

Invisible struggles, urgent priorities: mental health of ethnic migrant women and girls in Aotearoa New Zealand

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ABSTRACT

AIM: Ethnic communities in Aotearoa New Zealand are rapidly growing and highly diverse. Migration-related experiences are deeply gendered, shaping health and wellbeing in distinct ways. This multi-methods research study aimed to understand the mental health needs of ethnic migrant women and girls, and to highlight opportunities for culturally responsive support by co-designing a research agenda with high-priority research questions.

METHODS: In-depth interviews were conducted with 12 key stakeholders and analysed using thematic analysis. Insights informed a subsequent stakeholder consultation workshop, facilitated using a collaborative World Café approach to co-design research priorities.

RESULTS: Interview findings suggest nuanced contextual factors that affect mental health, lack of safe spaces including family networks, reluctance to engage with mental health services, and limited cultural responsiveness. The co-designed research priorities emphasise the importance of participatory approaches and evidence rooted in lived realities to inform services that are meaningful, culturally safe and responsive to ethnic women's needs.

CONCLUSION: Ethnic women's mental health requires a nuanced culturally responsive approach. Through community engagement and co-design, this study identified unmet needs and set clear research priorities to inform meaningful, evidence-based support and care.

Aotearoa New Zealand has experienced extensive demographic diversification as a result of increased migration, with 27.4% of the population in 2018 born overseas.¹ In 2023, 17.3% of Aotearoa New Zealand's population identified as Asian, and 1.9% identified as Middle Eastern, Latin American and African (MELAA) (hereafter, Asian and MELAA).² Among these two groups, 77% were born overseas, indicating a high proportion of first-generation migrants.^{3,4} The Asian and MELAA migrant population of Aotearoa New Zealand is heterogeneous, consisting of a wide range of cultures, religions, languages, nationalities and migration trajectories.⁵

Regardless of the various reported motivations driving migration,⁶ existing global studies show that migration is a highly stressful event, as people may experience multiple challenges in adjusting and settling to a new country.^{5,7,8} These are influenced by the reasons for migration, including forced migration, English language proficiency, shift in socio-economic status and experience of transition from country of origin to the final destination, which may include transiting from rural

to urban, or through war zones or areas affected by natural calamities.⁹ Migrant experiences are frequently shaped by the intersection of social inequalities (including limited employment opportunities and access to education and income) and migration-related inequalities (such as limited familiarity with new systems, lower access to health and social services, loss of social networks, and limited English proficiency).¹⁰⁻¹² Additionally, psychosocial factors such as longing for their own culture and family, religious differences and experiences of discrimination, racism and xenophobia across public, education and workplace settings can further affect mental wellbeing.^{6,13}

The impact of migration disproportionately impacts women as they additionally experience gender-related inequalities.^{14,15} In their systematic review on migrant women, Yazdankhoo et al. (2025) suggest how structural conditions and gendered power dynamics, rooted in patriarchal frameworks, disadvantage women and shape gendered experiences and inequalities across social, political and economic contexts.¹⁶ Gendered

experiences may include gender-based violence, increased household responsibilities and decline in work status,¹⁷ conflict related to cultural expectations while adapting to the host culture and limited financial autonomy.^{12,14,17–20}

The intersection and interaction of these psychosocial factors affect overall mental health, which, as defined by the World Health Organization, is the “*state of mental wellbeing that enables people to cope with the stresses of life, realize their abilities, learn and work well, and contribute to their community*”.²¹ It is therefore not surprising that several international studies have noted the high risk of poor mental health outcomes, including anxiety, depression, post-traumatic stress disorder and suicidal behaviours, among migrant women.

Ethnic migrant women have been historically under-studied, particularly in health and clinical research.²² Mental health of migrant women has received some attention in certain migrant-receiving countries, such as Australia, Canada and the United Kingdom.^{23–27} The limited evidence provides valuable but fragmented insights as it tends to focus on narrow sub-groups, such as refugees or women in perinatal contexts. Similarly, in Aotearoa New Zealand, an understanding of contextual factors that affect mental health and wellbeing of this population group is still missing.^{15,28}

To address this gap, our study provides key insights into the challenges and opportunities in understanding and addressing the mental health needs of Asian and MELAA migrant women and girls in Aotearoa New Zealand. We also present preliminary research ideas co-designed with community stakeholders to guide future research in this area.

