



Research Report

Access to reproductive healthcare: Experiences of women from the African Great Lakes Region living in Sydney

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We hope that this report is useful to understand the challenges and issues related to the access of reproductive health services for women from the African Great Lakes Region living in Sydney and in shedding further light on how to improve healthcare for refugee and migrant women in Australia by providing culturally responsive and safe services.

KEY WORDS

Migrants, Refugees, Asylum seekers, Africa, Reproductive health, Access to care

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COVER PHOTO

The cover photo is of participants at a GLAPD workshop on domestic and family violence workshop in 2022.

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ACRONYMS

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
DR Congo	Democratic Republic of Congo
FG	Focus Group
GLAPD	Great Lakes Agency for Peace and Development
GP	General Practitioner
MCWH	Multicultural Centre for Women’s Health
NSW	New South Wales
NSW MOH	New South Wales Ministry of Health
PIS	Participant Information Sheet
TIS	Translating and Interpreting Service
UN	United Nations
UNSW	University of New South Wales
RCA	Refugee Council of Australia
SWSLHD	South Western Sydney Local Health District
SWSPHN	South Western Sydney Primary Health Network
WHO	World Health Organisation
WSU	Western Sydney University

KEY TERMS

Migrants	People who choose to leave their country and settle in another country (RCA, 2018). In this report, people who were born overseas whose usual residence is Australia (ABS, 2021b). Permanent migrants enter Australia via one of two formal programs: the Migration Program for skilled and family migrants, or the Humanitarian Program for refugees and those in refugee-like situations (Phillips & Simon Davies, 2016).
Refugees	People who are subject to persecution in their home country and in need of resettlement. The majority of applicants who are considered under this category are identified by the United Nations High Commissioner for Refugees (UNHCR) and referred by UNHCR to Australia (ABS, 2021b).
Asylum seekers	People who have fled their own country and applied for protection as a refugee, but have yet to receive confirmation of their refugee status (NSW MOH, 2022).
Humanitarian program/entrant	The Humanitarian Program is designed for refugees and others in special humanitarian need. There are two permanent humanitarian streams: the refugee stream and the special humanitarian stream (ABS, 2021b). The Australian Government often uses the term ‘humanitarian entrant’ interchangeably with the term ‘refugee’ (NSW MOH, 2022).

EXECUTIVE SUMMARY

Migrants and refugees often face challenges in accessing healthcare in Australia. Recent decades have seen a significant increase in the number of arrivals from Africa. The African population originates from countries with very different cultures, languages and traditions. The aim of this research was to gather information on reproductive healthcare experiences of women from three countries in the African Great Lakes Region (Rwanda, Burundi and the Democratic Republic of Congo), with the findings used to inform the design of culturally responsive services. Understanding and addressing barriers to access is crucial to meeting the reproductive health needs of this new and emerging community.

The main focus of this report, Study 1, was conducted in November and December 2015 and involved in-depth interviews with 13 women from the Great Lakes Region living in South Western Sydney. The interviews, which were conducted by female researchers with a medical background and in the participant's preferred language (Kirundi/Kinyarwanda, Swahili or English), explored the spectrum of reproductive health issues including family planning, cancer screening and maternity care. Thematic analysis identified three key themes: language barrier, healthcare experience and racial discrimination. In April 2024, Study 1 themes and recommendations were presented to three focus groups of women comprising 16 participants from the same community to see if they continued to have relevance for informing health service improvements (Study 2). While Study 2 participants endorsed the earlier findings, there was greater emphasis on primary care, mainly the lack of or reduced availability of bulk-billing GPs. Empowering women to address their health needs and the advocacy role of community organisations were also emerging themes.

Facilitating migrant and refugee women's access to individualised, culturally responsive and trauma-informed reproductive health services and information is essential for their overall health and wellbeing and successful settlement and integration. This research has addressed a gap in the literature relating to the experiences of women who come from African Great Lakes Region. The study findings confirm previous research on access to reproductive healthcare, including preventive and clinical services, among African women in Australia. They reinforce the importance of working on both the supply-side (service provider) and demand-side (service user) determinants of access. In addition to dismantling barriers, it is important to reinforce factors associated with positive healthcare experiences.

Achieving equitable access to healthcare for new migrants and refugees requires a systems approach, with a role for settlement services, health services and community organisations. Based on the literature and our study findings, we have identified several recommendations for improving access to reproductive healthcare for women from the African Great Lakes Region.

Recommendations for settlement services, health services and community organisations are listed on the next page.

Recommendations for settlement services

As the first point of contact in Australia, settlement organisations should:

- Connect refugees and migrants to GPs and other relevant healthcare providers as soon as they arrive in the country so that they could learn and benefit from all the necessary health information and services as early as possible.
- Offer culturally and linguistically competent interpreting and translation services to support effective communication between clients and service providers.
- Offer bilingual/bicultural caseworkers from new and emerging communities to assist in navigating the health system.

Recommendations for health services

Health services and reproductive healthcare providers including GPs should:

- Provide culturally competent and trauma-informed care.
- Source and make use of appropriate interpreter services—engage professional interpreters matched for language, culture and gender and preferably trained in medical terminology.
- Facilitate ongoing culture and trauma training for health professionals, including how to work effectively with interpreters.
- Recruit bilingual/bicultural health professionals, including doctors, nurses, midwives and allied health, to meet local community needs.
- Support access to female GPs for women who express a preference for a female provider due to personal choice, or cultural or religious beliefs.
- Provide bulk-billing services to enable access for those who are unable to pay the consultation fees.
- Plan and take extra time during consultations to explain and provide details of available screening and diagnostic services, especially to newly-arrived refugees and migrants.
- Develop targeted health promotion strategies to engage African immigrant women to enhance their knowledge about cervical cancer and screening practices.

Language services that support the health sector, such as those provided by NSW Health and TIS National, should:

- Develop training pathways for interpreters in new community languages and dialects.

Recommendations for community organisations

Community organisations and members should:

- Facilitate smooth integration and social support for newly-arrived migrants and refugees by connecting them with their respective communities.
- Organise education sessions to inform new arrivals of available reproductive health services, including family planning and screening, and how to access them.
- Support African immigrant women to access reproductive healthcare and information and advocate for their rights when requested.

BACKGROUND

Access to health services among immigrant Australians

Australia has a rich mix of cultural backgrounds and heritage, with the number of people who were born overseas continuing to grow (Australian Bureau of Statistics [ABS], 2021; Australian Government, 2024). The literature concerning migrant and refugee access and engagement with health services in Australia has tended to treat immigrants as a homogenous population (captured in statistical reports by the category 'overseas born'), as opposed to diverse cultural, linguistic, ethnic and racially diverse communities comprised of various subgroups in need of specifically directed health services (Cavaleri et al., 2021; Renzaho, 2023). In a somewhat more nuanced approach, the overseas born are broken down by place of origin (e.g., global region or country of birth) or native language.

Immigrants often face challenges when dealing with the health system and experience inequities in health care and health outcomes (MCHW, 2021; AIHW, 2024). Factors identified as playing significant role in the way newcomers access health services include language and communication barriers (low levels of English amongst certain populations, trouble translating complex medical terminologies, and difficulty locating services catering to their linguistic needs), cultural barriers (poor understanding of cultural norms and taboos amongst healthcare professionals, health perceptions and beliefs of patients), levels of acculturation and socioeconomic position (Kelaher et al., 1999; Blignault et al., 2008; Hach, 2012; Maneze et al., 2015; Rogers & Earnest, 2015; Zwi et al., 2017). In recent years, the special needs of refugees and asylum seekers have received greater attention (e.g., NSW MOH, 2022).

Africans in Australia

The ABS classification of countries has a three-tiered structure with nine major groups, 27 minor groups and 251 countries. Major groups include 'North Africa and the Middle East' and 'Sub-Saharan Africa', which includes the minor groups 'Central and West Africa' and 'Southern and East Africa' (ABS, 2016).

