enhanced maternal and child health outcomes, reduced rates of preventable illnesses, and improved mental wellbeing.

Extended author information available on the last page of the article

Published online: 07 August 2025

Keywords Africa · African refugee women · African immigrant women · African migrant women · Female · Women · Access · Experience · Health · Healthcare · Immigrant · Migrant · Refugee · And Australia

Background

Access to healthcare for women refugees and immigrants is crucial, as it directly impacts their overall wellbeing, safety, and capacity to rebuild their lives in a new environment (Chalouhi et al., 2025; Rajaratnam & Azman, 2022; Shahawy et al., 2022). Ensuring that they receive comprehensive healthcare is a matter of fundamental human rights and dignity (Caulford & Rahunathan, 2019; Guruge et al., 2018). Healthcare access aligns directly with Sustainable Development Goal (SDG) 3: Good Health and Wellbeing, which calls for universal health coverage, including access to quality essential healthcare services and medicines for all, including refugees and migrants (Barragan et al., 2017; O'Neil et al., 2016). Additionally, SDG 5: Gender Equality underscores the importance of eliminating barriers to healthcare for women, especially marginalised groups such as refugees and immigrants (Saunders et al., 2022; Summerfield & Regan, 2021). Achieving these goals requires creating inclusive health systems that recognise and address the specific health needs of refugee and immigrant women, providing them with equitable access to healthcare and ensuring that no one is left behind (Barragan et al., 2017). Refugee and immigrant women in developed countries face significant challenges to healthcare (Adibelli & Şahan, 2025; Akellot, 2021; Floyd & Sakellariou, 2017). This scoping review includes both refugee and immigrant women of African descent to understand how cultural, social, and structural factors affect healthcare access in Australia. It also acknowledges that many studies, service providers, and policymakers do not always distinguish between these groups in health service design and delivery.

Australia has an increasingly significant African community (Fozdar, 2023; Parliament of the Commonwealth of Australia, 2011). The African diaspora in Australia is a diverse and heterogeneous collective comprising individuals from various ethnic, sociocultural, and political backgrounds, as well as diverse migration pathways (Fozdar, 2023; Gatwiri & James, 2024). Over the past two decades, individuals of African descent have arrived in Australia through two primary avenues: as migrants and as refugees (Boese & Moran, 2021; Fozdar, 2023; Parliament of the Commonwealth of Australia, 2011; Shergold et al., 2019). Refugees typically arrive in Australia through humanitarian programs and may have experienced trauma, displacement, and prolonged stays in refugee camps, which affect their health status and service needs (Shergold et al., 2019). Immigrants, on the other hand, often arrive in Australia through skilled, family, or student visa pathways and may have more autonomy in their migration decisions (Boese & Moran, 2021). However, both groups often face overlapping challenges in accessing healthcare, particularly when they share similar ethnic, cultural, and regional backgrounds, such as those from African countries (Hawkey et al., 2022; Ikafa et al., 2024; Metusela et al., 2017; Power et al., 2022). The literature indicates that African migrants who have settled in Australia face various resettlement challenges, regardless of their migration status

(Ikafa et al., 2024). Foremost among these challenges are language barriers, which not only obstruct effective communication but also limit access to essential support services (Ikafa et al., 2024). Additionally, African refugees and migrants face racial discrimination, which adversely affects their mental health and diminishes their sense of belonging within the broader society (Gatwiri & James, 2024; Ikafa et al., 2024; Peprah et al., 2024). The separation from family members, particularly for refugees, exacerbates these stressors and perpetuates feelings of isolation (Ikafa et al., 2024; Mwanri et al., 2022). Moreover, limited awareness of healthcare services leads to delayed treatments and screening, as well as health complications (Anaman et al., 2017a, 2017b, 2017c, 2018; Mohale et al., 2017).

The literature indicates that women's access to healthcare depends on their control of resources and ability to make personal health decisions (Lattof et al., 2018; Osamor & Grady, 2016). Female migrants often face additional challenges in accessing care due to marginalisation and vulnerability stemming from their gender and migrant status (Lattof et al., 2018). Furthermore, refugee women face complex barriers to accessing sexual and reproductive health services, including transportation challenges, language issues, limited interpreter availability, under-resourced clinics, insurance restrictions, fragmented referral systems, stigmatisation and lack of culturally appropriate resources (DeSa et al., 2022b; Vu et al., 2022). These systemic obstacles hinder access, continuity, and quality of care, highlighting the urgent need for targeted, structural interventions to improve service delivery (Vu et al., 2022).

Understanding the factors that influence healthcare access and utilisation is crucial. The Model of Healthcare Utilisation by Andersen (1995) provides a solid framework for examining these factors, especially in relation to African refugee and immigrant women. This model posits that three main factors influence healthcare utilisation: predisposing, enabling, and need (Andersen, 1995). Predisposing factors encompass individual traits, including demographic characteristics, such as age, gender, cultural and social background, religion, and education, which influence a person's likelihood of seeking medical care (Andersen, 1995). Refugee women often have low health literacy and misconceptions about preventive care, leading to the underutilisation of screening services (Babatunde-Sowole et al., 2020a, 2020b). African refugee and immigrant women come from backgrounds where traditional medicine is prominent, and poor health literacy can hinder their ability to navigate Western healthcare systems (Shewamene et al., 2021; Wångdahl et al., 2014). Cultural norms and gender expectations may also limit healthcare access, as some women might need spousal or community consent before pursuing medical care (Hawkey et al., 2022; Mengesha et al., 2017; Metusela et al., 2017). Furthermore, in maternity care, women face challenges related to pain management, support during labour, and cultural sensitivity (Mohale et al., 2017).

Enabling factors involve the structural and resource-related aspects that can either facilitate or obstruct healthcare access, including family support, income and health insurance (Andersen, 1995). Many African refugees and immigrants encounter economic challenges, making healthcare unaffordable (Goldenberg et al., 2023; Mwanri et al., 2022; Tsai & Ghahari, 2023; White & Rispel, 2021). The literature shows that refugees and immigrants in countries such as Australia, Canada, and the United Kingdom typically benefit from universal health coverage (UHC) or publicly funded

healthcare systems (El-Gamal & Hanefeld, 2020; Pandey et al., 2022; Saunders et al., 2023). However, in the United States, the fragmented, insurance-based system results in many undocumented migrants having limited or no access to regular medical care (Rahman, 2021). Even in countries with universal healthcare, navigating complex bureaucracies can be challenging (Caulford & Rahunathan, 2019). Furthermore, legal documentation issues, fear of deportation, and uncertainty about healthcare rights also affect the accessibility of healthcare services (Funge et al., 2020; Goldenberg et al., 2023). Language barriers are another obstacle; limited proficiency in the host country's language can result in delays or miscommunication with healthcare providers, misdiagnosis, and non-adherence to treatment (Barrio-Ruiz et al., 2023; Chawhanda et al., 2024; Msabah, 2022; Pandey et al., 2021; Vange et al., 2024). Systemic barriers such as lengthy wait times, inadequate culturally competent care, and complex healthcare policies often deter these women from seeking medical assistance (Benza & Liamputtong, 2017; Due et al., 2022; Mohale et al., 2017; Tsai & Ghahari, 2023). Nevertheless, social networks and ethnic communities can serve a dual purpose—providing support in terms of translation and transportation while also potentially reinforcing traditional beliefs that dissuade engagement with formal healthcare services (Joshi et al., 2013; Theodosopoulos et al., 2024).

Need factors relate to perceived and actual health conditions that drive the urgency of seeking care, including chronic conditions and how individuals assess their health (Andersen, 1995). African refugee women frequently face a high incidence of chronic diseases such as hypertension and diabetes, alongside reproductive health challenges and mental health issues (Im et al., 2024; Msabah, 2022). Maternal services and preventative healthcare measures, such as vaccinations and screenings, are frequently neglected by African refugee and immigrant women due to a lack of awareness or mistrust in the healthcare system (Anaman et al., 2017a, 2017c; Drummond et al., 2011; Mohale et al., 2017; Tefera & Yu, 2022). These challenges are particularly pronounced in sexual and reproductive health (SRH) services and mental health care (DeSa et al., 2022a).

Improving access and quality of care requires effective models of care for refugee and immigrant women, which incorporate culturally responsive approaches, continuity of care, and effective communication strategies (Rogers et al., 2020). Furthermore, it requires adequate case management, interpreters, bilingual staff, and specialised refugee health workers (Joshi et al., 2013). Multidisciplinary teams, low-cost or free services, and outreach programs enhance accessibility (Caulford & Rahunathan, 2019).

Despite these efforts, refugee and immigrant women still experience disparities in health outcomes compared to native-born populations (Newbold et al., 2013). Factors such as temporary visa status greatly affect the healthcare access of refugee and immigrant women, often leading to limited services and unmet health needs (Gateri, 2024; Goldenberg et al., 2023; Tefera & Yu, 2022; Wenner et al., 2022). In Canada, women with temporary refugee status find it challenging to get prenatal and postnatal care due to issues related to health coverage, immigration status, and discrimination, which causes them to underutilise available services (Gateri, 2024). In Germany, asylum seekers encounter restricted healthcare access during an initial waiting period (Wenner et al., 2022). Furthermore, gaps in public health insurance

for immigrant women result in unmet healthcare needs in British Columbia, Canada, contributing to ongoing discrimination and exclusion (Goldenberg et al., 2023). Similarly, in the United States, immigrant women face both personal and systemic barriers, such as a lack of insurance and discrimination, that impede their access to healthcare (Tefera & Yu, 2022).

In Australia, temporary visa status significantly restricts healthcare entitlements for refugee and immigrant women, as they often do not have access to the Australian Medicare system (Wu et al., 2022). This exclusion can increase their vulnerability and create barriers to adequate healthcare, such as language difficulties and economic constraints from their home countries (Wu et al., 2022). Other obstacles affecting African refugee and immigrant women in accessing healthcare in Australia include language difficulties, cultural differences, and unfamiliarity with the healthcare system (Anaman et al., 2017a; Clark et al., 2014; Hawkey et al., 2022; Mohale et al., 2017). Many experience isolation, loneliness, and challenges in developing social networks (Ogunsiji et al., 2012). Healthcare professionals report difficulties providing culturally appropriate care, citing time constraints, lack of resources, and funding issues (Mengesha et al., 2017). Fear of judgment, shame, and logistical difficulties further impede access to healthcare (Drummond et al., 2011; Power et al., 2022).

Improving healthcare access requires culturally competent care, better information sharing, and addressing systemic barriers (Au et al., 2019; Due et al., 2022). Policy reforms in Australia significantly influence the health and wellbeing of refugees and immigrants (NSW Health, 2022a, 2022b; Queensland Health, 2022a, 2022b). Queensland's 2022 strategy prioritises culturally safe care, improved interpreter services, integrated healthcare delivery, and community empowerment. It also emphasises workforce diversity and better monitoring of health outcomes for culturally and linguistically diverse (CALD) groups (Queensland Health, 2022a, 2022b). Similarly, the NSW Refugee Health Plan for 2022–2027 emphasises the importance of enhancing communication in preferred languages, increasing cultural responsiveness, and improving access to essential services, particularly in regional areas (NSW Health, 2022a, 2022b). Both states emphasise the need for coordinated care and targeted health education to support refugees and immigrants in navigating the healthcare system and achieving equitable health outcomes.

In response to the challenges faced by refugee and immigrant women of African descent in Australia, this scoping review aims to map the existing literature on their healthcare access and lived experiences to inform future research and policy development. Furthermore, by synthesising evidence across both groups, this review offers insights applicable to a range of individuals with an African background and highlights the need for tailored, culturally sensitive healthcare interventions that consider the diversity within these populations.

Aim of the Study

This scoping review aims to map the existing literature on healthcare access and utilisation among African refugee and immigrant women in Australia.

Methodology

A scoping review was conducted to map key concepts and evidence regarding African refugee and immigrant women's access to health care and experience in Australia. The Levac et al. (2010) framework provided a systematic approach to conducting the scoping review, and the following steps were followed:

1) identifying the research questions
2) identifying relevant studies
3) selecting relevant studies
4) charting the data
5) collating, summarising, and reporting the results

Identifying the Research Questions

The first step helped to develop a precise and structured research question to guide the review, focusing on the scope of the inquiry. Levac et al. (2010) emphasise balancing breadth and comprehensiveness while ensuring feasibility. Key considerations include defining the population, concepts, context, and primary objectives. The research questions were sufficiently broad to encompass various studies and specific enough to produce insightful results. The following were the research questions:

- What healthcare services are accessed and used by African refugee and immigrant women in Australia?
- What factors influence African refugee and immigrant women's access and use of healthcare services in Australia?

Identifying Relevant Studies

This step focuses on identifying relevant studies by identifying databases, keywords, and additional sources (e.g., grey literature) for a comprehensive search (Levac et al., 2010). This study used a thorough search strategy to locate peer-reviewed articles and grey literature. The databases utilised included CINAHL, Medline, Scopus, and Web of Science. A combination of the keywords was used to search these databases: African refugee, African immigrant, migrant, women, female, healthcare, health care, health, access, experience, and Australia. Search terms were customised to each database. A hand search strategy was also used for additional sources in Google and Google Scholar. A time frame of 10 years was considered (2014 to 2024).