Methods

This study is part of a large multi-method

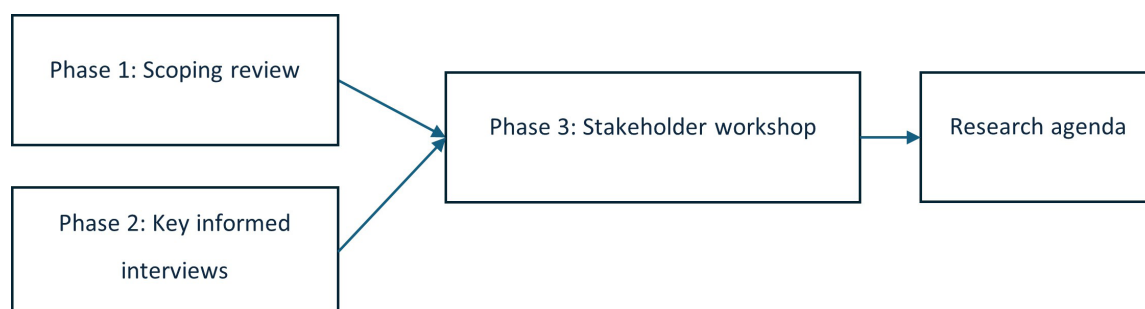
research study, as described in Figure 1. Overall, the study aimed to co-design research priorities to address the mental health needs of Asian and MELAA migrant women and girls in Aotearoa New Zealand. Findings from Phase 1 have been published separately.²⁸ This article presents findings from Phase 2 and Phase 3, which were approved by the Auckland Health Research Ethics Committee (reference no. AH26354).

Key informant interviews

Key informant interviews aimed to explore the contextual factors that affect poor mental health as well as barriers and facilitators in accessing mental health and support services (including those in education and community settings) for Asian and MELAA migrant women and girls, as well as opportunities to improve gender responsiveness in existing services. Purposive as well as snowball sampling was used to recruit participants who self-identified as Asian and MELAA women with lived experience of mental health conditions or as mental health and support service providers who work closely with Asian and MELAA women in Aotearoa New Zealand. Study recruitment was promoted via the professional networks of the research team who closely work with several ethnic community organisations. The sample was diversified to include participants who work with different sub-ethnic and community groups across a range of geographical locations and areas of professional expertise. Recruitment was discontinued once data sufficiency was achieved.^{29,30} All participants provided written informed consent. The lead author conducted all the interviews in English via Zoom or in-person, depending on the participant’s preference.

All interviews were transcribed verbatim for analysis. Reflexive thematic analysis was undertaken using a general inductive approach.³¹ During data collection, interview transcripts and field notes were reviewed and analysed.

Figure 1: Overview of the study design.



This interim analysis helped monitor data sufficiency and pursue emerging avenues of enquiry in further depth. Codes were analysed and collated to identify overarching themes and sub-themes, and were verified across authors. In total, 12 participants were interviewed, as shown in Table 1. Most identified as service providers, women, first-generation Asian and MELAA migrants and having English as a second language but being fluent in it. One participant reported a diagnosed mental health condition.

Stakeholder workshop

As the last phase of the larger study, a half-day stakeholder workshop was organised to identify research priorities on improving the mental health and wellbeing of Asian and MELAA women and girls in Aotearoa New Zealand. Similar to Phase 2, purposive sampling was used to recruit participants who worked with Asian and MELAA communities or self-identified as Asian and MELAA women. The workshop invite was promoted via professional networks of the research team, which included several community-based organisations as well as stakeholders in government/semi-government organisations with portfolios related to health and wellbeing of ethnic communities. To broaden the sample, we further utilised snowball sampling to reach community members outside our initial points of contact. Key informants from

Phase 2 who agreed to be contacted for the workshop were also invited. Overall, 21 participants attended the workshop. Table 2 describes the profile of the participants.

We used the World Café approach, a participatory action research methodology, to facilitate engagement with stakeholders and community members to lead collective change.^{32,33} To set the context, the research team provided an overview of the findings from Phases 1 and 2, and participants were invited to reflect on and discuss the insights shared. Following this, participants formed four discussion groups (one per table). To ensure diversity, participation was limited to one person per organisation in each group. While the traditional World Café method typically involves rotating participants between tables to encourage cross-pollination of ideas, this step was omitted to maintain the rapport already established within each group.

Each table was supported by a facilitator (or table host) and a note taker from the research team. Over the course of four conversation rounds (approximately 20 minutes each), groups explored four themes developed from the earlier research phases (see Table 3). The table host introduced each discussion question and summarised the key points from previous conversations, enabling each group to build on the previously discussed ideas. The workshop concluded with a

Table 1: Profile of participants—key informant interviews.