In the 2021 Census, 447,524 people, or 1.7% of Australia's total population and 6.4% of the overseas-born population reported that they were born in an African country. Most of this population, 59.1% or 264,582 people, originate from South Africa (often white South Africans with European backgrounds) or North Africa countries (primarily Egypt). The remaining 40.9% come from 46 different Sub-Saharan countries with vastly different cultures, languages and histories, reflecting the enormous diversity of the African continent (ABS, 2021). Around 50% of African immigrants speak English at home, with the remainder speaking Afrikaans, Swahili, Somali, Shona, Dinka, Amharic, Kirundi and various other African languages as well as French and Arabic (ABS, 2021).

Africans have arrived in Australia in a number of different waves. Recognising these waves of immigration helps explain different community capacities and the depth of social networks available to support newcomers (Jakubowicz, 2010). Before 1976, most came from South Africa, or from Egypt and Mauritius, and through the skilled and family migration program. Other highly skilled and educated migrants have come from Ghana, Kenya, Uganda, Nigeria, Zambia and Tanzania. The eruption of major political and environmental crises in northern and central Africa (including the Ethiopian-Eritrean war and civil wars in Somalia, Sudan, Rwanda and the Democratic Republic of Congo [DR Congo]) in the 1990s led to an increase in the humanitarian intake. These new arrivals brought with them very different national and cultural expectations—different among the various African ethno-tribal groups and different from earlier immigrant arrivals and the Australian-born population (Jakubowicz, 2010).

Since the mid-2000s, several African communities have had rapid increase in numbers, usually from a low base. They include people from Burundi (from 100 in 2004 to 3,180 in 2023), Rwanda (from 130 in 2004 to

1,270 in 2023), the DR Congo (from 360 in 2005 to 7,240 in 2023), Liberia (from 530 in 2004 to 3,360 in 2023), and South Sudan (from 100 in 2010 to 9,060 in 2023) (ABS, 2023).

Africans from all parts of Africa are now firmly part of Australian society. Like most immigrants, they settle in the capital cities (Hugo, 2009). Over the last two decades, a significant community of African migrants and refugees has developed in South Western Sydney, including people from the Great Lakes Region (named for the freshwater lakes and river basins in central and eastern Africa), which includes the DR Congo, Burundi, Rwanda, and Uganda.

This report focuses on women migrants and refugees from the DR Congo, Burundi and Rwanda. While the three countries differ somewhat in terms of their history, politics and level of development, all have suffered prolonged and violent conflict (Kanyangara, 2016). In the DR Congo, where more than 200 languages are spoken, Swahili is one of four 'national' languages. Kirundi is the national language of Burundi and Kinyarwanda is the national language of Rwanda; the languages are mutually intelligible (Encyclopedia Britannica).

Reproductive health

The COVID-19 pandemic shone a spotlight on the health inequities and access barriers faced by diverse migrant populations globally, including those related to communicable and non-communicable diseases, mental health and reproductive health (Goldenberg & Fisher, 2023). Reproductive health is an important part of a person's overall physical, mental and emotional health and wellbeing, as well as quality of life (Australian Government Department of Health, 2023). It encompasses a state of physical, mental and social wellbeing in matters relating to the reproductive system; the ability to have a safe and satisfying sex life; the ability and freedom to have a child if, when and how often you choose to; and the ability to have a healthy pregnancy, safe delivery and healthy baby. Good reproductive health includes having

access to information and family planning services; health care, including preventive screening, diagnosis and treatment of reproductive health related issues, abortion services, and pregnancy and delivery care; health care and support in cases of family, domestic and sexual violence; contraception; and protection from, and treatment of, sexually transmissible infections (Australian Government, Department of Health, 2023).

There is little research on reproductive healthcare among African women in Australia, and the studies that exist have been conducted mostly with communities from outside the Great Lakes region; generally Sudan, Somalia, Liberia, Ghana and Nigeria. They include a survey of cervical screening among 254 migrant and refugee women from several African countries living in Brisbane (Anaman et al., 2017). Countries of origin included Liberia (18.5%), Sudan (15.0%), Ghana (12.2%), Nigeria (10.2%), Zimbabwe (6.3%), Sierra Leone (6.3%), Congo (5.5%) and Other (5.0%). Correa-Velez & Ryan (2012) explored the key elements that characterise best practice in maternity care for African women from refugee backgrounds through a chart audit of 83 women who birthed at the Mater Mothers Hospital in Brisbane (including 43 from Sudan and 12 from Somalia) and interviews with 23 women (including 14 from Sudan and 5 from Burundi). In Adelaide, Mohale et al. (2017) explored the maternity experiences of 14 women who had given birth in both Sub-Saharan Africa and Australia (including 7 from South Sudan and 2 each from Liberia and Uganda). Hawkey et al. (2022) investigated migrant and refugee women's preferences for the delivery of reproductive healthcare and information in communities of migrant and refugee women living in Australia and Canada. A total of 84 individual interviews and 16 focus groups comprising 85 participants were conducted with migrant and refugee women aged 18 years and over from Somalia (38), Sudan (20), South Sudan (11), as well as Afghanistan (35), Iraq (27), Sri-Lanka (12), India (9) and various South American backgrounds (17).

There is a lack of empirical knowledge about engagement with reproductive health services by women who have come from African Great Lakes Region, who comprise a new and emerging community in this country. Greater understanding of their experiences is crucial to meeting their reproductive health needs.

RESEARCH AIMS

This research aimed to gather information on the experiences of reproductive healthcare by African women refugees and migrants from the Great Lakes Region (Rwanda, Burundi, DR Congo) living in Sydney, with the findings used to inform the delivery of culturally-responsive services.

RESEARCH DESIGN

Overview

Qualitative research design is a systematic and flexible approach to conducting research that is oriented to understanding of the context, meaning and experiences of people's lives (Creswell, 2013). This type of research design is often adopted in health research, either as a standalone study or part of mixed-methods research, as it allows researchers to deeply explore the context and nuances of a particular topic (Grbich, 1999). An interpretive framework based on pragmatism focuses on the outcomes of the research, making it especially useful for applied research concerned to find actionable strategies for solving real-world problems (Creswell, 2013). Using methods such as interviews and focus groups, researchers aim to gather rich, detailed information that can provide insights into the subjective experiences of individuals or groups (Grbich, 1999). Cross-cultural qualitative research brings additional ethical and methodological challenges (Liamputtong, 2010).

The study that is the main focus of this report (Study 1) was conducted in November and December 2015 and involved in-depth interviews with 13 women from the African Great Lakes Region living in South Western Sydney. In April 2024, the findings from that study were presented to three focus groups of women comprising 16 participants from the same community to see if they continued to have relevance for informing health service improvements (Study 2).

Partners

The Great Lakes Agency for Peace and Development (GLAPD), established in 2012, is a not-for-profit, charitable organisation helping migrants, refugees and asylum seekers from Africa and beyond settle in Australia. The main office is in Harris Park in the heart of Western Sydney. GLAPD community services and initiatives aim to help new arrivals achieve better living standards while supporting them through the process of integrating and learning how to do things in a new country. Programs and services include regional resettlement, migrant services, community development and social integration, and youth support services. Research projects, conducted in partnership with universities, provide important insights for evidence-based programs tailored to community needs (e.g., Dagistanli et al., 2020; Umutoni Wa Shema et al., 2020).

The university partners in this research were UNSW Sydney and Western Sydney University.

Setting

At the 2011 Census, just under half of all immigrants in Australia lived in either Sydney or Melbourne, with 1.4 million Sydney residents and 1.2 million Melbourne residents being born overseas (ABS, 2014). South Western Sydney is one of the fastest growing regions in NSW and has one of the largest migrant and refugee populations in the state (SWSLHD & SWSPHN, 2019). The majority of humanitarian entrants who arrive in NSW tend to settle in the South Western Sydney and Western Sydney (RCA, 2018). An individual in South Western Sydney is 2.6 times more likely to speak a language other than English, and 1.6 times more likely to be born overseas, compared to rest of the NSW population. After English, the most common languages spoken are Arabic, Vietnamese and Cantonese (SWSPHN, 2024). Africans from the Great Lakes Region are a new and emerging community in this region.