Selecting Relevant Studies

Step three included reviewing and selecting studies meeting the inclusion criteria (Levac et al., 2010). The studies included were peer-reviewed and focused on healthcare access and the experiences of African refugee and immigrant women in

Australia. These papers were published in English. Studies were excluded if they were published in languages other than English, used non-empirical methodologies, or were outside the scope of the current review. The Mixed Methods Appraisal Tool (MMAT) and research question guided the selection of the relevant studies. EndNote version 20 was used to organise retrieved studies. After the quality appraisal, a PRISMA flowchart was developed to display the final number (Fig. 1).

The PRISMA flowchart (Fig. 1) depicts the systematic review process for selecting studies. Furthermore, Fig. 1 provides a structured and transparent approach, guaranteeing the rigour and reliability of the scoping review. Initially, 842 records were identified from databases (CINAHL, Medline, Scopus, and Web of Science)

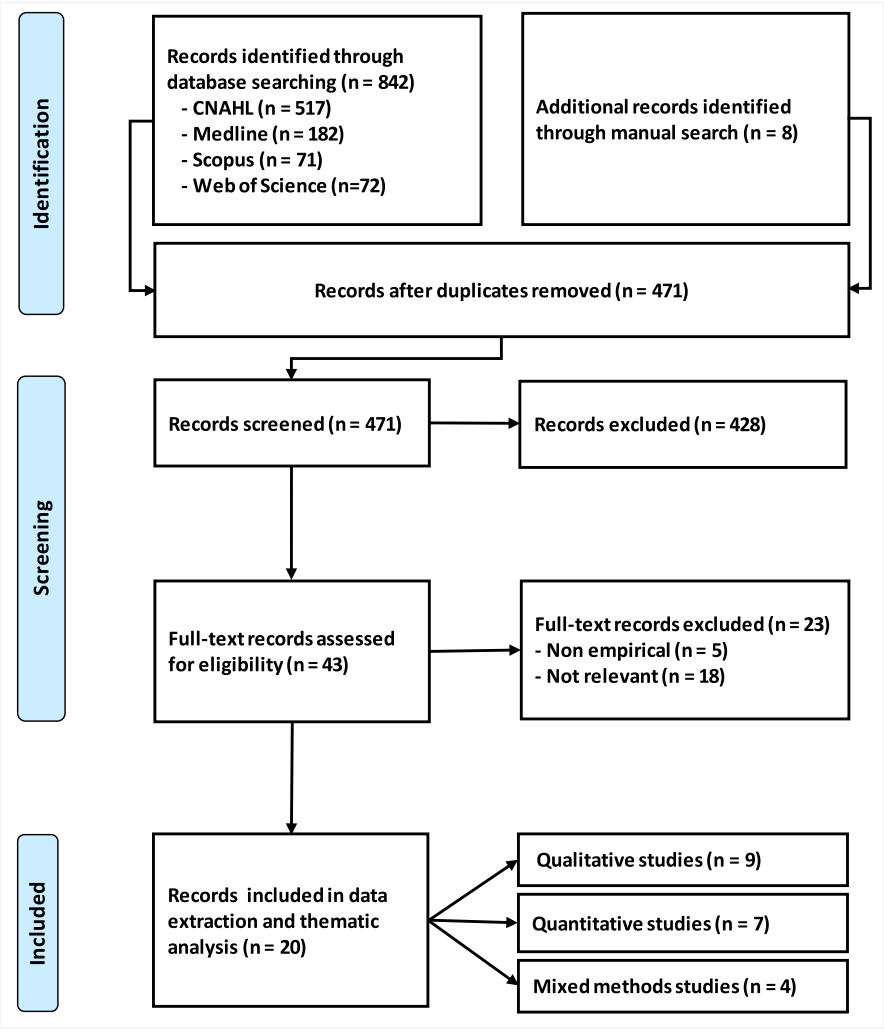

Fig. 1 PRISMA Flowchart

and eight from manual searches. After removing duplicates, a total of 471 unique records remained. During the title and abstract screening process, 428 records were excluded, resulting in 43 records eligible for full-text assessment. Following this assessment, an additional 23 records were excluded, comprising five non-empirical studies and 18 studies deemed irrelevant to the research scope. Consequently, 20 records were retained for data extraction and analysis, including nine qualitative, seven quantitative, and four mixed-methods studies. This diverse methodology ensured a comprehensive evidence base, addressing diverse research questions and identifying gaps across different study types. Qualitative studies offered rich insights into experiences and contexts about healthcare access and utilisation among African refugee and immigrant women in Australia, while quantitative studies provided measurable data and trends. Mixed methods studies enhanced both depth and breadth by combining these approaches.

Charting the Data

Step four aims to develop a structured overview of the existing literature, which aids in effectively summarising and comparing studies. In this study, the data-charting form included relevant variables such as Authors, year, location of the study, aim, population, study design, and findings (Table 1).

Collating, Summarising and Reporting the Results

Step five involved systematically extracting essential information from included studies. Levac et al. (2010) stress the importance of iterating the charting process to capture all relevant data effectively. This step entails determining which data to extract, and this study includes the authors, country, population, research design, and critical findings. As recommended by Levac et al. (2010), it emphasises organising data to support meaningful analysis and synthesis in later stages.

Findings

Study Characteristics

In this study, 20 articles were analysed, revealing that 45% (n = 9) employed qualitative research designs (Anaman et al., 2017a; Benza & Liamputtong, 2017; Due et al., 2022; Hawkey et al., 2022; Metusela et al., 2017; Mohale et al., 2017; Peprah et al., 2024; Watts et al., 2014a, 2014b). This was followed by quantitative research designs at 35% (n = 7) (Anaman et al., 2017c, 2018; Belihu et al., 2016, 2017a, 2017b; Gibson-Helm et al., 2014; Ogunsiji et al., 2017) and mixed methods at 20% (n = 4) (Anaman et al., 2017b; Power et al., 2022; Shewamene et al., 2020, 2021). Results displayed in Table 1 revealed that out of 20 studies, six were conducted in New South Wales, six in Victoria, and four in Queensland. Additionally, four studies did not specify the state or territory within Australia where the studies

Table 1 Summary of the studies

Authors/year	Region/Country	Study objectives	Population/sample size	Country of birth/ origin	Study design	Main findings
Anaman et al. (2017a)	Brisbane, Queensland, Australia	"Understand barriers to and facilitators of cervical screening practices among African women from refugee and non-refugee backgrounds living in Brisbane."	African refugee and non-refugee immigrant women (n = 19)	Liberia, Sierra Leone, South Sudan, Zimbabwe, Ghana, Nigeria, Botswana, Ethiopia and Kenya	Qualitative study design	"Lack of knowledge about cervical cancer and Pap smear tests is a significant barrier to screening among African immigrant women in Brisbane." "Cultural and religious beliefs and gender norms significantly hinder cervical screening practices." Barriers to healthcare systems include "the gender of service providers and the lack of privacy." Effective reminder systems are vital facilitators for increasing participation in cervical screening

Table 1 (continued)

Authors/year	Region/Country	Study objectives	Population/sample size	Country of birth/ origin	Study design	Main findings
Anaman et al. (2017b)	Brisbane, Queensland, Australia	"Report and comment on the views of refugee and non-refugee African-born women living in Brisbane on using mobile text messaging as a potential tool for promoting cervical screening."	African refugee and non-refugee immigrant women (n = 254 for the survey and n = 19 for interviews	Liberia, Sierra Leone, Sudan, Zimbabwe, Ghana, Nigeria, Botswana, Ethiopia and Kenya	Mixed methods	Most African-born women in Brisbane believe mobile text messaging can effectively promote cervical screening Refugee women are more receptive to receiving information via text messages compared to non-refugee women Mobile text messaging is preferred as a health education channel, especially among refugee women, and is most effective when used as a follow-up to other information sessions 78.7% of women believed in using text messages for cervical screening promotion, 80.7% wanted to receive such information, and 96.9% used text messaging on their phones

Table 1 (continued)

Authors/year	Region/Country	Study objectives	Population/sample size	Country of birth/ origin	Study design	Main findings
Anaman et al. (2017c)	Brisbane, Queensland, Australia	"Compare the level of cervical screening uptake between refugee and non-refugee African immigrant women living in Brisbane." "Examine the socio-demographic and health-related factors associated with receiving cervical screening services."	African refugee and non-refugee immigrant women (n = 254)	Liberia, Sudan, Ghana, Nigeria, Zimbabwe, Sierra Leone, Congo and others (not specified)	Quantitative, cross-sectional survey, observational study	In Brisbane, two out of every three African immigrant women have had Pap smears. However, non-refugee women are more likely to get screened than refugee women Immigration status alone does not predict how likely women are to get screened. Instead, factors like having a job, how many children they have, how often they visit healthcare providers, and what they know about Pap smears are more important Most women get screened by chance during regular doctor visits rather than through organised programs. This suggests a need for better health promotion efforts to encourage regular screening among African immigrant women

Table 1 (continued)

Authors/year	Region/Country	Study objectives	Population/sample size	Country of birth/ origin	Study design	Main findings
Anaman et al. (2018)	Brisbane, Queensland, Australia	"Examine the adequacy of knowledge and the factors associated with knowledge on cervical cancer and cervical screening tests among African-born women living in Brisbane, Australia." "Examine whether the level of knowledge varied between refugee and non-refugee women."	African refugee and non-refugee immigrant women (n = 254)	Liberia, Sudan, Ghana, Nigeria, Zimbabwe, Sierra Leone, Congo and others (not specified)	Quantitative, cross-sectional survey, observational study	Most participants (78.3%) had heard of cervical cancer and Pap smear tests, but only a minority had adequate knowledge about them (24.8%) Refugee women had significantly less knowledge about cervical cancer and Pap smear tests compared to non-refugee women Higher education levels were associated with better knowledge about Pap smear tests

Table 1 (continued)

Authors/year	Region/Country	Study objectives	Population/sample size	Country of birth/ origin	Study design	Main findings
Belihu et al. (2016)	Australia	"Investigate perinatal health outcomes of women from four African countries: Eritrea, Ethiopia, Somalia, and Sudan."	Immigrant women from four Eastern African countries (n = 4812) and Australian-born women (n = 427,755)	Eritrea, Ethiopia, Somalia, Sudan, and Australia	Quantitative, population-based observational study (Retrospective)	East African immigrant women in Victoria had increased odds of adverse perinatal outcomes like SGA, deficient birth weight, very preterm birth, and perinatal mortality compared to Australian-born women Eritrean and Sudanese women showed particularly high risks for adverse perinatal outcomes "East African women had lower odds of preterm birth and macrosomia compared to Australian-born women."

Table 1 (continued)

Authors/year	Region/Country	Study objectives	Population/sample size	Country of birth/ origin	Study design	Main findings
Belihu et al. (2017a)	Victoria, Australia	"Investigate the use of episiotomy and incidence of severe perineal tear (third or fourth-degree lacerations) among women born in Eastern African countries (Eritrea, Ethiopia, Somalia and Sudan) compared with Australian-born women, using birth data routinely reported to the Victorian Perinatal Data Collection (VPDC)"	African immigrant women from four Eastern African countries (n = 3,502) and Australian-born women (n = 203,206)	Eritrea, Ethiopia, Somalia, Sudan, and Australia	Quantitative, population-based observational study (Retrospective)	"Eastern African immigrant women had a higher incidence of episiotomy compared to Australian-born women during both non-instrumental and instrumental vaginal births." "The odds of severe perineal trauma were significantly higher for Eastern African immigrants during non-instrumental vaginal births, especially for women from Eritrea and Sudan." "Healthcare providers need to be aware of these increased risks and develop strategies to reduce unnecessary episiotomies and enhance perineal safety."

Table 1 (continued)

Authors/year	Region/Country	Study objectives	Population/sample size	Country of birth/ origin	Study design	Main findings
Belihu et al. (2017b)	Victoria, Australia	"Study variations in first-time caesarean birth, particularly unplanned CS in labour, between Eastern African immigrants (Eritrea, Ethiopia, Somalia, Sudan) and Australian-born women using the Victorian Perinatal Data Collection (VPDC)."	African immigrant women from Eastern African countries (n = 4,057) and Australia (n = 237,943)	Eritrea, Ethiopia, Somalia, Sudan, and Australia	Quantitative, population-based observational study (retrospective)	Eastern African immigrants in Victoria have significantly higher odds of unplanned first-time caesarean sections in labour compared to Australian-born women These disparities are not explained by socio-demographic or clinical risk factors, indicating potential influences from communication difficulties and support systems
Benza and Liamputtong (2017)	Melbourne, Victoria, Australia	"Discuss the meanings and experiences of motherhood from the perspectives of Zimbabwean women living in Melbourne, Australia."	Zimbabwean immigrant women (n = 15)	Zimbabwe	Qualitative study design	"Unfamiliarity with the Australian health and social care systems contributes to feelings of being overwhelmed among migrant women."

Table 1 (continued)

Authors/year	Region/Country	Study objectives	Population/sample size	Country of birth/ origin	Study design	Main findings
Due et al. (2022)	Australia	"Understand the relationship between psychological wellbeing and perinatal care amongst women with refugee backgrounds from African countries." "Identify areas for improved perinatal healthcare services in Australia in relation to the psychological wellbeing outcomes in this population."	African refugee women (n = 19)	Sierra Leone, Liberia, Democratic Republic of Congo, Somalia, Ethiopia, Burundi, Ghana, Nigeria	Qualitative study design	"Continuity of care is crucial for the psychological wellbeing of refugee women from African backgrounds." "Culturally safe and trauma-informed care is essential to meet the needs of refugee women effectively." Empowering refugee women to be "equal decision-makers in their perinatal care can improve wellbeing outcomes."