Participant 1 (P1)	Service provider, Asian, first-generation migrant, female
Participant 2 (P2)	Service provider, Asian, second-generation migrant, gender diverse, lived experience of mental health conditions
Participant 3 (P3)	Service provider and researcher, Latin American, first-generation migrant, female
Participant 4 (P4)	Researcher, Asian, first-generation migrant, female
Participant 5 (P5)	Service provider, Asian, first-generation migrant, female
Participant 6 (P6)	Service provider, Asian, first-generation migrant, gender diverse
Participant 7 (P7)	Service provider, Asian, first-generation migrant, female
Participant 8 (P8)	Service provider, Asian, first-generation migrant, female
Participant 9 (P9)	Service provider, Pākehā, female
Participant 10 (P10)	Community leader, Caucasian, first-generation migrant, female
Participant 11 (P11)	Service provider, Asian, 1.5-generation migrant, male
Participant 12 (P12)	Community leader, Middle Eastern, first-generation migrant, female

Table 2: Participant profile—stakeholder workshop.

Participant profile	Number of participants
Ethnicity	
African	2
Asian	10
Latin American	3
Middle Eastern	5
Caucasian	1
Gender	
Women	19
Men	2
Work setting*	
Researchers	4
Clinicians	4
Service providers	11
Community members	2
Policymaker	1

*Some participants identified with more than one work profile.

Table 3: Discussion themes.

How can we address the data gaps to gain a better understanding of the mental health and wellbeing of Asian and MELAA women?	How can we improve the availability and accessibility of support services to better support the mental health and wellbeing of Asian and MELAA women?
How can we improve the availability and accessibility of health services to better support the mental health and wellbeing of Asian and MELAA women?	How can we create an enabling environment within the community for Asian and MELAA women to support their mental health and wellbeing?

MELAA = Middle Eastern, Latin American and African.

45-minute wrap-up session, where participants from all groups reconvened to share reflections and each participant voted individually for their top three ideas; all votes were computed.

All workshop notes were transcribed, and key discussion points were translated into potential research questions. After the workshop, these were shared with participants via email to invite further feedback. Suggested revisions were incorporated, and a final version was subsequently circulated. Participants were encouraged to use or disseminate these research ideas within their networks, enabling broader uptake by those with the interest, time or resources to pursue them.

Results

Findings from the key informant interviews

Three themes were identified from the key informant interviews: contextual factors affecting the mental health of Asian and MELAA women and girls, barriers in help-seeking for mental health and experiences of navigating mental health services in Aotearoa New Zealand.

Contextual factors affecting mental health

A range of cultural and migration-related factors that affected the mental health and well-being of Asian and MELAA women and girls in Aotearoa New Zealand were reported. Participants noted that the life stage at which migration occurs influenced their mental health. For example, adult women who migrated with partners and/or children were more likely than men to gain employment but often in low-paying roles, and achieve social autonomy more quickly. Despite contributing to household income, they typically remained the primary caregivers with limited support. Participants considered that this dual burden of precarious work and caregiving frequently led to significant distress and, in many cases, family conflict. On the other hand, elderly migrant women experienced social isolation, financial dependence and continued household responsibilities, including caregiving for grandchildren. As for young Asian and MELAA women, they were made to feel “different” due to their gendered ethnic identity, such as skin colour, hair texture and cultural norms and practices. Participants argued their efforts to adapt themselves to the “Kiwi culture” (e.g., accent, dietary habits, sartorial choices, family norms) led to conflicts with family members who insisted on practising traditional

values and way of life. P1 described:

“The stress and the turmoil that forms, particularly around family issues, where there’s conflict between ideologies of someone who has grown up here and someone who hasn’t, that’s a huge contributing factor to mental health issues.”

Participants noted the distress was particularly high for young Muslim women who reported being harassed for their visible identity (wearing a headscarf) and thus experienced “*anxiety in public spaces*” (P10).

Barriers in help-seeking

Participants unanimously agreed that Asian and MELAA communities have distinct understandings of mental health, i.e., they understand, define, express and respond to it differently. Some of these differences stem from their limited awareness about risk and protective factors, information about common mental health conditions and available care and support services. Participants believed that recent migrants arriving from settings where mental health remains a neglected priority may find it harder to acknowledge and prioritise it in Aotearoa New Zealand, where it is relatively more openly discussed. Participants noted that while this makes it hard to seek any support, its impact tends to vary across the age groups and migration histories of women. For example, “*Young girls (born and/or raised in New Zealand) were more likely to be aware of mental health needs and available services*” (P8) than elderly women or those who have recently migrated. Participants also discussed that, for women who arrived on short-term or dependant visas, the precariousness of their immigrant status was often an insurmountable challenge. They worried that seeking mental health services or disclosing distressing family situations leading to mental health issues (e.g., family violence, gambling harm) could curtail the opportunities to secure long-term residency in Aotearoa New Zealand. Other emotional barriers, such as guilt and shame in disclosing situations of family violence/conflict, were also considered common.