South Western Sydney is also socioeconomically diverse, with large disparities between most and least disadvantaged people and places. Such cultural and socioeconomic diversity brings challenges for service delivery (SWSLHD & SWSPHN, 2019).

Target group

The target group for the research project was women aged 18 and above from the Great Lakes Region, either refugees or migrants, living in South Western Sydney.

Researcher backgrounds and roles

This research was conducted by five researchers who actively participated in the different stages of the project. The team members have extensive experience in designing, coordinating and undertaking research. The African researchers (NUWS, AN and AI), all from Rwanda, were involved in both studies. NUWS is co-founder and the Settlement Operations Manager at GLAPD. She is an overseas-trained medical doctor, a public health professional and a refugee advocate. AN now works as Senior Epidemiologist with NSW Health. An overseas-trained doctor with post-graduate qualifications in public health and health management, her daily work focuses on notifiable disease surveillance and management, and her research interests include using available and purpose collected health data to conduct research that inform practices. AI now works for the International Organisation for Migration in Africa. Like the other two African researchers, she obtained her medical degree overseas and post-graduate qualifications in public health and health management at UNSW Sydney.

The two academic researchers, HW and IB, were involved in Study 1 and Study 2, respectively. At the time of her involvement HW was Professor of Global Health at the School of Public Health and Community Medicine at UNSW Sydney. She is an international expert in the social aspects of gender, sexual and reproductive health, as well as HIV in the Pacific region. IB joined the research in 2023. She is Adjunct Associate Professor at the Translational Health Research Institute, Western Sydney University. She has extensive experience working in cross-cultural settings and her research interests include the social and cultural determinants of health, health service delivery in a multicultural society, and health promotion.

For Study 1, NUWS, AN and AI administered and transcribed/translated the interviews and conducted the analysis under the leadership of HW. As female doctors from the Great Lakes Region, coming from the same background and speaking the same languages, and with experience in conducting interviews, they were trusted by community and participants felt comfortable to give honest answers to the interview questions. For Study 2, where IB provided academic leadership, NUWS facilitated the focus groups with AN and AI as co-facilitators; all three contributed to the analysis. NUWS played a key coordination role in both studies. IB and NUWS drafted the final report.

STUDY 1

Methods

Recruitment

Participants were recruited in three different ways: via email, text messages and word-of-mouth. The GLAPD caseworker emailed all female clients from the Great Lakes Region on the GLAPD database asking them if they would consider being part of the research.

For women who said 'yes', the African researchers (NUWS, AN and AI) shared the Participant Information Sheet (PIS) and the Consent Form in the preferred language. Those who agreed to participate were enrolled and the researchers scheduled an interview. Additionally, the researchers sent text messages and spoke to eligible women from the three communities in their networks asking if they would consider being part of the research project. As before, for those who said 'yes', they shared PIS and the Consent Form in the preferred language. Those who agreed to participate were enrolled and interviews were scheduled at a time and place (GLAPD office or home) convenient for them.

Data collection

The method used in Study 1 was in-depth interviews. In-depth interviews are useful in conducting qualitative research for 'understanding complex and contradictory social processes' (Gregory et al., 2009, p. 393) as they provide space for participants to discuss and elaborate on their accounts. Within this research, it was particularly important to use this method as it provides each participant with the opportunity to articulate her specific experience in depth and allows for accounts that may not have been anticipated by the research team.

An important aspect of cross-cultural research is the consideration of specific language needs. For this research, the main languages spoken by participants were Kirundi/Kinyarwanda, Swahili and English. Members of the research team speak each of these languages fluently, and participants were invited to be interviewed in the language of their choosing. The PIS and Consent Form were translated into both Kirundi/Kinyarwanda and Swahili. This is significant given that lack of English has been identified as a barrier to participation for research in instances where other language options were not made available to participants (Liamputtong, 2010). Conducting research in a familiar language can support more trusting research relationships (Madriz, 1998) and allows participants to gain a better understanding of the research aims, and therefore make more informed consent for participation (Gillam, 2013; Obijiofor et al., 2018).

The semi-structured interview guide incorporated open-ended questions to ensure continuity within the data while allowing space for participants to discuss aspects of their reproductive health access that were important to them (Appendix 1). It was divided into four sections. The first questions explored the women's knowledge and understanding of reproductive health issues and the information and services available. After that, they were asked to describe their experiences (including the barriers and challenges) of accessing reproductive health services in their area, including family planning and cancer screening, and health facility and health worker practice.

Thirteen interviews were conducted by the three African researchers (NUWS 7 interviews, AN 3 interviews and AI 3 interviews); two were conducted in English, one in Swahili, and ten in Kirundi/Kinyarwanda. Twelve were conducted at participant's homes and one at the GLAPD office. Participants felt more comfortable at their homes and some of them had children to look after, therefore travelling to another place with children could have been very difficult for them. A safety assessment was done via phone beforehand.

Analysis

The interviews, which were audio recorded with consent, lasted between 30 and 45 minutes. Those conducted in English were simply transcribed. Where a language other than English was used, the interviews were translated and transcribed into English by a member of the research team. This was the quickest and most effective way to have all the interview transcripts in English to facilitate the thematic analysis (Braun & Clarke, 2006).

Following transcription, the interviews were closely read and manually coded by NUWS. Initially, ten subthemes were identified that loosely followed the interview questions. Participants' accounts of their experiences were complex and rich and several of the subthemes intersected with one another. With the support of HW, and with the existing literature in mind, they were ultimately organised into three key themes and recommendations. For each theme, NUWS extracted quotes from different participants, summarised the issues and provided explanations. IB wrote up the findings which were reviewed by NUWS.

For this report, the participants were given virtue names to keep them anonymous. The following sociodemographic characteristics were recorded for each woman: age (18-29, 30-39, 40-49, 50-59 years); country of origin (Burundi, Rwanda, DR Congo); length of time in Australia (0-5, 6-10, 11-15, 16-20 years); education (none, primary, secondary, university); marital status (single, married, widowed, separated); and number of children. Proficiency in spoken English was rated by NUWS according to the ABS classification (very well, well, not well, not at all).

Ethics

Ethics approval to conduct the study was obtained from the UNSW Human Research Ethics Committee (HC 15711).

Findings

Participant characteristics

Six of the 13 participants came from Rwanda, four came from Burundi and three came from the DR Congo (Table 1). In terms of migration pathway, four came to Australia as migrants, four came as refugees and five were asylum seekers. Five participants had been in Australia for 0–5 years, five for 6–10 years and three for 11–15 years. Most of the women were aged in their thirties and married with two or three children (mean 2.7, range 0–7). Six had attended university, five had only secondary education and two had only primary education. Regarding English proficiency, three participants were assessed as speaking English 'very well'. Of the rest, six spoke English 'well' and four spoke English 'not well'.

Table 1. Participant characteristics

Name*	Age (years)	Country of origin	Migration pathway	Years in Australia	Education	Speaks English
Peace	30-39	Rwanda	Asylum seeker	0-5	Secondary	Not well
Joy	30-39	Rwanda	Migrant	6-10	University	Very well
Faith	30-39	Burundi	Asylum seeker	0-5	University	Not well
Grace	50-59	DR Congo	Refugee	11-15	Secondary	Well
Blessing	30-39	Rwanda	Migrant	6-10	Secondary	Well
Precious	18-29	Rwanda	Asylum seeker	0-5	University	Well
Hope	50-59	Burundi	Refugee	11-15	Primary	Not well
Favour	30-39	DR Congo	Migrant	6-10	Secondary	Well
Trust	30-39	Rwanda	Asylum seeker	0-5	University	Very well
Promise	18-29	Burundi	Refugee	6-10	University	Very well
Mercy	18-29	DR Congo	Asylum seeker	0-5	University	Well
Charity	30-39	Burundi	Refugee	11-15	Primary	Not well
Felicity	30-39	Rwanda	Migrant	6-10	Secondary	Well

*We gave participants virtue names to keep them anonymous.