Table 1 (continued)

Authors/year	Region/Country	Study objectives	Population/sample size	Country of birth/ origin	Study design	Main findings
Gibson-Helm et al. (2014)	Australia	"Report maternal health, pregnancy care attendance and pregnancy outcomes among three cohorts of women born in African humanitarian source countries (HSC) compared to women born in African non-HSC, at one of Australia's largest health services."	African refugee and immigrant women (n = 2173)	North Africa (Algeria, Egypt, Libya, Morocco, Tunisia, and Sudan) Middle, East and Southern Africa (Angola, Burundi, Comoros, the Democratic Republic of Congo, Eritrea, Kenya, Mauritius, Mozambique, Rwanda, Seychelles, Tanzania, Zambia, and Zimbabwe) West Africa (Burkina Faso, Ghana, Guinea, Liberia, Mali, Mauritania, Nigeria, and Sierra Leone)	Quantitative, observational study (retrospective)	"Women of refugee backgrounds from African regions are at greater risk of adverse pregnancy outcomes compared to non-refugee migrant women." "Gestational diabetes mellitus is more common among women from Middle and East African humanitarian source countries." Stillbirth rates are highest in the West African humanitarian source country group

Table 1 (continued)

Authors/year	Region/Country	Study objectives	Population/sample size	Country of birth/ origin	Study design	Main findings
Hawkey et al. (2022)	Sydney, Australia, and Vancouver, Canada	"Identify migrant and refugee women's preferences for SRH information and service delivery."	Women refugees and migrants from Africa, Asia and South America (n = 84 for individual interviews and n = 85 for focus groups)	African countries: South Sudan, Sudan, Somalia Asia: Afghanistan, India, Iraq, Sri Lanka Various South American countries (not specified)	Qualitative study design	"Migrant and refugee women are eager to learn about sexual and reproductive health" across their lifespan using diverse modalities like group education, online resources, and GP consultations "Women emphasised the need for empathetic SRH care, including longer consultation times, privacy, and female healthcare providers" (women-centred care) Embedded programmes and community ownership Greater engagement of men in SRH education was needed to address women's SRH concerns effectively

Table 1 (continued)

Authors/year	Region/Country	Study objectives	Population/sample size	Country of birth/ origin	Study design	Main findings
Metusela et al. (2017)	Sydney, Australia, and Vancouver, Canada	"Examine constructions and experiences of sexual and reproductive health (SRH) among recent migrant and refugee women in Sydney, Australia, and Vancouver, Canada."	African, Asian and South American refugee or migrant women (n = 169)	South Sudan, Sudan, Somalia Afghanistan, India, Iraq, Sri Lanka, and various South American countries	Qualitative study design	Inadequate knowledge of SRH due to sociocultural taboos among migrant and refugee women impacts their access to necessary services Barriers to accessing SRH services, including cultural and relational factors Adverse health outcomes resulting from inadequate knowledge and barriers to service access

Table 1 (continued)

Authors/year	Region/Country	Study objectives	Population/sample size	Country of birth/ origin	Study design	Main findings
Mohale et al. (2017)	Australia	"Examine the maternity experiences of Sub-Saharan African women who had given birth in both Sub-Saharan Africa and Australia."	African migrant women (n = 14)	Burundi, Liberia, Malawi, South Africa, South Sudan and Uganda	Qualitative study design	Sociocultural norms shaped the experience of maternity Challenges to accessing maternity care include communication barriers, unfamiliarity with health systems, and differing perceptions of pain management Improving access involves enhancing health literacy, affordable care, respectful midwifery, effective communication, and cultural sensitivity

Table 1 (continued)

Authors/year	Region/Country	Study objectives	Population/sample size	Country of birth/ origin	Study design	Main findings
Ogunsiji et al. (2017)	Australia	"Report breast cancer screening status among African migrant women in Australia." "Investigate the factors associated with breast cancer screening behaviours in Australia."	Women migrants from African backgrounds (n = 264)	East Africa, West Africa, North Africa and Southern Africa (countries not specified)	Quantitative study design	"Low participation rates in breast cancer screening among African migrant women in Australia" A small percentage practice breast awareness monthly, but a more significant percentage have mammograms as recommended Practical barriers, age, employment status, and attitudes towards health check-ups are important factors affecting participation in breast cancer screening

Table 1 (continued)

Authors/year	Region/Country	Study objectives	Population/sample size	Country of birth/ origin	Study design	Main findings
Peprah et al. (2024)	Australia	"Examine the perspectives of African refugees on how culturally and religiously conditioned, constructed, and bound health beliefs, knowledge, and practices influence their experiences of access to, acceptance, and use of primary health care services and information in Australia."	African refugees (n = 11 women and n = 8 men)	Originally from 9 African countries (countries not specified)	Qualitative study design	African refugees experience "services as inaccessible and monocultural, providing information in a culturally unsafe and insensitive manner." The clinical environment was viewed as being non-inclusive and lacking diversity "Significant unmet needs and expectations regarding services." Enhanced organisational health literacy was needed to address these challenges and "reduce disparities in health access and outcomes." African refugees often resort to traditional healing practices and seek culturally familiar providers due to "unmet needs in the current health care system."

Table 1 (continued)

Authors/year	Region/Country	Study objectives	Population/sample size	Country of birth/ origin	Study design	Main findings
Power et al. (2022)	Western Sydney, New South Wales, Australia	"To assess the feasibility and acceptability of co-designed, culturally tailored cervical screening health promotion forums to address the lack of understanding of changes to the Australian cervical screening program and limited health literacy around cervical screening within CALD communities."	Refugee and migrant women from African or Middle Eastern backgrounds (n = 71 for forums and n = 49 for the evaluation)	Originally from Africa, Middle East countries (Not specified)	Mixed methods (feasibility study)	Co-designed, culturally tailored cervical screening forums are feasible and acceptable for CALD women The forums effectively improved health literacy and screening intentions among participants A 92% intention to screen post-intervention, up from 82% pre-intervention The approach successfully engaged 'hard to reach' CALD women through practical cultural tailoring

Table 1 (continued)

Authors/year	Region/Country	Study objectives	Population/sample size	Country of birth/ origin	Study design	Main findings
Shewamene et al. (2020)	Australia	"Examine African migrant women's experiences and perspectives about traditional and complementary medicine use in relation to their maternal health and wellbeing in Australia."	Migrant women from African backgrounds (n = 319 for the survey and n = 15 for the interview)	Different regions in Africa, such as Nigeria, Cameroon, and Sierra Leone in West Africa; Ethiopia and Tanzania in East Africa; Rwanda and Gabon in Central Africa; Sudan in Northern Africa; and Zimbabwe in Southern Africa	Mixed methods	"A high prevalence (72.7%) of traditional and complementary medicine (TCM) use was observed among African migrant women in Australia for maternal health and wellbeing." "Herbal medicine (61.7%) and spiritual (55.3%) were the most commonly used forms of traditional medicine." "Socio-demographic factors such as older age, lower education, higher parity, and lower income were strong predictors of traditional medicine use."

Table 1 (continued)

Authors/year	Region/Country	Study objectives	Population/sample size	Country of birth/ origin	Study design	Main findings
Shewamene et al. (2021)	Sydney, New South Wales, Australia	"Determine if acculturation influences the use of traditional medicine (TM) among African migrant women in Australia." "Explore how cultural health practices or beliefs are manifested among African migrant women in Australia."	Migrant women from African backgrounds (n = 319 for the survey and n = 15 for the interviews)	Ethiopia, Ghana, Liberia, Nigeria, Sierra Leone, South Sudan, Sudan, Zimbabwe, and 35 other countries (Not specified)	Mixed methods	"African migrant women in Sydney retain traditional medicine as a key part of their cultural identity and community cohesion." The majority used TCM, and the following factors played a crucial role: older age at arrival, shorter residency, and lower English proficiency TM remains important despite access to conventional healthcare, reflecting deep cultural roots

Table 1 (continued)

Authors/year	Region/Country	Study objectives	Population/sample size	Country of birth/ origin	Study design	Main findings
Watts et al. (2014a),	Melbourne, Victoria, Australia	"Discuss the contraception knowledge, attitudes and beliefs of African Australian teenagers and women with a refugee background in Melbourne."	African Australian women with a refugee background who have experienced teenage pregnancy (n = 16)	Sudan, Liberia, Burundi, Ethiopia, and Sierra Leone	Qualitative study design	Limited knowledge about contraception among African Australian teenage mothers "Cultural attitudes and external factors influencing contraception use." Cultural attitudes and myths significantly influence their decisions regarding contraception Lack of support from family and partners further hinders effective contraceptive use

Table 1 (continued)

Authors/year	Region/Country	Study objectives	Population/sample size	Country of birth/ origin	Study design	Main findings
Watts et al. (2014b)	Melbourne, Victoria, Australia	"Examine contraception awareness and use among African Australian women in Melbourne who have experienced teenage pregnancy." "Explore the social contexts that shape these women's attitudes towards contraception."	African Australian mothers who have experienced teenage pregnancy (n = 16) Key informants (African: n = 3 and Anglo Australian: n = 2)	Australia, Sudan, Liberia, Burundi, Ghana, Ethiopia, and Sierra Leone	Qualitative study design	"Parental sexual health literacy, gender roles, and cultural beliefs around motherhood influence attitudes towards contraception among young African Australian mothers." "There is low sexual health literacy among young African Australian mothers and their parents", affecting contraception knowledge and use Cultural beliefs and gender roles create barriers to contraceptive use, with a high value placed on motherhood influencing young women's choices

were conducted. The findings of this review demonstrate a diverse representation of African women in Australia, originating from various regions across the continent (Table 1). Participants included individuals originating from East Africa, West Africa, Central Africa, North Africa and Southern Africa. This diversity highlights the extensive geographic and cultural backgrounds of women of African origin residing in Australia.

Access and Utilisation of Healthcare Services

In Australia, African refugee and immigrant women accessed healthcare services for different purposes including cervical screening (Anaman et al., 2017a, 2017b, 2017c, 2018; Power et al., 2022), breast cancer screening (Ogunsiji et al., 2017), use contraceptives (Hawkey et al., 2022; Metusela et al., 2017; Watts et al., 2014a, 2014b), antenatal services and women clinics (Mohale et al., 2017; Watts et al., 2014a), maternity health services (Belihu et al., 2017a, 2017b; Benza & Liamputtong, 2017; Mohale et al., 2017), access to TCM (Shewamene et al., 2020, 2021), and mental healthcare (Due et al., 2022).

Reproductive Health Care Services

Three studies indicated that reproductive health knowledge among African migrant and refugee women was a notable concern (Hawkey et al., 2022; Metusela et al., 2017; Watts et al., 2014b). Significant gaps also persisted in menstrual health knowledge, and many women reported inadequate education prior to menarche, resulting in fear and confusion upon the onset of menstruation (Metusela et al., 2017). Furthermore, there was a widespread lack of awareness regarding fertility and menopause. In some contexts, menopause was viewed negatively, accompanied by misconceptions that it indicates illness or that menstruation should persist indefinitely (Metusela et al., 2017). Three studies revealed significant knowledge gaps about various aspects of SRH, especially in understanding sexually transmitted infections (STIs) (Hawkey et al., 2022; Metusela et al., 2017; Watts et al., 2014b). Five studies found a lack of awareness beyond human immunodeficiency virus (HIV) and widespread misconceptions regarding STI transmission and prevention (Anaman et al., 2017a; Hawkey et al., 2022; Metusela et al., 2017; Watts et al., 2014a, 2014b).

This review identified significant gaps in SRH knowledge among women of African descent in Australia, particularly regarding menstruation, menopause, STIs, and fertility. Given the extensive gaps, healthcare providers must deliver comprehensive information throughout a woman's lifespan, from adolescence to menopause (Hawkey et al., 2022; Metusela et al., 2017). Women-centred care is crucial for addressing the SRH needs of migrant women. Healthcare providers must prioritise listening to women's concerns, demonstrating empathy, and fostering trust, particularly for those who may feel stigmatised or ashamed when seeking sexual health care (Hawkey et al., 2022; Metusela et al., 2017). Increased male engagement was viewed as essential for advancing women's SRH. Women's choices regarding contraception and healthcare were often influenced by their husbands and family

members (Hawkey et al., 2022). Involving men in SRH education could facilitate cultural norm shifts and promote women's autonomy in reproductive health decisions. Programs that incorporate men as partners in health could enhance sexual relationships and empower women to obtain necessary care (Hawkey et al., 2022).

Contraceptive Use

Four studies (Hawkey et al., 2022; Metusela et al., 2017; Watts et al., 2014a, 2014b) revealed that contraceptive use among women of African origin in Australia was influenced by cultural, gender, and systemic factors. Socioeconomic status and migration experiences played a crucial role in shaping contraceptive use among African refugee and immigrant women. Refugee women faced multiple barriers, including economic hardship and instability in their resettlement, which restricted their access to and consistent use of contraceptive methods (Watts et al., 2014b). Moreover, the interplay between migration status and deeply ingrained cultural beliefs can result in low health literacy and decreased engagement with necessary health services, further impeding informed decision-making regarding contraception (Peprah et al., 2024). A study by Hawkey et al. (2022) found that language barriers and unfamiliar healthcare systems further impede access to contraceptive services.