Absence of family support and lack of safe spaces for adult women to discuss mental well-being were also noted as significant challenges in seeking support. Participants considered safe spaces particularly relevant as there is often

considerable stigma and shame related to mental health, as well as minoritised identities such as gender/sexual identity. For older women, internalised stigma was noted as a key factor as women worry about “*looking weak*” or even “*losing face*” (P11) in front of their doctor, family and community. P11 further explained:

“They might say, oh no, it’s nothing, or they may deliberately fill in the PHQ-9 and give themselves low scores because they don’t feel that this is what they have. Sometimes it’s purely because [of] the patient’s own denial and they don’t want to sort of express this...”

A few stakeholders (P3, P8 and P10) noted that, in contrast to professional help, Asian and MELAA women preferred informal help, including friends, family and religious places. Two stakeholders (P6 and P12) cited anecdotal evidence regarding growing use of transnational online consultations with practitioners, who are both culturally and linguistically compatible, have minimal waiting time and are less expensive.

Experiences of navigating mental health services in Aotearoa New Zealand

Given the challenges in help-seeking, as outlined above, participants noted that access to mental health and related services is commonly low among Asian and MELAA women and girls. Stakeholders reported that referrals often occur only during times of crisis—when they are worried for their lives or are unable to provide for their children—usually through family violence agencies. P5 explained:

“Often desperation. Want to keep the relationship alive for the children, they don’t come for themselves often. If something is really problematic for the family not able to function, cook well for their family, then it’s like, oh, I need help.”

Perinatal mental health services served as another referral pathway but were not frequently used. Two participants (P1 and P6), who led community-based mental health support services, noted that low awareness about perinatal mental health services is a key barrier in uptake of these services.

Stakeholders also noted that some of the frequently used assessment tools for mental

health conditions are not culturally validated, and thus, there is a risk of an incorrect diagnosis. They believed that even when Asian and MELAA women access services, their experiences are often unsatisfactory. Two participants (P4 and P12) argued that decision making can feel overwhelming, as many are unaccustomed to it, and sharing personal or emotional issues with strangers can be challenging. Proficiency in English creates an additional barrier, particularly for elderly and recently migrated adult Asian and MELAA women. Therefore, participants stated that requests for linguistically or at least culturally matched service providers are fairly common, as they find it easy to communicate about their family dynamics with these service providers. However, participants also noted that many Asian and MELAA women are either not aware of this resource or may experience additional waiting times. In situations when family members act as interpreters, there were concerns around inaccurate communication, masking of mental health issues and potential family conflicts.

Several stakeholders noted the impact of a lack of cultural competency on engagement with healthcare (P1, P11 and P12). For example, somatic presentations of mental distress are commonly overlooked or misinterpreted, leading to referrals to physical health clinics, which is considered unhelpful. There were also concerns that culturally relevant practices, such as the importance of building rapport, are compromised due to short consultation times. As a result, participants believed Asian and MELAA women may require multiple sessions to feel comfortable to discuss their mental health. They also considered that young Asian and MELAA girls seem to be aware of services like helplines but often do not want to risk accidental disclosure to their parents. There were also concerns about involving social services if they were still minors and dependent on their parents. More importantly, participants stated that even when they do access healthcare, the support is not often helpful, or, as explained by P12, “*They don’t feel like they get a solution that’s going to be any other than consoling for the day.*”

Findings from the stakeholder workshop

Through multiple rounds of discussion, participants collectively developed several research ideas across the four themes described in Table 3, and towards the end, individually voted for their top three ideas. Overall, the findings

suggest a solution-driven approach, shown through prioritised research ideas that focus on developing community engagement approaches that are both culturally and gender responsive. Overall, the proposed questions cluster around a few foundational themes—strengthening mental health literacy, improving access to services and enhancing the collection and reporting of data to better understand ethnic migrant women’s mental health needs. In the context of the population studied, the evidence is still at a stage where basic, context-setting inquiries are essential before more specialised work becomes meaningful. Taking a gendered approach to these early investigations can help surface the culturally responsive strategies required to address long-standing and often overlooked challenges. The list of research ideas that were prioritised via individual voting by the participants at the end of the workshop is presented below.