Key themes

Language barrier

Most of the interviewees reported language as the major barrier in utilising the available reproductive health services. They struggled to express themselves in English or to fully understand what they were being told and the information provided. Even those who spoke English well had difficulty with some service providers' accents. Lack of understanding of the Australian health system was stated to be a contributing factor. The following quotations are illustrative.

"I can say it is language. Because sometimes you want to express in your own language then you can't. Because you can't speak to the nurse or the doctor in your language. That is only the problem that most African refugees face in this country. There is a stage you feel you want to talk in your language, but you can't." (Favour)

"I know some English but I couldn't understand some of the doctors' accent at all. No information, everything is up to the patient to decide etc." (Mercy)

Three participants explained that they relied on their husbands to interpret what the health worker was saying, for example one stated:

“I have never accessed a facility which speaks my language, but we struggle just to make sure we understand what they are explaining to us... I was with my husband, whenever the point I don’t understand I clarify from him.” (Favour)

Another woman explained how she used a friend to help:

“I do not understand the language and I miss on much information especially because they seem to not have enough time for me. I am most of the time unable to ask things that I want to know. For example, last time while pregnant I was told that I had DVT and had to stay in the hospital, but I couldn’t understand till I called my friend from my country who spoke to the doctor and explained to me better. It is really hard when you don’t understand, and they have no time to explain to you.” (Charity)

Although professional healthcare interpreters were used on some occasions, even this could be problematic. One woman described how she was provided a wrong interpreter—a man from another country who did not speak her language and did not correctly interpret what she said:

“English is very difficult and it’s still a big challenge for us. There are some places where you are fairly treated and some places where you are not. I went somewhere and I had an issue with my leg, I was therefore taken to a hospital in the city, I can’t even remember properly where it was because it was just after I arrived in Australia. I told them that I speak Kinyarwanda and Kirundi, then they looked for an interpreter who was speaking Swahili, he was Sudanese. I would tell them that I was feeling pain in my legs and the interpreter would tell them that I had had pain in my head for four years. Not speaking English is a big challenge here for many women.” (Hope)

The same woman had concerns about confidentiality when using a professional interpreter, explaining:

“The language barrier is a big deal. There are some conditions that you don’t feel comfortable to tell the interpreters because you don’t want it to be revealed in the community, but if you have a doctor or a nurse who can speak your language it’s easier because you know that you are talking to a professional.” (Hope)

Only two participants felt that did not have any problem with language:

“I did not have any language barrier and I think everywhere they respect everyone’s belief. Like the services are not specific for any culture, they just help everyone they have, they don’t take into consideration anything, so I did not experience anything.” (Joy)

“I didn’t meet any challenge because I had the chance to know bit of English and everywhere I went I could communicate, and whenever I had trouble expressing myself they would help me.” (Blessing)

Healthcare experience

While recognising that the service providers were busy—"they seem to have a lot of work"—many participants considered that Australian health system was not sufficiently patient-centered. Long waiting times and short consultation times were seen as problematic, along with a lack of continuity of care.

"It is very different from my country; we had our family doctor and he was so nice to us. Anyway, maybe this is how it is here." (Charity)

"I was always given an appointment of 9am but I had to wait until 1pm doing nothing, which was not convenient for me as I had to take the child to childcare in morning. Because of the long waiting time, I had to leave the hospital running to be able to take the child on time". (Peace)

"What I didn't like most was seeing different faces, whenever you go there were different people. I was expecting maybe one person to deal with me through my chain of pregnancy but that wasn't the case." (Trust)

Several participants remarked that they needed to learn more about the health system and how it works, but this was not necessarily easy. One woman said:

"Language is the major problem, but I think I also don't understand how everything works despite living more than 10 years here. I am still learning each and everything." (Felicity)

Most participants had mixed experiences at different times and with different services and service providers - "some were good and some were not good". Not being given any or enough information was a common complaint - "everything I had to try and find out myself".

"I got pregnant and tried accessing health services. I only had an ultrasound once and couldn't understand why at least I wasn't able to get three as it is in my country of origin. I was diagnosed with preeclampsia and had an emergency caesarean section at 38 weeks. I lost a lot of blood and the sutures were very bad. I have to say through this process nobody explained to me in a satisfactory manner what I was going through. They would tell me you have this and that and it is your choice for management. This sounded so strange to me because doctors, midwives and nurses at home explains everything and helps you to choose what is good unlike here where they tell you it is up to you what you chose is what we do sometimes with no or limited information given." (Promise)

Two participants reported contraception side effects, saying that if they had been informed about the side effects they wouldn't have agreed to the treatment.

"In 2013, I got an injection from hospital and since then it has caused more pain in my arm until now. They did not explain to me properly the side effect of the drug if they would have done so, I could not accept they inject me that drug." (Hope)

"My first experience was not good because the method that I was given to use, it worked but it wasn't like... Every treatment has side effect, my side effect was weight gain. So, let's say that in three months I put on like 13 kg, which I was not happy with... I discussed it with the doctor, but the doctor seemed to say that it was okay, you won't have any problem. So, I wasn't happy then you know, I left the service for good. So, I did it my own way because I wasn't happy with the service." (Promise)

Lack of cultural understanding, including gender sensitivity, was also a common complaint. Other concerns related to lack of privacy and respect.

“[When] I had my Pap smear check, my GP who was a female, she left, and I moved as well to a different place. So, I had to change my GP and he was a male. The issue that I had is that he couldn’t understand my culture because we had different cultural practices. The way he was asking me questions and the way he was examining my body, I found it very uncomfortable, I felt that he breached my privacy. Being a man, it didn’t matter really but he just didn’t understand my culture because we have different cultures. My privacy was not respected.” (Promise)

“I was lying on the bed with a female midwife and all over a sudden a guy comes in and they started checking together. It was uncomfortable and she told me don’t worry he is also a doctor or nurse, something, I don’t know... He is trying to find out what is going on. Then I felt uncomfortable because they didn’t tell me before then he just came...” (Trust)

Some women described terrible experiences, which left them very upset and angry and not wanting to return to the same health facility or to refer anyone else there. Feeling alone and unsupported was very distressing. Communication issues, lack of information and lack of empathy were reported to be at the heart of the issue.

“I went for contraception then they decided to do the test. They told me: ‘Open your legs we want to do this test’; there is no consent letter to sign or to say: ‘Today we are going to use this cotton...’. They put the cotton; they didn’t tell me anything. I went for contraception; they started to look inside my vagina. I can’t go back again. And there is no interpreter. This time now, you know, I am Australian, I understand English very well, I went to school, I studied now, I know they did wrong stuff. They didn’t book any interpreter... and they didn’t respect me at all.” (Grace)

“When I was in labour ward that is when I got some challenges. I felt not really cared for because I struggled alone for almost three hours and the midwife on duty was just there looking at me, not telling me to do anything. They checked me then sent me to the ward and whenever I had contractions, there is a way you can be helped, maybe by words or by actions, but she was just there looking at me and I felt like: Oh my God I am just alone in this room. So, it is like I did everything on my own. Everything on my own, if it is moving, I could move, sitting, everything. That is when I felt like I am left alone.” (Trust)

“No one spoke my language, no one cared for my understanding, I wanted to express my feelings but no one gave me time, and I may say that I had 100 percent say on my treatment because everything was left to me to decide with no directions. It was my worst experience in any country ever, sorry.” (Mercy)

Other participants stated that they usually had good experiences. They found the health service providers welcoming and friendly and said that everything was explained and that they had enough information to make treatment decisions. The healthcare experience was more enjoyable when privacy concerns were met and they had a say in their own care. For reproductive health matters, female providers were preferred - "female to female is much better".