African women residing in Australia came from conservative backgrounds where contraception was not openly discussed (Watts et al., 2014b). Family and community attitudes critically influenced contraceptive behaviours; in conservative African communities, parents might view contraception as promoting promiscuity, leading young women to avoid its use for fear of parental disapproval, as noted by Watts et al. (2014b). Furthermore, Watts et al. (2014a) found that contraceptive use might be perceived as promiscuity or distrust by male partners, further undermining women's autonomy over reproductive health. Misinformation regarding side effects, such as fears of infertility, discouraged African women from utilising contraceptives. Watts et al. (2014b) noted that these misconceptions and limited access to accurate health information contributed to low contraceptive uptake.

Cancer Screening

Six studies explored breast and cervical cancer screening among African migrant and refugee populations living in Australia, five focusing on cervical cancer screening (Anaman et al., 2017a, 2017b, 2017c, 2018; Power et al., 2022), and one study on breast cancer screening (Ogunsiji et al., 2017). These studies demonstrated that while some women were aware of Pap smear tests, many lacked adequate knowledge about cervical screening, as reported in four studies (Anaman et al., 2017a, 2017b, 2017c, 2018). Ogunsiji et al. (2017) reported similar findings for breast cancer screening. Although most African migrant women in Australia had heard of breast awareness and mammography, their participation in regular screening practices was low. Refugee women were less likely to participate in screening compared to non-refugee women, and misconceptions about cancer, particularly cervical cancer, serve as significant barriers to accessing screenings (Anaman et al., 2017c). Participation in cancer screening was negatively affected by women's cultural and religious

beliefs, fear, and gender norms (Anaman et al., 2017a). Many women viewed cervical screening as unnecessary or inappropriate, mainly when performed by male healthcare providers (Anaman et al., 2017a). Moreover, some women harboured misconceptions about the causes of cervical cancer, linking it to supernatural forces or cultural practices like female circumcision, which further deterred them from screening (Anaman et al., 2017a).

To address these barriers, culturally tailored and community-based interventions have proven to be effective in enhancing participation in screening programs. Educational sessions conducted within trusted community settings, particularly those that address cultural taboos and correct misinformation, have been linked to increased intentions to participate in screening among African refugee and migrant women in Australia (Power et al., 2022). In addition, the use of mobile health (mHealth) strategies—such as SMS reminders and culturally appropriate health information—offered a low-cost, scalable approach to enhance screening awareness and engagement (Anaman et al., 2017b). These findings highlight the necessity of integrating culturally responsive education with accessible delivery channels to enhance cervical and breast cancer screening among African migrant and refugee women (Anaman et al., 2017b; Power et al., 2022).

Pregnancy and Maternity Health Services

Six studies explored pregnancy and maternity health services (Belihu et al., 2017a, 2017b; Benza & Liamputtong, 2017; Due et al., 2022; Gibson-Helm et al., 2014; Mohale et al., 2017). A study by Mohale et al. (2017) identified that maternity health services and outcomes for immigrant and refugee women of African origin were influenced by a multifaceted combination of cultural, social, and healthcare factors. Despite Australia's comprehensive healthcare system, which includes universal access to maternal services through Medicare, many African women faced challenges in effectively utilising these services (Mohale et al., 2017). A study by Due et al. (2022) found that African women with refugee backgrounds in Australia experienced diverse challenges in perinatal care that significantly affected their psychological wellbeing. Continuity of care was highly valued yet infrequently received, with women seeking consistent relationships with healthcare providers to foster trust and rapport (Due et al., 2022). Cultural safety emerged as a critical issue, with numerous women encountering culturally insensitive practices, particularly concerning privacy and discussions on sensitive topics such as female genital mutilation (Due et al., 2022; Mohale et al., 2017). A primary barrier was insufficient awareness of available maternity services (Mohale et al., 2017). This lack of knowledge could result in delayed antenatal care attendance, as many women did not recognise the significance of early and regular check-ups, thus complicating access to maternity care (Benza & Liamputtong, 2017; Mohale et al., 2017).

A study by Gibson-Helm et al. (2014) found that women who were refugees from African regions faced a higher risk of complications during pregnancy compared to women who were migrants but not refugees. A study by Belihu et al. (2017a) discovered that African immigrant women had a higher rate of episiotomy (30.5%) than Australian-born women (17.2%). Gibson-Helm et al. (2014) reported that

women of refugee backgrounds from African regions were at greater risk of adverse pregnancy outcomes compared to non-refugee migrant women. A study by Belihu et al. (2017a) found that African immigrant women had higher rates of episiotomy (30.5%) compared to Australian-born women (17.2%). Severe perineal trauma was also more common among African immigrants (2.1%) than Australian-born women (1.6%). Another study by Belihu et al. (2017b) showed African immigrants had a greater likelihood of unplanned caesarean sections in labour compared to Australian-born women. Obstetric complications were more common among immigrants from Eastern Africa, and they were less likely to use epidural pain relief during childbirth (Belihu et al., 2017b). Due et al. (2022) reported that some African women experienced suboptimal perinatal care and recounted a traumatic stillbirth as a negative outcome. Communication difficulties and lack of culturally responsive health services might have contributed to these outcomes (Belihu et al., 2017b). These results present a compelling case for enhancing perinatal care for women of African descent who are refugees in Australia (Belihu et al., 2016, 2017a, 2017b; Due et al., 2022; Gibson-Helm et al., 2014). They emphasise the need for systemic changes, such as improved surveillance, continuity of care, cultural safety, and trauma-informed approaches, to reduce perinatal disparities and improve both physical and psychological health outcomes.

Mental Healthcare

Refugee women with acute mental health issues during pregnancy often faced inadequate care, revealing significant gaps in service responsiveness (Due et al., 2022). Negative experiences in the healthcare system adversely impacted the psychological wellbeing of African refugees and migrants, leading to their hesitance in seeking professional care (Due et al., 2022; Hawkey et al., 2022; Peprah et al., 2024). In a study by Due et al. (2022), a participant who had a history of multiple suicide attempts and trauma recounted distressing experiences in a closed mental health ward. She found her care to be unsuitable, which intensified her feelings of fear and vulnerability, particularly in light of her past trauma (Due et al., 2022).

Factors like psychological distress and traumatic experiences affected the utilisation of health services (Due et al., 2022; Mohale et al., 2017). Stigma and cultural beliefs often stopped African women refugees and immigrants in Australia from seeking professional mental health care (Metusela et al., 2017; Peprah et al., 2024). In one study, refugee women were afraid of losing custody of their children if they revealed mental health issues to healthcare professionals (Due et al., 2022). This fear stems from experiences in which women, especially those facing severe mental health challenges like suicidality or postnatal depression, have had their children taken away after psychiatric hospitalisation or interventions by social services (Due et al., 2022).

Mental health conditions among African refugee and migrant women were often associated with spiritual forces, punishment, or supernatural causes, which hindered their willingness to seek professional help (Peprah et al., 2024). Instead, they turned to religious or traditional healing practices rather than Western medicine (Metusela et al., 2017; Peprah et al., 2024; Shewamene et al., 2020, 2021). Furthermore, a lack

of trust in the healthcare system caused refugee women to avoid seeking help even when they were struggling with severe mental health problems (Due et al., 2022).

The mental health of African women in Australia was shaped by interrelated cultural, social, and systemic determinants. Addressing these issues requires the provision of culturally sensitive healthcare services, heightened awareness among healthcare providers, and active community engagement to improve access to and utilisation of mental health services (Peprah et al., 2024; Power et al., 2022). Studies highlighted an urgent need for trauma-informed mental healthcare that prioritises the voices of refugee and immigrant women and takes their unique trauma histories into account (Due et al., 2022; Mohale et al., 2017).

Factors Influencing the Accessibility and the Utilisation of Healthcare Services

The results from this study, framed within the Andersen Model (Andersen, 1995), identified critical predisposing, enabling, and needs factors that influenced access and utilisation of healthcare services by immigrant and refugee women of African origin residing in Australia (Table 2).

Predisposing factors, including older age at migration, shorter residency duration, and lower acculturation levels, contributed to a reliance on traditional medicine and reduced healthcare utilisation (Shewamene et al., 2020, 2021). Gender norms, patriarchal values, and lower educational attainment restricted autonomy and perpetuate misconceptions regarding healthcare (Anaman et al., 2017c; Metusela et al., 2017; Watts et al., 2014a, 2014b). Gender preferences, particularly for female practitioners, also influenced access to healthcare services (Anaman et al., 2018; Power et al., 2022). Furthermore, four studies revealed that religious beliefs may deter preventive care (Anaman et al., 2017a, 2018; Metusela et al., 2017; Ogunsiji et al., 2017), while eight studies reported that cultural practices such as female genital mutilation (FGM), cultural insensitivity and fear of medical interventions further inhibited access to healthcare services (Anaman et al., 2017b; Belihu et al., 2017a, 2017b; Gibson-Helm et al., 2014; Hawkey et al., 2022; Mohale et al., 2017; Peprah et al., 2024; Power et al., 2022; Watts et al., 2014b). Cultural insensitivity could be observed through the lack of recognition of diverse beliefs and practices within various healthcare environments (Anaman et al., 2017a; Hawkey et al., 2022; Mohale et al., 2017; Watts et al., 2014b). The lack of acknowledgement of cultural differences could have made individuals feel marginalised or disrespected. Hawkey et al. (2022) highlighted the need for healthcare professionals to consider cultural and religious contexts and to receive training to address culturally specific issues and improve communication strategies.

Enabling factors such as language barriers, unfamiliarity with the healthcare system, and financial constraints hindered access to services and ability to navigate healthcare systems, whereas the availability of interpreters, community support, and culturally sensitive care enhanced healthcare utilisation (Belihu et al., 2016; Benza & Liamputtong, 2017; Due et al., 2022; Gibson-Helm et al., 2014; Hawkey et al., 2022; Mohale et al., 2017; Ogunsiji et al., 2017; Peprah et al., 2024; Power et al., 2022; Shewamene et al., 2021; Watts et al., 2014a, 2014b). While physical

Table 2 Factors influencing the accessibility and the utilisation of healthcare services

Factors	Influence	Authors
Predisposing factors		
Age and migration history	- Older age at migration, shorter duration of residence, and lower levels of acculturation are associated with a greater reliance on traditional medicine and reduced healthcare utilisation - Young African Australian mothers have low sexual health literacy, affecting contraception knowledge and use	(Shewamene et al., 2020, 2021) (Watts et al., 2014a, 2014b)
Gender norms and roles	- Patriarchal values, submissiveness, male dominance in decision-making, and gender-based stigma discourage women from seeking reproductive healthcare	(Metusela et al., 2017; Watts et al., 2014b)
Education level	- Higher education enhances health awareness, whereas lower education is associated with poor health literacy and misconceptions, which can limit healthcare utilisation	(Anaman et al., 2017c, 2018; Shewamene et al., 2020; Watts et al., 2014a)
Religious beliefs	- Some religious affiliations discourage preventive care, like cancer screening, leading to lower healthcare engagement	(Anaman et al., 2017a, 2018; Metusela et al., 2017; Ogunsiji et al., 2017)
Cultural beliefs and norms	- Cultural beliefs such as FGM, negative perceptions, fear, embarrassment, shame, and misconceptions about healthcare services discourage utilisation of cervical screening, contraception, reproductive health, maternity care and medical interventions	(Anaman et al., 2017b; Belihu et al., 2017a, 2017b; Gibson-Helm et al., 2014; Hawkey et al., 2022; Mohale et al., 2017; Peprah et al., 2024; Power et al., 2022)
Enabling factors		
Language proficiency and services	- Availability of interpreters and translated materials improves access, while language barriers hinder healthcare utilisation	(Belihu et al., 2016; Gibson-Helm et al., 2014; Hawkey et al., 2022; Mohale et al., 2017; Ogunsiji et al., 2017; Peprah et al., 2024; Shewamene et al., 2021)
Health system structure	- Universal healthcare increases accessibility, but unfamiliarity with healthcare systems, lack of culturally tailored services, and discrimination reduce trust	(Benza & Liamputtong, 2017; Mohale et al., 2017; Peprah et al., 2024)
Financial resources	- Low income and unemployment reduce access to care, increasing reliance on traditional medicine	(Anaman et al., 2017c, 2018; Shewamene et al., 2020)

Table 2 (continued)

Factors	Influence	Authors
Community and social support	- Community-based interventions improve access, while a lack of family and community support and social isolation hinder healthcare utilisation	(Benza & Liamputtong, 2017; Power et al., 2022; Watts et al., 2014a, 2014b)
Healthcare provider engagement	- Encouragement from healthcare providers facilitates uptake, but a lack of engagement and mistrust discourage utilisation	(Anaman et al., 2017a; Due et al., 2022)
Culturally sensitive care	- Culturally centred care for refugees improves healthcare access by addressing language barriers, recognising cultural beliefs, and providing trauma-informed services. In its absence, refugees face discrimination, fear, miscommunication, and restricted access to healthcare, leading to exacerbated health outcomes	(Due et al., 2022; Hawkey et al., 2022; Mohale et al., 2017; Peprah et al., 2024; Power et al., 2022)
Needs factors		
Health literacy and perceived need	- Awareness of health conditions and screening tests increases utilisation, while poor health literacy leads to misconceptions and reluctance	(Anaman et al., 2017a, 2017b, 2017c; Power et al., 2022; Watts et al., 2014a, 2014b)
Medical conditions and vulnerabilities	- History of practices such as FGM, trauma, and high disease burden increases the need, but fear and misconceptions about disease risks limit utilisation	(Belihu et al., 2016, 2017a, 2017b; Gibson-Helm et al., 2014; Hawkey et al., 2022; Power et al., 2022)
Traditional and cultural health beliefs	- Preference for traditional medicine over conventional healthcare reduces engagement with mainstream services	(Peprah et al., 2024; Shewamene et al., 2020, 2021)

access to care generally improved in Australia, African immigrant women still faced extended waiting times and unfamiliarity with the appointment system (Mohale et al., 2017). Furthermore, African refugee and immigrant women struggled to navigate the healthcare system due to poor communication methods, complex healthcare systems, transport difficulties, cost of services, lack of standardised and culturally appropriate information, lack of awareness about available services, experiences of stigma and discrimination, prioritisation of family needs over personal health, and competing demands during early settlement (Anaman et al., 2017a, 2017b, 2018; Belihu et al., 2017a, 2017b; Benza & Liamputtong, 2017; Due et al., 2022; Hawkey et al., 2022; Mohale et al., 2017; Shewamene et al., 2021). Even women with some proficiency in English often faced challenges understanding rapid speech and unfamiliar terminology used by healthcare providers (Mohale et al., 2017). This communication gap led to misunderstandings, adversely affecting care quality (Benza & Liamputtong, 2017; Mohale et al., 2017). Encouragement from healthcare providers facilitated patient engagement, while mistrust and experiences of discrimination served to discourage it (Anaman et al., 2017a; Due et al., 2022).