1. How can access to information about existing mental health and support services be improved, including consideration to centralising the information?
2. How can cultural competency of service providers be enhanced, such that it reflects the spiritual and cultural understanding around mental health and documents/ records/reports it appropriately?
3. How can better information (culturally and gender responsive) be provided about mental health and available clinical and support services?
4. How can awareness of mental health/ distress or mental health literacy among Asian and MELAA women be improved?
5. What data sovereignty framework can be used for measuring mental health and wellbeing of Asian and MELAA women?
6. What are the key protective and risk factors (ecological/contextual) for good and poor mental health for Asian and MELAA women, particularly for elderly women?
7. How can the disconnect between parents and young women’s access to health services be addressed?
8. What are some key culturally responsive strategies to engage with faith leaders to get support for mental health and wellbeing of Asian and MELAA women?
9. What does mental health and wellbeing mean for different Asian and MELAA communities?
10. What administrative data are routinely available, what is their quality and what do they tell us about mental health of Asian and MELAA women in Aotearoa New Zealand?
11. What could an “early prevention package” for mental health for Asian and MELAA women look like?

Discussion

Asian and MELAA communities have experienced rapid growth in recent years, yet their specific mental health needs have remained largely unexplored. Given the well-documented risks associated with migration and settlement, particularly for women and girls, it is crucial to understand these specific needs in Aotearoa New Zealand. Using robust evidence to inform tailored support approaches is a vital first step toward achieving equitable mental health outcomes.

The present article reports the findings of the last two phases of a large multi-methods research study. It offers valuable insights into some of the unique contextual factors influencing the mental health of Asian and MELAA women and girls. The findings highlight the tension between navigating gender roles and cultural expectations between Western contexts and those from their communities of origin. The absence of familiar social support systems compounds this stress, often making integration and adaptation more challenging, particularly for older women. At the same time, help-seeking behaviours are shaped by a range of barriers, with both women and girls facing social and internalised stigma, as well as a lack of safe and culturally affirming spaces. Even for those who do access services, experiences are often undermined by a lack of cultural responsiveness. Issues such as culturally inappropriate models of care, limited opportunities to build trust and a lack of reflexivity among providers hinder effective support.

Given the breadth of issues that impact mental health and engagement with services, community involvement in setting priorities is not only respectful but essential. Our stakeholder workshop, which drew participants from diverse organisations serving a range of ethnic communities, allowed us to ground our findings from Phases 1²⁸ and 2 in the process of shaping a research agenda that would be responsive to the needs and strengths of Asian and MELAA women and girls in Aotearoa New Zealand. Despite the heterogeneity of participants,

common challenges emerged, reinforcing the importance of cross-cutting themes.

The identified priorities emphasise the need for a multi-layered approach. This includes addressing data gaps, enhancing service provision and accessibility and ensuring that information is communicated in ways that are meaningful to communities. While these could be perceived as exploratory questions, if pursued these identified priorities have clear potential to improve the quality and responsiveness of mental health care for Asian and MELAA women and girls in Aotearoa New Zealand. Additional areas warranting future research—such as the impact of mental health service use on visa application outcomes, confidentiality concerns when interpreters are involved and the use of transnational mental health services—were not ranked as high priorities but remain critical and deserve deeper investigation to inform system-level changes.

As with all research, this study has limitations. Including a more diverse group of participants—particularly women with lived experience of mental health conditions—would have undoubtedly strengthened the study findings. However, high levels of stigma against mental health within ethnic communities^{34–36} as well as limited project

resources made this difficult to achieve. Despite this limitation, given that many of the participants identified as ethnic migrant women themselves gives us confidence in the findings of this study. Additionally, the consistency of themes across interviews and workshop discussions highlights the salience of the identified priorities. While some of these factors may also affect men, the intersection of gender and migration amplifies their impact on women and girls. Finally, while the identified priorities have largely focussed on addressing existing needs and gaps, they also challenge some of the common deficit-based narratives pathologising culture and ignoring the effect of structural factors such as discrimination or data recording practices as a way to understand mental health.

In conclusion, there is a growing need to generate evidence that captures the complexity of the experiences of Asian and MELAA women and girls in Aotearoa New Zealand, and to use these insights to develop local evidence-based culturally and gender-responsive interventions. Our findings provide an initial foundation for researchers and practitioners seeking to advance meaningful and community-relevant inquiry into the mental health of ethnic migrant women.

COMPETING INTERESTS

None of the authors have any conflict of interest.

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