"Every time I went to the health facility, they respected privacy and they were very welcoming... They explained to me every single step and listened to me as well. I am very appreciative. I would recommend my friends to go there because I was satisfied with the service provided to me." (Precious)

"I have been in this area for many years; I have been having my children at the same hospital. So, I can say yes, it's really a welcoming hospital... They would come to you smiling, greeting you. Because I have never been to other hospital to be diagnosed with other sickness, I just go to hospital to have a baby. All the time I have there it is good." (Favour)

"Frankly speaking I didn't have any challenges at all. I was taken care of very well. Even after I had my child I had nurses who used to come at home to help me especially for many things that I didn't know how to manage myself such as feeding the baby, how to put the child to bed, how to play with the baby and what kind of appropriate toys and books I have to buy for her, things like that. I would say that I didn't have any problem at all." (Faith)

Racial discrimination

Two participants stated that they had experienced racial discrimination—occasions when they were not given timely or appropriate care by public or private health service providers because of the colour of their skin - "I felt rejected".

"Well, they are really good, but for me because of my skin, sometimes they may delay giving me services, and sometimes they ask me a question and before I responds, they become impatient, as if they want to say, hurry up I have to receive others. And this may not be a problem if I was Australian. But in general, their service is convenient and quicker, the issue is our race." (Peace)

"The challenge is that I think because of the colour, I am African, they thought that I cannot afford the money they were charging because it is private... The way they welcomed me was very negative... The specialist was minimising me, they thought that I could not afford the money... And I was very disappointed, and I didn't go back again until today." (Grace)

One woman recounted the following experience and stated that she wouldn't recommend to any African to go to that specific hospital, preferring to attend another hospital where "they are fair and take good care of me".

"One day I had a very bad experience and I hated everything here in Australia. I arrived from Africa... in 2014. The ambulance took me from home at 11pm and I had a temperature of 40 degrees. I couldn't even breathe properly, I was in very bad shape, they took me to hospital. As soon as I got there, they told me that I was bringing Ebola saying: 'You bring Ebola, you bring Ebola'. Then I thought that they were going to treat me, but I slept there up to 6am without any treatment." (Hope)

Recommendations for improvement

Many participants highlighted the need for more professional healthcare interpreters who spoke their language, and for service providers to be trained in using professional interpreters. Of course, having doctors, nurses and midwives who themselves spoke the languages of the African Great Lakes region would be even better—"If possible, we can have someone who speaks our language".

"I assume for example for people who have language barrier, to provide access to interpreters even if it is telephone interpreter especially when it is urgent, because some people are not familiar with the language so if you don't really understand everything they tell you, before you make any decision or consent I think it may affect them in a way they don't know. So, if they do not have access to interpreter already yeah then that would be my recommendation." (Joy)

"Especially for people who don't speak the language, my recommendation is to have more interpreters to facilitate the patients to easily express themselves and to make health providers understand better the issues of their clients." (Precious)

"Having medical personnel who speaks my language would be the overall solution for me." (Felicity)

Participants also highlighted the need to build cultural sensitivity among service providers and to address racial discrimination.

"I wish someone who understands my culture was there. I am sure if anyone understood where I come from, they would be able to help me in an appropriate manner. I used to go to a university teaching hospital in my country and medical students used to treat me better." (Mercy)

"As I said, it's more like cultural need. If the medical staff there, they understand different backgrounds, or if not, they try to ask you before they do the service. What is your cultural background? What do you think about this? That would be much better. More of cultural than anything else." (Promise)

"What I can suggest to be improved is the way they discriminate based of the skin colour... If they make a change on that, it will be very good". (Peace)

One woman suggested taking a public health approach and building understanding of health services in the broader community.

"My recommendation is that the services providers should work with the community people, the leaders and others so that when they go for the services, they know already what they are going to do and what to expect". (Grace)

STUDY 2

Methods

Nine years later, we discussed the Study 1 findings and recommendations with women from the same community, with the aim of establishing whether they continued to be relevant and useful, and incorporating any further suggestions for improvements to local reproductive health services.

Recruitment

Participants were recruited by NUWS who sent a message on WhatsApp to her contacts and friends from the Great Lakes Region, asking for their help with the research. The message invited women aged 18 years and above from Rwanda, Burundi and the DR Congo to join an online discussion where the results of Study 1 would be presented so the research team could check if the results were still relevant. The sessions were timetabled from 7.30 – 8.30 pm on a Wednesday, and participants were offered a choice of three dates. Women who agreed to participate were sent another message containing the videoconference link close to the day of their session.

Data collection

For this study, the data were collected in focus groups, a form of group interview that capitalises on the interaction between participants to generate data (Kitzinger, 1995). Like other qualitative research methods, focus groups are useful for gathering in-depth information on people's perceptions and experiences. The facilitator creates a safe environment that encourages people to share their points of view, guiding them through a predetermined set of topics or questions. Groups are typically composed of 4–8 people who share similar characteristics or common interests (Kitzinger, 1995). While focus groups are traditionally conducted in person, since the COVID-19 pandemic they are increasingly adapted for videoconferencing (Santosh et al., 2021).

Three focus groups were conducted a week apart, using the Zoom videoconference platform. They were conducted in the evening as this was a suitable time for participants, and lasted between 64 and 80 minutes. NUWS took the role of facilitator, with AN and AI as co-facilitators and IB as observer. Participants were invited to speak in their preferred language. FG1 and FG2 were conducted mostly in English. FG3, whose participants came only from Rwanda and Burundi, switched to using Kinyarwanda halfway through.

At the beginning of each session, after introductions (research team and participants), the facilitator reiterated the background and purpose of the discussion and explained what was covered by 'reproductive health services'. She set out the discussion group rules, emphasising the importance of hearing from everyone and keeping confidentiality, and obtained consent for recording to support writing up the final summary. Participants with concerns about any of the issues raised or wanting to talk further were invited to contact the facilitator afterwards.

Participants were asked to consider the following questions:

- Do you think the study findings are still applicable today?
- Do you think the recommendations for health service improvements are still useful?
- What actions would you like to see to improve reproductive health services for African women from your country?

Appendix 2 contains the discussion guide, including a summary of the earlier study findings - key themes and recommendations.

Analysis

As for Study 1, the participants were given virtue names to keep them anonymous. For comparison purposes, basic sociodemographic characteristics were recorded for each woman: age group; country of origin; years in Australia; education; marital status; and number of children. Proficiency in spoken English was rated by NUWS.

Working from the focus group transcripts, each of three African researchers (NUWS, AN and AI) summarised one of the discussions. The summaries were reviewed by NUWS, following which a combined summary was produced by IB and reviewed by NUWS.

Findings

Participant characteristics

For Study 2, we recruited a total of 16 women: 6 from Rwanda, 5 from Burundi and 5 from the DR Congo (Table 2). Five of them (1 from Burundi and 2 each from Rwanda and the DR Congo) were interviewed in the original study; the others were new. Nine participants came to Australia as migrants, three came as refugees and four were asylum seekers.

Compared to Study 1, Study 2 had a higher proportion of migrants. Focus group participants were older and had been in Australia longer than the interviewees (all for over 5 years and 12 for over 11 years). Additionally, they were more educated and more proficient in English (all but one spoke English 'very well' or 'well'). As before, most were married with two or three children (mean 2.5, range 1-7).

Table 2. Participant characteristics, Study 2

Focus group	Name*	Age (years)	Country of origin	Migration pathway	Years in Australia	Education	Speaks English
1	Justice	40-49	Burundi	Migrant	11-15	University	Well
1	Serenity	40-49	Rwanda	Migrant	11-15	Secondary	Well
1	Faith**	30-39	Rwanda	Asylum seeker	11-15	University	Well
1	Love	30-39	Rwanda	Migrant	6-10	University	Very well
1	Royal	40-49	DR Congo	Refugee	16-20	Secondary	Well
1	Hope**	50-59	Burundi	Refugee	16-20	Primary	Not well
2	Honor	18-29	Burundi	Migrant	11-15	University	Very well
2	Favour**	30-39	DR Congo	Migrant	16-20	Secondary	Well
2	Trinity	30-39	Burundi	Asylum seeker	11-15	University	Very well
2	Harmony	30-39	DR Congo	Refugee	16-20	University	Well
2	Mercy**	30-39	DR Congo	Asylum seeker	11-15	University	Very well
2	Liberty	40-49	DR Congo	Migrant	6-10	Secondary	Very well
3	Felicity**	30-39	Rwanda	Migrant	11-15	Secondary	Well
3	Destiny	40-49	Burundi	Migrant	6-10	University	Well
3	Patience	30-39	Rwanda	Asylum seeker	11-15	University	Very well
3	Prudence	30-39	Rwanda	Migrant	6-10	University	Well

*We gave participants virtue names to keep them anonymous.