Needs factors encompassed health literacy, medical conditions, and traditional beliefs, with misconceptions and fear acting as barriers to healthcare engagement (Anaman et al., 2017a, 2017b, 2017c; Belihu et al., 2016, 2017a, 2017b; Gibson-Helm et al., 2014; Hawkey et al., 2022; Peprah et al., 2024; Power et al., 2022; Shewamene et al., 2020, 2021; Watts et al., 2014a, 2014b). Three studies (Mohale et al., 2017; Shewamene et al., 2020, 2021) reported the use of TCM among women from African backgrounds. Shewamene et al. (2020) found that 72.7% used TCM, particularly for maternity healthcare services. This practice was influenced by traditional beliefs, with some women relying on TM due to perceived supernatural causes of pregnancy complications (Mohale et al., 2017; Shewamene et al., 2020). TM was pivotal for cultural cohesion and identity among these women, particularly those with limited English proficiency or shorter residency in Australia (Shewamene et al., 2021). Shewamene et al. (2020) found that age, education, parity, and income were significant predictors of TM use among these women.

Ten studies (Anaman et al., 2017a, 2017b, 2017c; Due et al., 2022; Metusela et al., 2017; Mohale et al., 2017; Peprah et al., 2024; Power et al., 2022; Watts et al., 2014a, 2014b) suggested that improving access to healthcare services for African refugees and immigrant women required boosting their health literacy through culturally sensitive education programs. Mobile health interventions (mHealth) showed promise in increasing knowledge and participation in cancer screenings by providing accessible and culturally tailored health information (Anaman et al., 2017b). These interventions and community-based health education initiatives were essential for overcoming barriers to healthcare access and improving outcomes for African migrant women (Power et al., 2022). African refugee and migrant women encountered unmet needs in healthcare systems, creating a substantial gap between their expectations and reality. This discrepancy often resulted in frustration and disillusionment, as patients perceived inadequate attention to their unique cultural requirements (Peprah et al., 2024).

This review highlights the complex and interrelated barriers that African refugee and immigrant women face in accessing healthcare in Australia. Structural and

individual-level obstacles were compounded by experiences of cultural insensitivity and discrimination within healthcare settings, which diminished trust and deterred women from ongoing engagement with services. Although many women recognised the high standard of healthcare in Australia (Mohale et al., 2017), unmet cultural and contextual needs significantly hindered their ability to fully utilise available services (Benza & Liamputtong, 2017; Mohale et al., 2017). To address these disparities, studies suggested implementing culturally competent care models, targeted health literacy interventions, and community-based support mechanisms designed explicitly for African migrant and refugee populations (Due et al., 2022; Hawkey et al., 2022; Peprah et al., 2024).

Discussion

Results from this study indicated that African refugee and immigrant women accessed healthcare services for different purposes in Australia, including cervical screening, breast cancer screening, contraceptives, antenatal services and maternity health services. However, studies indicated significant knowledge gaps in various aspects of SRH. The literature indicates that refugee and immigrant women of African origin face multiple barriers to accessing healthcare services in high-income countries, including linguistic challenges, low health literacy, transportation costs, and cultural differences (Higginbottom et al., 2019; Njue et al., 2021). Early initiation of antenatal care is prevalent, often due to a lack of awareness or understanding of available services (Saunders et al., 2022). Utilisation of preventive SRH, such as cervical cancer screening, remains low (Cudjoe et al., 2019; Davidson et al., 2022). Conversely, facilitators include the presence of female providers, access to primary care, and social support (Cudjoe et al., 2019; DeSa et al., 2022a). This misinformation is exacerbated by a lack of culturally sensitive education, hindering access to essential health interventions (Anaman et al., 2017a; Hawkey et al., 2022; Metusela et al., 2017; Watts et al., 2014a, 2014b). Linguistically and culturally tailored interventions have demonstrated efficacy in enhancing SRH outcomes, with participation in preventive measures increasing by nearly 18% (Redden et al., 2021).

Gender norms and male dominance significantly influence healthcare access for women refugees and migrants (Darebo et al., 2024). Furthermore, discrimination against women in accessing healthcare and gender-based violence, combined with inadequate male involvement in sexual and SRH decision-making, significantly impacts the dynamics of traditional gender power structures (Darebo et al., 2024; Hawkey et al., 2022). Gender-based power imbalances and sociocultural sensitivities obstruct women's ability to openly articulate their health needs (Diab et al., 2024). A discourse of shame, secrecy, and silence permeates cultural constructions of women's sexual embodiment across various migrant groups (Ussher et al., 2017). Implementing trauma-informed care and culturally sensitive strategies is essential for meeting the distinct needs of refugee women, especially those subjected to gender-based violence (Granero-Molina et al., 2023; Mathis et al., 2024). This study highlighted the importance of actively involving men in addressing the SRH needs of migrant and refugee women (Hawkey et al., 2022), and without men's support,

women may continue to feel disempowered and struggle to access essential SRH services (Hawkey et al., 2022). Engaging men as active participants in SRH education and preventive health services is a crucial solution to the challenges immigrant and refugee women face in these areas (Hawkey et al., 2022; Power et al., 2022). Men's involvement in female reproductive health fosters gender equality and improves health outcomes (Hawkey et al., 2022).

The use of contraceptives among African migrant and refugee women in Australia was associated with several factors, including sociocultural, gender, and systemic factors (Hawkey et al., 2022; Metusela et al., 2017; Watts et al., 2014a, 2014b). Research on contraceptive use among refugee and migrant women of African descent in Western countries highlights intricate challenges and patterns (Agbemenu et al., 2020; Watts et al., 2014a, 2014b). Agbemenu et al. (2020) reported low contraceptive use rates, with only 35% of participants reporting current usage. Factors influencing contraceptive use include parental attitudes, gender roles, and cultural perceptions of motherhood (Watts et al., 2014a, 2014b). Common barriers encompass concerns regarding side effects and future fertility (Agbemenu et al., 2020; Pfeil et al., 2022). Refugee women frequently experience elevated rates of unintended pregnancies and unmet contraceptive needs (Aptekman et al., 2014; Korkut et al., 2022). Researchers emphasise the necessity for culturally congruent education and community-based strategies to enhance contraceptive knowledge and access among African refugee and immigrant women (Agbemenu et al., 2020; Olorunsaiye et al., 2024).

Results showed that women of African origin in Australia had some awareness about cervical cancer and Pap smear tests, and few had adequate knowledge. Challenges to cervical cancer included cultural and religious beliefs, fear, embarrassment, and gender norms that posed significant barriers to cervical cancer screening (Anaman et al., 2017a). Similarly, the literature on cancer screening among African refugee and immigrant women identified significant barriers and low uptake rates, and common obstacles include language barriers, lack of awareness regarding screening procedures, cultural beliefs, fear of examinations, and difficulties navigating healthcare systems (Elizabeth et al., 2021; Ghebrendrias et al., 2021). Culturally tailored patient navigation programs effectively enhance screening rates (Rodriguez-Torres et al., 2019). Developing innovative, culturally appropriate educational materials and interventions that address the socio-ecological factors influencing screening behaviours among refugee and immigrant women (Luft et al., 2021; Racine & Isik Andsoy, 2022).

Data from studies on breast and cervical cancer screening (Anaman et al., 2017a, 2017b, 2017c, 2018; Ogunsiji et al., 2017; Power et al., 2022) highlighted the need for a multifaceted approach to improving cervical and breast cancer screening among African migrant women in Australia. Practical solutions, such as mHealth tools and culturally tailored health education, offer promising pathways to addressing the socio-economic and cultural barriers that prevent women from regular cancer screening (Anaman et al., 2017b). By combining technological interventions with community-based, culturally sensitive programs, healthcare providers can better reach hard-to-reach populations such as refugees and migrants and improve knowledge and participation in life-saving cancer screening programs (Anaman

et al., 2017b; Power et al., 2022). Through this integrated approach, the persistent disparities in cancer screening among African migrant women can be significantly reduced, leading to better health outcomes and earlier detection of cancer (Power et al., 2022).

In Australia, studies on healthcare services access and utilisation among African refugees and immigrant women indicated that traditional therapies were frequently used alongside Western biomedical care (Mohale et al., 2017; Shewamene et al., 2020, 2021). Traditional and complementary medicine (TCM) is gaining global recognition and popularity, with a significant number of the world's population relying on traditional techniques for healthcare (Zhang et al., 2024), particularly in developing countries where it is often the primary healthcare source (Adam et al., 2023; Makunga et al., 2008). The prevalence of traditional plant-based remedies is notably high in many African nations; in Ghana, for example, most of the population relies on TM for healthcare (Adam et al., 2023). This trend can be attributed to the traditional healing practices' cultural and spiritual significance and the limited availability and high costs associated with Western biomedical care (Legesse & Babanto, 2023). The increasing demand for TCM is driven by its accessibility, affordability, and potential economic opportunities (Tosun et al., 2020). However, challenges remain in evaluating the safety, efficacy, and quality of TCM products and practices (Lin et al., 2021). Efforts are being made to integrate TCM into evidence-based clinical practice and health systems globally, focusing on scientisation and standardisation (Mordeniz, 2019; Zhang et al., 2024). This integration aims to provide a more comprehensive approach to healthcare, combining traditional wisdom with modern scientific methods (Mordeniz, 2019).

African refugee and immigrant women face unique challenges in accessing maternity healthcare, contributing to higher rates of adverse events such as low birth weight, preterm birth, and perinatal mortality among this population. However, a study conducted in the United States by Agbemenu et al. (2019) suggested that refugee women may have better reproductive health outcomes than native-born populations, potentially due to the healthy immigrant effect (HIE). In Australia, significant disparities in perinatal outcomes have been observed between African immigrant and Australian-born women (Belihu et al., 2016, 2017a, 2017b). In this review, it was noted that the HIE remains significantly underexplored among women from refugee and migrant backgrounds. Only three studies provided comparative data on maternity health outcomes between African migrant and refugee women and Australian-born women (Belihu et al., 2016, 2017a, 2017b), underscoring a notable gap in the literature. Results from those studies indicated that African women, specifically those from Eritrea and Sudan, faced heightened risks of adverse outcomes such as small-for-gestational-age births, low birth weight, and perinatal mortality compared to their Australian-born counterparts (Belihu et al., 2016). Furthermore, increased rates of episiotomy and unplanned caesarean sections have been documented among this population (Belihu et al., 2017a, 2017b).

The literature indicates that HIE in Australia is generally a nuanced and dynamic phenomenon shaped by multiple factors, including the specific health domain, immigrants' country of origin, language background, and duration of residence

(Jatrana et al., 2017; Lee, 2019; Pasupuleti et al., 2016). While a considerable body of literature confirms that newly arrived immigrants often exhibit better physical health compared to native-born Australians—a trend attributed to selective migration policies that favour healthier individuals—this advantage tends to diminish over time, typically within 10 to 20 years post-migration (Elshahat et al., 2022; Huang et al., 2023; Markides & Rote, 2018). Health convergence is frequently observed, with some immigrant groups eventually reporting poorer health outcomes than their Australian-born counterparts. In contrast, mental health trajectories are more complex: non-English-speaking immigrants commonly report lower mental health status, while third-generation immigrants have been shown to experience comparatively better mental health outcomes (Elshahat et al., 2022; Lee, 2019).

Barriers, including language difficulties, unfamiliarity with healthcare systems, and cultural disparities, hinder women's access to care (Kasper et al., 2022; Njue et al., 2021). Yeo et al. (2023) argue that refugee women often begin prenatal care later and attend fewer visits than recommended. Healthcare experiences vary widely; while some women report receiving positive, culturally sensitive care, others encounter discrimination and insensitivity (Higginbottom et al., 2019; Pangas et al., 2019). Improving care for refugee and immigrant women requires adequate, culturally competent, trauma-informed services, ensuring continuity of care and addressing psychosocial needs (Due et al., 2022). Undocumented immigrants face additional obstacles, including fears of deportation and concerns about payment (Funge et al., 2020).