**Interviewed in the original study.

Appraisal of Study 1 themes and recommendations

In all three focus groups, there was consensus that women from the African Great Lakes Region continue to experience barriers and challenges in accessing reproductive health services and that the Study 1 findings—themes and recommendations—still apply.

Language barrier

The language barrier was seen as an ongoing problem, more so for refugees who tend to be less proficient in English than others when they arrive. Providing the 'right interpreter', a female healthcare interpreter who speaks the same language as the patient, remains a challenge. For example, although Kinyarwanda and Kirundi are mutually intelligible, they are different languages and many words have different meanings, which can lead to providing wrong interpretation of the information provided. Without full comprehension of all points discussed, it is not possible for the patient to make an informed decision.

Healthcare experience

In general, accessing and navigating the Australian health system was seen as more problematic for newly-arrived migrants and refugees, not only due to the language barrier but also lack of health literacy and lack of agency to address their health needs. Participants noted that the number of bulk-billing General Practitioners (GPs) has declined and there is a shortage of female GPs. Lack of continuity of care between GPs and specialists leads to fragmented care and inadequate follow-up and management. Lack of continuity and coordination means the patient sometimes has to retell her history from the beginning. Short consultations don't allow enough time for healthcare providers to explain and for patients to understand or ask questions. Longer consultations, cultural sensitivity and 'appropriate interpreters' were seen as especially important for health education and discussions on family planning.

In two of the focus groups (FG1 and FG3), participants mentioned uncomfortable and upsetting experiences. These included being "forced" to sign a consent form without fully understanding the content, violation of privacy during a consultation, and absence of compassion during a difficult labour and childbirth.

Racial discrimination

In all three focus groups, racial discrimination received less attention than the other two themes: language barrier and healthcare experience. In FG1, it was remarked, while that some of the decisions or actions taken by healthcare professionals were discriminatory based on race, others were more likely to be related to the high overload, negatively affecting the way they handle clients. In FG3, one of the participants (a woman who had been interviewed in Study 1) described a horrible experience during and after childbirth 13 years ago, attributing her bad treatment to discrimination. Other participants said they didn't experience any discrimination but heard about it from other people.

Recommendations

Focus group participants supported the earlier recommendations for health service improvement and proposed further measures, mostly related to language services (interpreting and translation) and building individual and organisational cultural competence—"Referrals to healthcare providers who speak your language could be a game changer". They also spoke about empowering women and the need for community education regarding the Australian healthcare system, available services and patient rights, including when and where to raise complaints in case of mistreatment and discrimination. Specific recommendations are listed below.

Language services

- NSW Health Care Interpreting Services should provide interpreters who speak “exactly the same language” as the clients, not those who speak similar languages.
- NSW Multicultural Health Communication Service should ensure that consent forms and health information/education materials are translated in as many African languages as possible, including those of the Great Lakes Region.
- A cultural, country and language-specific training pathway should be established for healthcare interpreters from the African Great Lakes Region to facilitate their support during consultations.
- The Australian Government Translation and Interpreter Service (TIS National) (which provides interpreter services for GPs) language list should be expanded to include most if not all the African Great Lakes Region languages.

Service providers

- All health service providers should be trained in using professional interpreters.
- Both health professionals and interpreters should be educated regarding language differences. (For example, a Swahili speaker from Tanzania cannot interpret for a Swahili speaker from the DR Congo especially in health-related issues where specifics need to be clear rather than a general understanding.)
- Cultural competence training for health professionals should emphasise patient-centred care, understanding cultural differences, taking time and treating patients with dignity.
- Health service providers working with refugees should also be trained in trauma-informed care.

Community

- Ways to empower women and address barriers that constraint their ability to communicate their health needs should be explored and implemented at community level—“Each community can find someone who can help with interpreting health care information”.
- Advocacy should be provided for people who have experienced discrimination or had other negative experiences while seeking reproductive healthcare and healthcare in general.

GENERAL DISCUSSION

Over time, immigrants have arrived in Australia from around the world, increasing the diversity of Australia's population (ABS, 2021). As a result of successive changes to immigration policy, increasing numbers of Africans have resettled in Australia. Africa is a vast continent and the Sub-Saharan migrant population originates from countries with very different cultures, languages and traditions. Within this population, migrants and refugees from the Great Lakes Region constitute a new and emerging community (ABS, 2023).

Successful resettlement has many aspects, among them housing, employment, education and training, and access to culturally-responsive healthcare and human services. Reproductive health services are important in their own right; they are also an early point of contact with health system for new arrivals. The systemic barriers faced by migrants and refugees in accessing mainstream health services have been well-documented (Cavaleri et al., 2021; MCWH, 2021). Achieving health equity requires dismantling these barriers and “a collaborative effort between government, healthcare providers and community organisations, with a focus on culturally-sensitive solutions and improved access to services” (Australian Government Department of Home Affairs, 2024, p. 106).

Access has been defined as the opportunity to reach and obtain appropriate healthcare in situations of perceived need for care. It is influenced by factors on the supply-side (the approachability, acceptability, availability and accommodation, affordability and appropriateness of services) and the demand-side (the ability of patients to perceive a need and then to seek, reach, pay and engage with services) (Levesque et al, 2013). Acceptability and appropriateness are primarily determined by the cultural sensitivity of the health service (Agunwa & Obi, 2018). The ability to perceive relates to health literacy and beliefs, trust and expectations, while the ability to engage relates to empowerment, information and

social support (Levesque et al, 2013). Service providers are advised to consult with migrant and refugee groups in their local community to identify specific issues relating to access and then collaborate on the design, implementation and evaluation of culturally-tailored or targeted models of care (Agunwa & Obi, 2018; NSW MOH, 2022).

Among women from the Great Lakes Region who participated in this research, language was considered the major barrier to having their needs for reproductive healthcare fulfilled. Participants reported that they often struggled to express themselves in English and to fully understand the information provided, making informed consent problematic. When used, professional healthcare interpreters were not always adequately matched for gender and language. Some participants felt welcomed and were completely satisfied with the care they received. However, others thought that Australian health services were not sufficiently women-centred (there was a strong preference for female service providers) or coordinated, and that clinicians did not take the time to understand them and their situation and lacked care and compassion. Navigating our complex health system—knowing where to seek help for what or how to make a complaint—was challenging even for women who had been in Australia for several years. Experiences of racial discrimination became a barrier to further engagement and were shared within the community.

Our findings are consistent with research among migrant and refugee women from other African countries living in other Australian cities (Correa-Velez & Ryan, 2012; Anaman et al., 2017; Mohale et al., 2017; Bali et al., 2024). They underline the importance of working on both supply-side and demand-side factors. In addition to dismantling barriers, it is important to reinforce factors associated with positive healthcare experiences (Bali et al., 2024). When recounting their experiences, participants spoke about interpersonal factors, such as

empathy and cultural sensitivity, as much as the provider's clinical skills. For refugees and women with refugee-like backgrounds, trauma-informed care is essential (NSW MOH, 2022).

Like the surrounding society, immigrant communities are not static; with time and support, services develop, individuals acculturate, and communities become more established. While the Study 2 participants endorsed the Study 1 findings, there were some differences in their responses. It is likely that these reflect changes in the health system over the nine years as well as participant characteristics. Compared to Study 1, Study 2 participants were older and had been in Australia for longer, thus gaining familiarity with local health services and pathways. First, there was more emphasis on primary care, with concern expressed about the reduced availability of bulk-billing GPs. Second, there was more emphasis on empowering women, patient rights and the advocacy role of community organisations. Both groups of participants were clear about the need to build cultural competence and diversity within the health workforce. Overall, the research findings point to the need for a systems approach with a role for settlement services, health services and community organisations.

Settlement organisations, such as AMES Australia, Settlement Services International and Australian Red Cross Migrant Services, deliver a range of services and support to assist individuals and families in adapting to their new environment. Bilingual/bicultural case workers are an important part of the workforce. Providing orientation and information is a key function—helping newcomers understand their rights, responsibilities and how to navigate life in Australia. Other functions typically include language support (e.g., English language classes and translation services) and general health and wellbeing support (e.g., connecting people to a GP and facilitating access to health services and programs tailored to the needs of migrants and refugees).

In the Australian health system, Medicare is key to ensuring equitable access to essential health services in the community and in hospital (AIHW, 2024). Many migrants and refugees come with misinformation and misconceptions about reproductive health issues (Hach, 2012). As the health system entry level and main site for preventive health activities, GPs are a critical source of accurate information, advice and referral. Mainstream community education and health promotion must be complemented by activities that target vulnerable population groups. Community organisations, such as GLAPD, may serve a specific cultural, linguistic, ethnic or religious group or community or several groups or communities. Depending on size and location, they address a wide range of social, cultural and economic needs for migrants, refugees and asylum seekers, often working in collaboration with government agencies, other non-government organisations and private sector partners. They are also integral to building social cohesion and advocating for positive societal changes (Australian Government Department of Home Affairs, 2024).

Strengths and limitations

This research was undertaken by a 'culturally competent research team', with members bringing a mix of expertise, experience and resources, including language skills and community networks (Woodland et al. 2021). Study 1 strengths include participants being interviewed in their first language enabling women who were not proficient in English to participate. The African researchers, all females with a medical background, were also able to explain terms such as contraception and cervical screening in language that the participants understood. In Study 2, the focus participants were invited to express themselves in whatever language they felt comfortable. Limitations include the research participants being recruited entirely from the GLAPD database and researcher networks. Given the small number of women involved from each country, the experiences and perceptions may not be representative of the communities as a whole. Similarly, given that the research conducted in Sydney, the findings may not be fully transferable to other Australian cities where migrants and refugees from the Great Lakes Region have settled. Further research, including multi-site mixed-methods studies and program evaluations, is needed to inform the development of reproductive health services in an increasingly diverse multicultural society.

CONCLUSION

Facilitating migrant and refugee women's access to individualised, culturally-responsive and trauma-informed reproductive health services and information is important to their overall health and wellbeing and successful settlement and integration. This research has addressed a gap in the literature relating to the experiences of women who have come to Australia from African Great Lakes Region. It explored the spectrum of reproductive health issues including family planning and cancer screening as well as maternity care. It also highlighted the need for continued efforts and new initiatives to remove the language barrier and improve the healthcare experience, especially for newly-arrived migrants and refugees, while still attending to their broader resettlement needs. Achieving equitable access to healthcare for migrants and refugees requires a system approach, with a role for settlement services, health services and community organisations.

RECOMMENDATIONS

Based on the literature and our study findings, we have identified the following recommendations for improving access to reproductive healthcare for women from the African Great Lakes Region.

Settlement services

As the first point of contact in Australia, settlement organisations should:

- Connect refugees and migrants to GPs and other relevant healthcare providers as soon as they arrive in the country so that they could learn and benefit from all the necessary health information and services as early as possible.
- Offer culturally and linguistically competent interpreting and translation services to support effective communication between clients and service providers.
- Offer bilingual/bicultural caseworkers from new and emerging communities to assist in navigating the health system.

Health services

Health services and reproductive healthcare providers including GPs should:

- Provide culturally competent and trauma-informed care.
- Source and make use of appropriate interpreter services—engage professional interpreters matched for language, culture and gender and preferably trained in medical terminology and trauma care.
- Facilitate ongoing culture and trauma training for health professionals, including how to work effectively with interpreters.
- Recruit bilingual/bicultural health professionals, including doctors, nurses, midwives and allied health, to meet local community needs.
- Support access to female GPs for women who express a preference for a female provider due to personal choice, or cultural or religious beliefs.
- Provide bulk-billing services to enable access for those who are unable to pay the consultation fees.
- Plan and take extra time during consultations to explain and provide details of available screening and diagnostic services, especially to newly-arrived refugees and migrants.
- Develop targeted health promotion strategies to engage African immigrant women to enhance their knowledge about cervical cancer and screening practices.

Language services that support the health sector, such as those provided by NSW Health and TIS National, should:

- Develop training pathways for interpreters in new community languages and dialects.

Community organisations

Community organisations and members should:

- Facilitate smooth integration and social support for newly-arrived migrants and refugees by connecting them with their respective communities.
- Organise education sessions to inform new arrivals of available reproductive health services, including family planning and screening, and how to access them.
- Support African immigrant women to access reproductive healthcare and information and advocate for their rights when requested.

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APPENDIX 1.

Study 1 interview guide

African women migrants' and refugees' access to reproductive health services in South Western Sydney: a pilot study

Themes of the In-Depth Interviews

The themes of the interviews will be based on the tenets of access and experience of reproductive health services amongst women of the Great Lakes community. We will begin by assessing the current knowledge of the interviewees regarding reproductive health, and their understanding of the services available to them. This will cover areas ranging from what kinds of services they access, the extent of their knowledge regarding services available, their experiences of health facilities, and the role of decision-making processes in accessing and revisiting health services. We will then look specifically at access and experience of family planning and cancer screening services.

Reproductive health (family planning and preventive services)

Ubuzima bw' imyororokere

1. Access to RH services that includes but not limited to family planning, preventive services: screening for breast cancer, cervical cancer etc., sexually transmitted infection and HIV

Kugana serivisi z' ubuzima bw' imyororokere harimo kuringaniza imbyaro no kwirinda indwara zirimo virusi itera sida na kanseri y'amabere n'inkondo y'umura

(a) Tell me something about RH (could be anything, what you know? And so on) How did you get that information?

Niki mwaba muzi kubyerekeye ubuzima bw' imyororokere? (icyaricyo cyose waba uzi) Mwaba mwarakuyehe ayo makuru?

(b) Have you ever experienced any RH issues after you arrived in Australia?

Mwaba mwarahuye n'ibibazo birebana n'ubuzima bw'imyororokere kuva mwagera muri Australia?

(c) Have you ever accessed RH services after you arrived in Australia? What are those services? Where did you get those services?

Mwaba mwarigeze mugana serivisi z'ubuzima bw'imyororokere kuva wagera muri Australia? Izo serivisi waganye ni izihe? Ese waba warazihawe?

(d) Did you experience any challenge at the place where they receive RH services?

Haba hari ikibazo mwahuye nacyo aho mwaherewe izo seruvisi?

(e) Who made the decision to go for service? Who took care of children in your absence? Does your partner accompany you?

Ninde wafashe icyemezo kugira ngo ujye gushaka izo serivisi? Nide wagusigaraniye abana niba hari abo warufite? Ese uwo mwashakanye yaba yaraguherekeje?

(f) Geographic access - How far is the health facility? How do you reach to the health facility

Aho utuye naho usanga Izo serivisi haba hangana gute? Ugerayo ute?

(g) Cultural access (language, culture and belief - have you ever experienced a reproductive health service specifically catered to your language, beliefs or culture - for example, did the doctor speak your language, were they from the same background as you? If so, how did you find them?) Did you feel comfortable to express your feelings, and did you feel like you had a say in your treatment

Umuco (indimi , umuco n'imyemerere- waba warigeze uhabwa serivisi z'ubuzima bw'imyororokere mu rurimi rwawe? Kandi bijyanye n'umuco n'imyemerere byawe? Nk'urugero, umuganga wakwakiriye yavugaga ururimi rwawe? Ese yaba yaraturutse mu gihugu nawe waturusemo? Niba ari yego wabyakiriye ute?) byarakoroheye gusobanura neza uko wiyumvaga, ikibazo wari ufite? Ese waba waragize uruhare mugufata ibyemezo kubijyanye no kuvura uburwayi wari ufite?