Past experiences, cultural beliefs and fear of stigmatisation influence access and utilisation of mental health services and limit African women from refugee backgrounds from seeking professional help in Australia (Due et al., 2022; Peprah et al., 2024). The literature revealed that African migrant women, particularly refugees or undocumented immigrants, experience various mental health issues due to pressures in their new countries (Babatunde-Sowole et al., 2020; Olukotun et al., 2019). These pressures include family separation, cultural differences, and financial hardships (Mwanri et al., 2022). Although many African migrants struggle with mental health disorders (Osman et al., 2024), they often have difficulty accessing mental health services due to limited understanding of health systems, stigma around mental health, and a lack of culturally respectful services (Fauk et al., 2021). Enhancing access to mental health care for refugee and immigrant women requires efforts to raise awareness of mental illness, offer services that respect their cultural context and promote community involvement (DiClemente-Bosco et al., 2024; Fauk et al., 2021).

Implications of the Study

This study found that African refugee and immigrant women encountered various challenges when accessing healthcare in Australia, including difficulties in navigating healthcare systems, poor health literacy, language, and cultural and religious beliefs that discourage access and use of certain healthcare services. Gaps in SRH knowledge led to low contraceptive use, unintended pregnancies, and poor maternal

outcomes. Women of African origin in Australia face complications such as severe perineal trauma, high rates of episiotomy, and unplanned caesarean sections due to cultural practices like FGM and limited access to antenatal care. Furthermore, women often turn to TCM due to cultural familiarity and accessibility. Lack of awareness, cultural misunderstandings and gender norms can prevent them from participating in important screenings for cervical and breast cancer.

To improve healthcare for women of African descent in Australia, policies should focus on providing culturally sensitive services, ensuring access to interpreters, training healthcare providers in cultural awareness, and delivering gender-sensitive care. Community health education and mHealth technologies can help bridge knowledge gaps. Furthermore, engaging men in SRH initiatives necessitates the adoption of strategies that enhance their knowledge and shift attitudes, thereby fostering their roles as allies, partners, and agents of change. This should include implementing gender-transformative approaches, establishing male-friendly health services, and providing comprehensive sexuality education for boys. Additionally, expanding maternity healthcare services, ensuring continuity of care and incorporating traditional healing methods into mainstream healthcare can enhance overall health outcomes.

Furthermore, mental health care for African refugee and migrant women in Australia needs to be culturally sensitive and trauma-informed. It should specifically address issues such as stigma and mistrust of providers. Future research should examine the healthcare challenges faced by African-born women compared to Australian-born women with a focus on barriers to accessing and utilising healthcare services, SRH, maternal and child health, and mental health outcomes. Due to the diversity of African immigrants in Australia, future studies could compare the regions of origin of refugees and immigrants to examine whether these backgrounds have any positive or negative influence on healthcare outcomes. Future research should disaggregate data by immigration status, age at migration, education level, length of stay in Australia, and English proficiency to accurately reflect variations in healthcare access and needs. Additionally, future research and policy must prioritise the perspectives and experiences of women of African origin to ensure that the Australian health systems are inclusive. It is recommended to assess the success of culturally tailored interventions, examine long-term health effects, and consider how gender and culture influence the healthcare decision-making of women refugees and immigrants in Australia.

Conclusion

This scoping review highlights the complex interplay between healthcare access and the lived experiences of African refugee and immigrant women in Australia. Despite the availability of universal healthcare and national programmes offering subsidised services such as breast and cervical cancer screening, significant barriers persist. These include cultural and religious beliefs, language difficulties, mistrust of mainstream health systems, and a lack of culturally responsive care.

Consequently, many women turn to traditional and complementary medicine, and their engagement with essential services—especially mental health, maternal, and sexual and reproductive health—remains limited.

The similarity of obstacles experienced by both refugee and immigrant women underscores the need for a unified approach to healthcare service delivery that is culturally safe, trauma-informed, and contextually relevant. Interventions that build trust—such as the inclusion of respected community leaders, female healthcare providers, and trained interpreters—have shown promise in improving health literacy and reducing misconceptions about healthcare. These results imply that practical system-level changes are needed. Expanding access through mobile clinics, flexible service hours, and a diverse, culturally competent workforce, particularly one that includes female practitioners, can significantly reduce both structural and interpersonal barriers. Moreover, integrating traditional healing practices where appropriate may support better engagement and outcomes.

Future research should continue to explore the nuanced healthcare needs of African refugee and immigrant women, including cultural adaptation, sexual and reproductive health, maternal and child health, mental well-being, and the influence of gender norms on decision-making. Importantly, such research must centre the voices and lived experiences of these women to inform inclusive, equitable policy and practice. By addressing the identified gaps and implementing culturally responsive solutions, Australia can improve health outcomes for African migrant communities and reaffirm its commitment to equity and social inclusion in refugee and immigrant healthcare. The effective use of services would not only reduce preventable illness and improve maternal and mental health but also promote smoother cultural integration and long-term well-being.

Author Contributions Conceptualisation and design of the manuscript: Dr. Dr. mult. Alexis Harerimana, Professor Julian David Pillay, Professor Gugu Mchunu. Systematic literature search: Dr. Dr. mult. Alexis Harerimana. Data analysis: Dr. Dr. mult. Alexis Harerimana, Professor Julian David Pillay, Professor Gugu Mchunu. Study supervision: Professor Julian David Pillay, Professor Gugu Mchunu. Manuscript writing: Dr. Dr. mult.Alexis Harerimana, Professor Julian David Pillay, Professor Gugu Mchunu. Critical revisions for important intellectual content: Dr. Dr. mult. Alexis Harerimana, Professor Julian David Pillay, Professor Gugu Mchunu.

Funding Open access funding provided by Durban University of Technology. This study is funded by the Harnessing Talent (HANT) Post Doctoral Fellowship (PDF) from the Durban University of Technology (DUT), Durban, South Africa.

Data Availability Not applicable.

Declarations

Ethical approval Not applicable.

Informed consent Not applicable.

Conflicts of interests The authors declared no conflict of interest.

Clinical trial number Not applicable.

References

Adam, K., Tawiah, D., & Dorcas, A. (2023). Diseases and healthcare: The African indigenous religion practitioners' perspective in Ghana. E-Journal of Humanities, Arts and Social Sciences (EHASS), 4(6):754–760. https://doi.org/10.38159/ehass.2023465

Adibelli, D., & Şahan, Ö. (2025). Health and social problems of refugee women and their children: A qualitative case study. *Public Health Nursing*. https://doi.org/10.1111/phn.13520

Agbemenu, K., Auerbach, S., Ely, G. E., Aduloji-Ajijola, N., & Wang, H. H. (2020). Family planning trends among community-dwelling African refugee women. *Public Health Nursing, 37*(4), 478–486. https://doi.org/10.1111/phn.12725

Agbemenu, K., Auerbach, S., Murshid, N. S., Shelton, J., & Amutah-Onukagha, N. (2019). Reproductive health outcomes in African refugee women: A comparative study. *Journal of Women's Health, 28*(6), 785–793. https://doi.org/10.1089/jwh.2018.7314

Akellot, D. (2021). Challenges faced by immigrant women in accessing cervical cancer screening programmes in developed countries. *New Frontiers in Medicine and Medical Research, 14*, 163–170. https://doi.org/10.9734/bpi/nfmmr/v14/10375D

Anaman, J. A., Correa-Velez, I., & King, J. (2017b). Potential mHealth tool for promoting cervical screening: The views of refugee and non-refugee African-born women living in Brisbane, Australia. *Journal of Technology in Behavioral Science, 2*(3–4), 156–162. https://doi.org/10.1007/s41347-017-0029-z

Anaman, J. A., Correa-Velez, I., & King, J. (2017c). A survey of cervical screening among refugee and non-refugee African immigrant women in Brisbane. *Australia. Health Promotion Journal of Australia, 28*(3), 217–224. https://doi.org/10.1071/HE16017

Anaman, J. A., Correa-Velez, I., & King, J. (2018). Knowledge adequacy on cervical cancer among African refugee and non-refugee women in Brisbane. *Australia. Journal of Cancer Education, 33*(3), 716–723. https://doi.org/10.1007/s13187-016-1126-y

Anaman, J. A., King, J., & Correa-Velez, I. (2017a). Barriers and facilitators of cervical cancer screening practices among African immigrant women living in Brisbane, Australia. *European Journal of Oncology Nursing, 31*, 22–29. https://doi.org/10.1016/j.ejon.2017.09.005

Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior, 36*(1), 1–10. https://doi.org/10.2307/2137284

Aptekman, M., Rashid, M., Wright, V., & Dunn, S. (2014). Unmet contraceptive needs among refugees: Crossroads clinic experience. *Canadian Family Physician,60*(12), e613–e619.

Au, M., Anandakumar, A., Preston, R., Ray, R., & Davis, M. (2019). A model explaining refugee experiences of the Australian healthcare system: A systematic review of refugee perceptions. *Bmc International Health and Human Rights,19*, 1–23. https://doi.org/10.1186/s12914-019-0206-6

Babatunde-Sowole, O. O., DiGiacomo, M., Power, T., Davidson, P. M., & Jackson, D. (2020b). Resilience of African migrant women: Implications for mental health practice. *International Journal of Mental Health Nursing,29*(1), 92–101. https://doi.org/10.1111/inm.12663

Babatunde-Sowole, O. O., Power, T., Davidson, P., DiGiacomo, M., & Jackson, D. (2020a). Health screening and preventative health care in refugee women: A qualitative analysis. *Contemporary Nurse,56*(1), 62–79. https://doi.org/10.1080/10376178.2020.1739543

Barragan, E., Dhavan, P., Fortier, J. P., Mosca, D., Weekers, J., & Wickramage, K. P. (2017). Migration and health in the Sustainable Development Goals. International Organization for Migration (IOM).

Barrio-Ruiz, C., Ruiz de Viñaspre-Hernández, R., Colaceci, S., Júarez-Vela, R., Santolalla-Arnedo, I., Durante, Á., & Di Nitto, M. (2023). Language and cultural barriers and facilitators of sexual and reproductive health care for migrant women in high-income European Countries: An integrative review. *Journal of Midwifery & Women's Health, 69*(1), 71–90. https://doi.org/10.1111/jmwh.1354571

Belihu, F. B., Davey, M. A., & Small, R. (2016). Perinatal health outcomes of East African immigrant populations in Victoria, Australia: A population-based study. *BMC Pregnancy and Childbirth, 16*(1), 1–11. https://doi.org/10.1186/s12884-016-0886-z

Belihu, F. B., Small, R., & Davey, M. A. (2017a). Episiotomy and severe perineal trauma among Eastern African immigrant women giving birth in public maternity care: A population-based study in Victoria. *Australia. Women and Birth, 30*(4), 282–290. https://doi.org/10.1016/j.wombi.2016.11.008

Belihu, F. B., Small, R., & Davey, M. A. (2017b). Variations in first-time caesarean birth between Eastern African immigrants and Australian-born women in public care: A population-based investigation in Victoria. *Australian and New Zealand Journal of Obstetrics and Gynaecology,57*(3), 294–301. https://doi.org/10.1111/ajo.12491

Benza, S., & Liamputtong, P. (2017). Becoming an 'Amai': Meanings and experiences of motherhood amongst Zimbabwean women living in Melbourne, Australia. *Midwifery, 45*, 72–78. https://doi.org/10.1016/j.midw.2016.12.011

Boese, M., & Moran, A. (2021). The regional migration-development nexus in Australia: What migration? Whose development? *Frontiers in Sociology, 6*, 602487. https://doi.org/10.3389/fsoc.2021.602487

Caulford, P., & Rahunathan, S. (2019). Caring for refugees, new immigrants, and uninsured women. *Ethical Issues in Women's Healthcare, 2019*, 89–91. https://doi.org/10.1093/med/9780190851361.003.0003

Chalouhi, J., Currow, D. C., Dumit, N. Y., Sawleshwarkar, S., Glass, N., Stanfield, S., Digiacomo, M., & Davidson, P. M. (2025). The health and well-being of women and girls who are refugees: A case for action. *International Journal of Environmental Research and Public Health,22*(2), 204. https://doi.org/10.3390/ijerph22020204

Chawhanda, C., Ojifinni, O., Levin, J., & Ibisomi, L. (2024). Access to and provision of sexual and reproductive health services in Ekurhuleni, South Africa: Experiences and coping strategies of migrant women and healthcare workers. *African Journal of Reproductive Health,28*(8), 30–47. https://doi.org/10.29063/ajrh2024/v28i8.4

Clark, A., Gilbert, A., Rao, D., & Kerr, L. (2014). "Excuse me, do any of you ladies speak English?" Perspectives of refugee women living in South Australia: Barriers to accessing primary health care and achieving the Quality Use of Medicines. *Australian Journal of Primary Health,20*(1), 92–97. https://doi.org/10.1071/PY11118

Cudjoe, J., Turkson-Ocran, R.-A., Ezeigwe, A. K., Commodore-Mensah, Y., Nkimbeng, M., & Han, H.-R. (2019). Recruiting African immigrant women for community-based cancer prevention studies: Lessons learned from the Afropap study. *Journal of Community Health, 44*(5), 1019–1026. https://doi.org/10.1007/s10900-019-00677-y

Darebo, T. D., Spigt, M., Teklewold, B., Badacho, A. S., Mayer, N., & Teklewold, M. (2024). The sexual and reproductive healthcare challenges when dealing with female migrants and refugees in low and middle-income countries (a qualitative evidence synthesis). *BMC Public Health, 24*(1), 520. https://doi.org/10.1186/s12889-024-17916-0