(h) Economical access (to what extent is money an issue when you access RH services?)

=ubushobozi economique (ese waba ugira ikibazo cy'ubushobozi bwo kugana serivisi z'ubuzima bw'imyororokere?)

2. Family Planning

kuringaniza urubyaro

(a) Have you ever sought a family planning service? What was your experience?

Wari wakoreshaho services zo kuringaniza urubyaro? Wazakiriye ute kugiti cyawe?

(b) Where do you get information about family planning? What was your experience in accessing that information?

Mwaba mwarakuyehe makuru kubijyanye no kuringaniza urubyaro? Ese uyashakisha wakuyemo irihe somo?

(c) How did you decide to access family planning services? - Have you ever consulted a health provider to help decide what family planning option is best for you? Did you consult with your partner, or other family or friends?

Ni iki cyaguteye gufata icyemezo cyo kujya gushaka serivisi zo kuringaniza urubyaro? Waba warigeze ugana umuganga ngo agufashe guhitamo uburyo bwiza bukubereye bwo kuringaniza urubyaro? Waba warabiganiriyeho n'umugabo wawe cyangwa umuntu wo mufite icyo mupfana cyangwa inshuti?

2. Family Planning

Gupima ibyago byo kuba warwara cancer

(a) What do you know about cancer screening services in Australia? How did you get this information? What type of cancer screening do you think is important?

Niki waba uzi kubyerekeye services hano muri Australia zo gupima ko umuntu yaba yarwara cancer? Mwaba mwarakuyehe ayo makuru? Nubuho bwoko/buryo bwo gupima wunva bufite akamaro?

(b) How often do you think you need to have cancer screening? What do you know about self-testing for cancer?

Wumva ukwiye kwipimisha inshuro zingana iki? Haricyo waba uzi kubyerekeye kuba wakwipima cancer wowe ubwawe?

(c) Have you ever used a cancer screening service? How did you access it and what experiences did you have using it?

Wari wakoreshaho services zipima ibya cancer? Wazimenye ute? Wazibonye ute/nirihe soma wigiyeyo?

(d) How do you feel about using cancer screening services? If the screening process is uncomfortable, does it impact on your decision to go? Why/why not?

Ubona ute izo service? Ese niba zitarakunyuze byaba bigira ingaruka mugufata umwanzuro wo kujyayo?

4. Health facility and health workers practices on client

Imikorere y' ibigo by'ubuzima, n'imikorere y'abakozi b'ubuzima kubabagana.

a) How was your experience being at health facility? Was it welcoming? Did you maintain privacy?

Byakugendekeye gute ujya ku kigo cy'ubuzima? Wakiriwe neza/wabonye bakira neza ababagana?

b) What was the experience while attended by health workers (dr. nurse or allied health)

Kwakirwa n'abakozi b'ubuzima wabibonye ute (abaganga, abafomomo,..)?Ni irihe soma wavanye mo?

c) Did you feel coming in again and again? Would you recommend your neighbor to come to the facility and visit health worker?

Wumvise wakwongera ugasuburayo na nyuma yaho? Ese wakangurira abaturanyi bawe kugana icyo kigo cy'ubuzima ndetse n'abakozi bacyo?

d) What challenges and barriers that you face while accessing the services from health facility and/or health workers?

Ni ibihe bibazo hamwe n'imbogamizi ugira mugihe ugana cg uhabwa service muri icyo kigo cyangwa mu gihe ufashwa n'abo bakozi b'ubuzima?

e) Did you receive all the services that you anticipated (such as information, referral etc)

Ese wabonye service zose wari witeze (urugero: ibisobanuro, kwoherezwa murundi rwego cyangwa ku wundi muganga)?

f) Did you understand the information provided to you? What would be your recommendation to improve?

Ese wumvise neza ibisobanuro byoze baguhaye? Ni iki ubona cyarushaho kwitabwa ho kikanononsorwa neza?

APPENDIX 2.

Study 2 focus group discussion guide

Discussion on improving reproductive health services for women from the African Great Lakes Region

Background

Some years ago, the Great Lakes Agency for Peace and Development (GLADP) in conjunction with UNSW Sydney conducted a research study to gather information on the experience of reproductive health services by African women from the Great Lakes Region. The findings were intended to inform the work of GLADP and the design of culturally sensitive and appropriate services for migrant and refugee women in South Western Sydney.

That study involved in-depth interviews with 13 women from Rwanda, Burundi and the Democratic Republic of Congo. The interviews were conducted by Dr Umutoni Wa Shema, Dr Adelaide Nyinawingeri and Dr Ange Anitha Irakoze. Through qualitative analysis of the interview transcripts, three key themes were identified: language barrier, health care experience and racial discrimination. Participants also made recommendations for improving reproductive health services.

Aim

The aim of these online discussion groups, led by Dr Umutoni Wa Shema, is to present a summary of the study findings and recommendations to see if they are still relevant today (2024). This update activity is being conducted by GLADP in conjunction with Western Sydney University.

The discussion questions are:

- Do you think the study findings are still applicable today?
- Do you think the recommendations for health service improvements are still useful?
- What actions would you like to see to improve reproductive health services for African women from your country?

Summary of study findings

Theme 1. Language barrier

Most of the study participants viewed language as the major barrier when attending the available reproductive health services. They struggled to express themselves in English or to fully understand what they were being told and the information provided. Even those who spoke English well had difficulty with some service providers' accents. Lack of understanding of the Australian health system contributed to the problem.

Three participants explained that they relied on their husbands to interpret what the service provider was saying. Another woman used a friend to help.

Although professional healthcare interpreters were used on some occasions, even this could be problematic. One participant described how she was provided a wrong interpreter—a man from another country who did not speak her language and did not correctly interpret what she said. There was also concern about confidentiality when using a professional interpreter.

Only two participants felt that they did not have any problem with language.

Theme 2. Health care experience

While recognising that the service providers were busy, many participants considered that Australian health system was not sufficiently patient-centered. Long waiting times and short consultation times were seen as problematic, along with a lack of continuity of care. Several participants remarked that they needed to learn more about the health system and how it worked, but this was not necessarily easy.

Lack of cultural understanding, including gender sensitivity, was a common complaint. Other concerns related to lack of privacy and respect.

Some women described terrible experiences, which left them very upset and angry and not wanting to go back to that service or to refer anyone else there. Feeling alone and unsupported was very distressing. Communication issues, lack of information and lack of empathy were often at the heart of the issue. Two participants reported contraception side effects, saying that if they had been informed about the side effects they wouldn't have agreed to the treatment.

Other participants stated that they usually had good experiences. They found the service providers welcoming and friendly and said that everything was explained and that they had enough information to make treatment decisions. The healthcare experience was more enjoyable when privacy concerns were met and they had a say in their own care. For reproductive health matters, female providers were preferred.

Theme 3. Racial discrimination

Three participants stated that they felt that, on occasions, they were not given timely or appropriate care, by services providers—public and private—because of the colour of their skin.

Participant recommendations

To reduce the language barrier, participants highlighted the need for more professional healthcare interpreters who spoke their language, and for service providers to be trained in using professional interpreters. Of course, having doctors, nurses and midwives who themselves spoke the languages of the African Great Lakes region would be even better.

Participants also highlighted the need to build cultural understanding among service providers and to address racial discrimination.

One participant suggested taking a public health approach and building the understanding of health services in the broader community.

“*In the silence of displacement, the bodies of women speak louder than words—of lost opportunities, of dreams deferred, of health unmet. Yet, within their pain lies the power to rebuild, if only we listen to their needs.*”

(United Nations Population Fund, 2019)

“*In the struggle for survival, refugee women often lose more than their home—they lose their right to reproductive care. But still, in the dark, their strength and resilience light the way to a future where health is a right, not a luxury.*”

(World Health Organization, 2020)

“*A mother’s call for care echoes in the halls of hospitals, but in the confusion of paperwork and language barriers, her plea fades—until her health becomes a crisis, her pregnancy a perilous path.*”

(Women’s Health Victoria, 2016)