Davidson, N., Hammarberg, K., Romero, L., & Fisher, J. (2022). Access to preventive sexual and reproductive health care for women from refugee-like backgrounds: A systematic review. *BMC Public Health, 22*(1), 1–37. https://doi.org/10.1186/s12889-022-12576-4

DeSa, S., Gebremeskel, A. T., Omonaiye, O., & Yaya, S. (2022a). Barriers and facilitators to access mental health services among refugee women in high-income countries: A systematic review. *Systematic Reviews, 11*, 1–12. https://doi.org/10.1186/s13643-022-01936-1

DeSa, S., Gebremeskel, A. T., Omonaiye, O., & Yaya, S. (2022b). Barriers and facilitators to access mental health services among refugee women in high-income countries: A systematic review. *Systematic Reviews, 11*(1), 1–12. https://doi.org/10.1186/s13643-022-01936-1

Diab, J. L., Samneh, B., Masoud, D., & Cravero, K. (2024). Gender identity as a barrier to accessing adequate and inclusive healthcare for Syrian refugees in Lebanon's northern regions. *Frontiers in Human Dynamics,5*, 1205786. https://doi.org/10.3389/fhumd.2023.1205786

DiClemente-Bosco, K., Binyungu, A., Shabani, C., Pellowski, J. A., Operario, D., Nugent, N., & Harrison, A. (2024). 'I am because you are': Community support as a bridge to mental wellbeing for

resettled African refugee women living in Rhode Island. *Global Public Health, 19*(1), 2314106. https://doi.org/10.1080/17441692.2024.2314106

Drummond, P. D., Mizan, A., Brocx, K., & Wright, B. (2011). Barriers to accessing health care services for West African refugee women living in Western Australia. *Health Care for Women International, 32*, 206–224. https://doi.org/10.1080/07399332.2010.529216

Due, C., Walsh, M., Aldam, I., Winter, A., Cooper, S., Sheriff, J., & Ziersch, A. (2022). Perinatal care for women with refugee backgrounds from African countries: A qualitative study of intersections with psychological well-being. *BMC Pregnancy and Childbirth, 22*(1), 1–12. https://doi.org/10.1186/s12884-022-04957-9

El-Gamal, S., & Hanefeld, J. (2020). Access to health-care policies for refugees and asylum-seekers. *International Journal of Migration, Health and Social Care, 16*(1), 22–45. https://doi.org/10.1108/IJMHSC-07-2018-0045

Elizabeth, A., Maysa, A. I. A., & Rima, A. (2021). A qualitative study to understand cervical cancer awareness and prevention among African immigrant women (AIW) in Iowa City, Iowa. International Journal of Women's Health, 7:117. https://doi.org/10.23937/2474-1353/1510117

Elshahat, S., Moffat, T., & Newbold, K. B. (2022). Understanding the healthy immigrant effect in the context of mental health challenges: A systematic critical review. *Journal of Immigrant and Minority Health,24*(6), 1564–1579. https://doi.org/10.1007/s10903-021-01313-5

Fauk, N. K., Ziersch, A., Gesesew, H., Ward, P., Green, E., Oudih, E., Tahir, R., & Mwanri, L. (2021). Migrants and service providers' perspectives of barriers to accessing mental health services in South Australia: A case of African migrants with a refugee background in South Australia. *International Journal of Environmental Research and Public Health, 18*(17), 8906. https://doi.org/10.3390/ijerph18178906

Floyd, A., & Sakellariou, D. (2017). Healthcare access for refugee women with limited literacy: Layers of disadvantage. *International Journal for Equity in Health, 16*, 1–10. https://doi.org/10.1186/s12939-017-0694-8

Fozdar, F. (2023). Belonging in the land down under: Black Africans in Australia. *International Migration, 61*(1), 23–38. https://doi.org/10.1111/imig.12862

Funge, J. K., Boye, M. C., Johnsen, H. L., & Norredam, M. (2020). "No papers. No doctor": A qualitative study of access to maternity care services for undocumented immigrant women in Denmark. International Journal of Environmental Research and Public Health, 17(18):1–14. https://doi.org/10.3390/ijerph17186503

Gateri, H. (2024). Calculated kindness? The voices of women refugee claimants: accessing pre-and postnatal health care services in Toronto, Ontario. Refuge, 40(1):1–18. https://doi.org/10.25071/1920-7336.41186

Gatwiri, K., & James, S. (2024). What do we know about the experiences of belonging for [Black] Africans in Australia? A systematic scoping review. *Australian Journal of Social Issues, 59*(4), 955–978. https://doi.org/10.1002/ajs4.312

Ghebrendrias, S., Pfeil, S. K., Crouthamel, B., Chalmiers, M. A., Kully, G., & Mody, S. K. (2021). An examination of misconceptions and their impact on cervical cancer prevention practices among sub-Saharan African and middle Eastern refugees. *Health Equity,5*, 382–389. https://doi.org/10.1089/heq.2020.0125

Gibson-Helm, M., Teede, H., Block, A., Knight, M., East, C., Wallace, E. M., & Boyle, J. (2014). Maternal health and pregnancy outcomes among women of refugee background from African countries: A retrospective, observational study in Australia. *BMC Pregnancy and Childbirth, 14*(1), 1–11. https://doi.org/10.1186/s12884-014-0392-0

Goldenberg, S. M., Schafers, S., Grassby, M.H.-S., Machado, S., Lavergne, R., & Wiedmeyer, M.-L. (2023). 'We don't have the right to get sick': A qualitative study of gaps in public health insurance among Im/migrant women in British Columbia. *Canada. PLOS Global Public Health, 3*(1), e0001131. https://doi.org/10.1371/journal.pgph.0001131

Granero-Molina, J., Gómez-Vinuesa, A. S., Granero-Heredia, G., Fernández-Férez, A., Ruíz-Fernández, M. D., Fernández-Medina, I. M., & Jiménez-Lasserrotte, M. d. M. (2023). Sexual and reproductive health care for irregular migrant women: A meta-synthesis of qualitative data. Healthcare, 11(11), 1–13. https://doi.org/10.3390/healthcare11111659

Guruge, S., Sidani, S., Illesinghe, V., Younes, R., Bukhari, H., Altenberg, J., Rashid, M., & Fredericks, S. (2018). Healthcare needs and health service utilisation by Syrian refugee women in Toronto. *Conflict and Health, 12*, 1–9. https://doi.org/10.1186/s13031-018-0181-x

Hawkey, A. J., Ussher, J. M., & Perz, J. (2022). What do women want? Migrant and refugee women's preferences for the delivery of sexual and reproductive healthcare and information. *Ethnicity & Health, 27*(8), 1787–1805. https://doi.org/10.1080/13557858.2021.1980772

NSW Health. (2022). NSW Refugee Health Plan 2022–2027. NSW Ministry of Health. https://www.health.nsw.gov.au/multicultural/Publications/refugee-health-plan.pdf

Queensland Health. (2022). Refugee Health and Wellbeing Policy and Action Plan 2022–2027. Queensland Health. www.health.qld.gov.au/__data/assets/pdf_file/0033/1197447/Refugee-Health-and-Wellbeing-Policy-and-Action-Plan-2022-2027.pdf

Higginbottom, G. M. A., Evans, C., Morgan, M., Bharj, K. K., Eldridge, J., & Hussain, B. (2019). Experience of and access to maternity care in the UK by immigrant women: A narrative synthesis systematic review. *British Medical Journal Open, 9*, 1–23. https://doi.org/10.1136/bmjopen-2019-029478

Huang, G., Guo, F., Cheng, Z., Liu, L., Zimmermann, K. F., Taksa, L., Tani, M., & Franklin, M. (2023). Nativity in the healthy migrant effect: Evidence from Australia. *SSM,23*, Article 101457. https://doi.org/10.1016/j.ssmph.2023.101457

Ikafa, I., Holmes, C. A., Hack-Polay, D., & Kordowicz, M. (2024). Resettlement experiences of African migrants in Australia. *Sage Open,14*(1), Article 21582440241227776. https://doi.org/10.1177/21582440241227776

Im, H., Saleh, M., & Khetarpal, R. M. (2024). Embodiment of structural vulnerability: Illness experiences among Somali refugee women in urban displacement. *Ethnicity & Health, 29*(8), 963–986. https://doi.org/10.1080/13557858.2024.2385112

Jatrana, S., Richardson, K., & Pasupuleti, S. (2017). Investigating the dynamics of migration and health in Australia: A longitudinal study. *European Journal of Population,34*(4), 519–65.

Joshi, C., Russell, G. M., Cheng, I.-H., Kay, M., Pottie, K., Alston, M., Smith, M. M., Chan, B. C., Vasi, S., Lo, W., Wahidi, S., & Harris, M. F. (2013). A narrative synthesis of the impact of primary health care delivery models for refugees in resettlement countries on access, quality and coordination. *International Journal for Equity in Health, 12*, 88–88. https://doi.org/10.1186/1475-9276-12-88

Kasper, A., Mohwinkel, L. M., Nowak, A. C., & Kolip, P. (2022). Maternal health care for refugee women - A qualitative review. *Midwifery, 104*, 103157. https://doi.org/10.1016/j.midw.2021.103157

Korkut, B., Sevinc, N., & Adahan, D. (2022). An evaluation of obstetric characteristics and contraceptive use among refugee women. *Cureus, 14*(1), 1–7. https://doi.org/10.7759/cureus.24045

Lattof, S. R., Coast, E., & Leone, T. (2018). Priorities and challenges accessing health care among female migrants. *Health Services Insights,11*, Article 1178632918804825. https://doi.org/10.1177/1178632918804825

Lee, R. (2019). Apr). Does the healthy immigrant effect apply to mental health? Examining the effects of immigrant generation and racial and ethnic background among Australian adults. *SSM Popul Health, 7*, 011–011. https://doi.org/10.1016/j.ssmph.2018.10.011

Legesse, F. M., & Babanto, A. M. (2023). Factors associated with the use of traditional medicine in Wolaita Zone, Southern Ethiopia. *Sage Open*. https://doi.org/10.1177/21582440231153038

Levac, D., Colquhoun, H., & O'Brien, K. K. (2010). Scoping studies: Advancing the methodology. *Implementation Science, 5*(1), 69. https://doi.org/10.1186/1748-5908-5-69

Lin, L. W., Ananthakrishnan, A., & Teerawattananon, Y. (2021). Evaluating traditional and complementary medicines: Where do we go from here? *International Journal of Technology Assessment in Health Care, 37*(1), 1–6. https://doi.org/10.1017/S0266462321000179

Luft, H., Perzan, M., Mitchell, R., & Schmidt, A. (2021). An integrative literature review of barriers and facilitators to cervical cancer screening among refugee women in the United States. *Health Care for Women International, 42*(7–9), 992–1012. https://doi.org/10.1080/07399332.2020.1803872

Makunga, N. P., Philander, L. E., & Smith, M. (2008). Current perspectives on an emerging formal natural products sector in South Africa. *Journal of Ethnopharmacology, 119*(3), 365–375. https://doi.org/10.1016/j.jep.2008.07.020

Markides, K. S., & Rote, S. (2018). The healthy immigrant effect and ageing in the United States and other Western countries. *The Gerontologist, 59*(2), 205–214. https://doi.org/10.1093/geront/gny136

Mathis, C. M., Steiner, J., Kappas Mazzio, A., Bagwell-Gray, M. E., Wachter, K., Johnson-Agbakwu, C. E., Messing, J. T., & Nizigiyimana, J. (2024). Sexual and reproductive healthcare needs of refugee women exposed to gender-based violence: The case for trauma-informed care in resettlement contexts. *International Journal of Environmental Research and Public Health, 21*(8), 1–21. https://doi.org/10.3390/ijerph21081046

Mengesha, Z. B., Perz, J., Dune, T., & Ussher, J. (2017). Refugee and migrant women's engagement with sexual and reproductive health care in Australia: A socio-ecological analysis of health care professional perspectives. *PLoS One,12*(7), e0181421. https://doi.org/10.1371/journal.pone.0181421

Metusela, C., Ussher, J., Perz, J., Hawkey, A., Morrow, M., Narchal, R., Estoesta, J., & Monteiro, M. (2017). "In my culture, we don't know anything about that": Sexual and reproductive health of migrant and refugee women. *International Journal of Behavioral Medicine,24*(6), 836–845. https://doi.org/10.1007/s12529-017-9662-3

Mohale, H., Sweet, L., & Graham, K. (2017). Maternity health care: The experiences of sub-Saharan African women in sub-Saharan Africa and Australia. *Women and Birth, 30*(4), 298–307. https://doi.org/10.1016/j.wombi.2016.11.011

Mordeniz, C. (2019). Introductory chapter: Traditional and complementary medicine. *INTECH, 395*, 116–124. https://doi.org/10.5772/intechopen.86373

Msabah, B. A. (2022). "When Are You Going Back to Your Country?" The refugee phenomenon and the complexity of healthcare services in South Africa. *Black Theology, 20*(1), 78–90. https://doi.org/10.1080/14769948.2022.2041777

Mwanri, L., Fauk, N. K., Ziersch, A., Gesesew, H. A., Asa, G. A., & Ward, P. R. (2022). Post-migration stressors and mental health for African migrants in South Australia: A qualitative study. International Journal of Environmental Research and Public Health, 19(13). https://doi.org/10.3390/ijerph19137914

Newbold, K. B., Cho, J., & McKeary, M. (2013). Access to health care: The experiences of refugee and refugee claimant women in Hamilton, Ontario. *Journal of Immigrant & Refugee Studies,11*, 431–449. https://doi.org/10.1080/15562948.2013.808390

Njue, C., Sharmin, S., & Dawson, A. (2021). Models of maternal healthcare for African refugee women in high-income countries: A systematic review. *Midwifery, 104*, 1–12. https://doi.org/10.1016/j.midw.2021.103187

O'Neil, T., Fleury, A., & Foresti, M. (2016). Gender equality, migration and the 2030 Agenda for Sustainable Development. Overseas Development Institute. https://media.odi.org/documents/10731.pdf

Ogunsiji, O. O., Kwok, C., & Fan, L. C. (2017). Breast cancer screening practices of African migrant women in Australia: A descriptive cross-sectional study. *Bmc Women's Health,17*(1), 32. https://doi.org/10.1186/s12905-017-0384-0

Ogunsiji, O., Wilkes, L., Jackson, D., & Peters, K. (2012). Beginning again: West African women's experiences of being migrants in Australia. *Journal of Transcultural Nursing*. https://doi.org/10.1177/1043659612441018

Olorunsaiye, C. Z., Badru, M. A., Osborne, A., Degge, H. M., & Yaya, S. (2024). Mapping the evidence on factors related to postpartum contraception among sub-Saharan African immigrant and refugee women in the United States of America: A scoping review protocol. *PLoS ONE, 19*(5), 1–12. https://doi.org/10.1371/journal.pone.0304222

Olukotun, O., Gondwe, K., & Mkandawire-Valhmu, L. (2019). The mental health implications of living in the shadows: The lived experience and coping strategies of undocumented African migrant women. *Behavioral Sciences, 9*(12), 127. https://doi.org/10.3390/bs9120127

Osamor, P. E., & Grady, C. (2016). Women's autonomy in health care decision-making in developing countries: a synthesis of the literature. International Journal of Women's Health, 191–202. https://doi.org/10.2147/IJWH.S105483

Osman, W., Ncube, F., Shaaban, K., & Dafallah, A. (2024). Prevalence, predictors, and economic burden of mental health disorders among asylum seekers, refugees and migrants from African countries: A scoping review. *PLoS One,19*(6), e0305495. https://doi.org/10.1371/journal.pone.0305495

Pandey, M., Kamrul, R., Michaels, C. R., & McCarron, M. (2022). Identifying barriers to healthcare access for new immigrants: A qualitative study in Regina, Saskatchewan, Canada. *Journal of Immigrant and Minority Health, 24*(1), 188–198. https://doi.org/10.1007/s10903-021-01262-z

Pandey, M., Maina, R. G., Amoyaw, J., Li, Y., Kamrul, R., Michaels, C. R., & Maroof, R. (2021). Impacts of English language proficiency on healthcare access, use, and outcomes among immigrants: A qualitative study. *BMC Health Services Research, 21*, 1–13. https://doi.org/10.1186/s12913-021-06750-4

Pangas, J., Ogunsiji, O., Elmir, R., Raman, S., Liamputtong, P., Burns, E., Dahlen, H., & Schmied, V. (2019). Refugee women's experiences negotiating motherhood and maternity care in a new country: A meta-ethnographic review. *International Journal of Nursing Studies*. https://doi.org/10.1016/j.ijnurstu.2018.10.005

Parliament of the Commonwealth of Australia. (2011). Inquiry into Australia's relationship with the countries of Africa. The Parliament of the Commonwealth of Australia https://www.aph.gov.au/~/media/wopapub/house/committee/jfadt/africa%2009/report/fullreport_pdf.ashx

Pasupuleti, S. S., Jatrana, S., & Richardson, K. (2016). Effect of nativity and duration of residence on chronic health conditions among Asian immigrants in Australia: A longitudinal investigation. *Journal of Biosocial Science,48*(3), 322–341. https://doi.org/10.1017/s0021932015000206

Peprah, P., Lloyd, J., Ajang, D. A., & Harris, M. F. (2024). A qualitative study of negative sociocultural experiences of accessing primary health care services among Africans from refugee backgrounds in Australia: Implications for organisational health literacy. *BMC Primary Care, 25*(1), 1–14. https://doi.org/10.1186/s12875-024-02567-2

Pfeil, S., Crouthamel, B., Chalmiers, M. A., Ghebrendrias, S., Kully, G., & Mody, S. (2022). Exploring contraception attitudes, beliefs, and practices among refugee women. *Obstetrics and Gynecology,139*, 12S-13S. https://doi.org/10.1097/01.AOG.0000826500.82555.7c

Power, R., Ussher, J. M., Hawkey, A., Missiakos, O., Perz, J., Ogunsiji, O., Zonjic, N., Kwok, C., McBride, K., & Monteiro, M. (2022). Co-designed, culturally tailored cervical screening education with migrant and refugee women in Australia: A feasibility study. *BMC Women's Health, 22*(1), 1–17. https://doi.org/10.1186/s12905-022-01936-2

Racine, L., & Isik Andsoy, I. (2022). Barriers and facilitators influencing Arab Muslim immigrant and refugee women's breast cancer screening: A narrative review. *Journal of Transcultural Nursing,33*(4), 542–549. https://doi.org/10.1177/10436596221085301

Rahman, N. (2021). Undocumented immigrants shut out. *New Labor Forum, 30*(2), 62–69. https://doi.org/10.1177/10957960211007129

Rajaratnam, S., & Azman, A. (2022). Refugee and asylum seeker women's experiences with healthcare and social environment in Malaysia. *International Journal of Environmental Research and Public Health, 19*(11), 6542. https://doi.org/10.3390/ijerph19116542

Redden, K. L., Safarian, J., Schoenborn, C., Shortall, C., & Gagnon, A. J. (2021). Interventions to support international migrant women's reproductive health in Western-receiving countries: A systematic review and meta-analysis. *Health Equity,5*, 356–372. https://doi.org/10.1089/heq.2020.0115

Rodriguez-Torres, S., McCarthy, A. M., He, W., Ashburner, J. M., & Percac-Lima, S. (2019). Long-term impact of a culturally tailored patient navigation program on disparities in breast cancer screening in refugee women after the program's end. *Health Equity,3*, 205–210. https://doi.org/10.1089/heq.2018.0104

Rogers, H., Hogan, L., Coates, D., Homer, C., & Henry, A. (2020). Responding to the health needs of women from migrant and refugee backgrounds—Models of maternity and postpartum care in high-income countries: A systematic scoping review. *Health and Social Care in the Community, 28*(5), 1343–1365. https://doi.org/10.1111/hsc.12950

Saunders, S. L., Sutcliffe, K. L., McOrist, N. S., & Levett, K. M. (2022). The associations between women who are immigrants, refugees, or asylum seekers, access to universal healthcare, and the timely uptake of antenatal care: A systematic review. *Australian and New Zealand Journal of Obstetrics and Gynaecology, 63*(2), 134–145. https://doi.org/10.1111/ajo.13632

Saunders, S. L., Sutcliffe, K. L., McOrist, N. S., & Levett, K. M. (2023). The associations between women who are immigrants, refugees, or asylum seekers, access to universal healthcare, and the timely uptake of antenatal care: A systematic review. *Australian and New Zealand Journal of Obstetrics and Gynaecology, 63*(2), 134–145. https://doi.org/10.1111/ajo.13632

Shahawy, S., Onwuzurike, C., Premkumar, A., Henricks, A. A., & Simon, M. A. (2022). Perspectives of women of refugee background on healthcare needs in a major urban metropolitan community in the US: A qualitative needs assessment. *Health & Social Care in the Community,30*(6), e5637–e5646. https://doi.org/10.1111/hsc.13989

Shergold, P., Benson, K., & Piper, M. (2019). Investing in refugees, investing in Australia: The findings of a review into integration, employment and settlement outcomes for refugees and humanitarian entrants in Australia. Commonwealth of Australia. https://www.homeaffairs.gov.au/reports-and-pubs/files/review-integration-employment-settlement-outcomes-refugees-humanitarian-entrants.pdf

Shewamene, Z., Dune, T., & Smith, C. A. (2020). Use of traditional and complementary medicine for maternal health and well-being by African migrant women in Australia: A mixed method study. *BMC Complementary Medicine and Therapies,20*(1), Article 60. https://doi.org/10.1186/s12906-020-2852-6

Shewamene, Z., Dune, T., & Smith, C. A. (2021). Acculturation and use of traditional medicine among African migrant women in Sydney: A mixed method study. *BMC Complementary Medicine and Therapies, 21*, 1–9. https://doi.org/10.1186/s12906-021-03424-w

Summerfield, J., & Regan, L. (2021). How can we achieve sustainable development goal-5: Gender equality for all by 2030? *Clinical Obstetrics and Gynecology,64*(3), 415–421. https://doi.org/10.1097/grf.0000000000000643

Tefera, G. M., & Yu, M. (2022). Immigrant women's access to healthcare services in the United States: A qualitative meta-synthesis. *Journal of Social Service Research, 48*, 285–299. https://doi.org/10.1080/01488376.2022.2035300

Theodosopoulos, L., Fradelos, E. C., Panagiotou, A., Dreliozi, A., & Tzavella, F. (2024). Delivering culturally competent care to migrants by healthcare personnel: A crucial aspect of delivering culturally sensitive care. *Social Sciences, 13*(10), 530. https://doi.org/10.3390/socsci13100530

Tosun, N., Demir, Y., & Saglik, E. (2020). Traditional and complementary medicine from health tourism perspective. International Journal of Health Management and Tourism, 5(1):32–43. https://doi.org/10.31201/ijhmt.694384

Tsai, P.-L., & Ghahari, S. (2023). Immigrants' experience of health care access in Canada: A recent scoping review. *Journal of Immigrant and Minority Health, 25*(3), 712–727. https://doi.org/10.1007/s10903-023-01461-w

Ussher, J. M., Perz, J., Metusela, C., Hawkey, A. J., Morrow, M., Narchal, R., & Estoesta, J. (2017). Negotiating discourses of shame, secrecy, and silence: Migrant and refugee women's experiences of sexual embodiment. *Archives of Sexual Behavior, 46*, 1901–1921. https://doi.org/10.1007/s10508-016-0898-9

Vange, S. S., Nielsen, M. R., Michaëlis, C., & Smith Jervelund, S. (2024). Interpreter services for immigrants in European healthcare systems: A systematic review of access barriers and facilitators. *Scandinavian Journal of Public Health, 52*, 893–906. https://doi.org/10.1177/14034948231179279

Vu, M., Besera, G., Ta, D., Escoffery, C., Kandula, N. R., Srivanjarean, Y., Burks, A. J., Dimacali, D., Rizal, P., & Alay, P. (2022). System-level factors influencing refugee women's access and utilization of sexual and reproductive health services: A qualitative study of providers' perspectives. *Frontiers in Global Women's Health, 3*, 1048700. https://doi.org/10.3389/fgwh.2022.1048700

Wångdahl, J., Lytsy, P., Mårtensson, L., & Westerling, R. (2014). Health literacy among refugees in Sweden–a cross-sectional study. *BMC Public Health,14*, 1–12.

Watts, M. C. N. C., Liamputtong, P., & Carolan, M. (2014a). Contraception knowledge and attitudes: Truths and myths among African Australian teenage mothers in Greater Melbourne. *Australia. Journal of Clinical Nursing, 23*(15–16), 2131–2141. https://doi.org/10.1111/jocn.12335

Watts, M. C. N. C., McMichael, C., & Liamputtong, P. (2014b). Factors influencing contraception awareness and use: The experiences of young African Australian mothers. *Journal of Refugee Studies, 28*(3), 368–387. https://doi.org/10.1093/jrs/feu040

Wenner, J., Biddle, L., Gottlieb, N., & Bozorgmehr, K. (2022). Inequalities in access to healthcare by local policy model among newly arrived refugees: Evidence from population-based studies in two German states. *International Journal for Equity in Health, 21*(1), 11. https://doi.org/10.1186/s12939-021-01607-y

White, J. A., & Rispel, L. C. (2021). Policy exclusion or confusion? Perspectives on universal health coverage for migrants and refugees in South Africa. *Health Policy and Planning, 36*(8), 1292–1306. https://doi.org/10.1093/heapol/czab038

Wu, C., Little, O., & McCully, B. (2022). Inequalities limiting health care access for migrant Australians–the positive impact of multiculturalism and medical student rotation to remote hospital settings. Austin J Public Health Epidemio, 9(2):1125. https://doi.org/10.26420/AustinJPublicHealthEpidemiol.2022.1125

Yeo, S., Park, Y., McClelland, D. J., Ehiri, J., Ernst, K., Magrath, P., & Alaofè, H. (2023). A scoping review of maternal health among resettled refugee women in the United States. *Frontiers in Public Health, 11*, 1157098. https://doi.org/10.3389/fpubh.2023.1157098

Zhang, Z., Li, R., Chen, Y., Yang, H., Fitzgerald, M., Wang, Q., Xu, Z., Huang, N., Lu, D., & Luo, L. (2024). Integration of traditional, complementary and alternative medicine with modern biomedicine: The scientisation, evidence, and challenges for integration of Traditional Chinese medicine. *Acupuncture and Herbal Medicine, 4*(1), 68–78. https://doi.org/10.1097/HM9.0000000000000089

Authors and Affiliations

Alexis Harerimana[1,2] · Julian David Pillay[1] · Gugu Mchunu[1]

✉ Alexis Harerimana
alexis.harerimana@my.jcu.edu.au

[1] Faculty of Health Sciences, Durban University of Technology, Durban, South Africa

[2] College of Healthcare Sciences, James Cook University, Townsville, Australia