Aligning CALD Health Access Priorities with Australian Government Policies.

October 2025

Policy Brief

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Introduction

Culturally and Linguistically Diverse (CALD) communities in Australia represent a substantial and growing segment of the population, yet continue to experience structural and systemic barriers in accessing equitable healthcare. These include language and literacy barriers, limited cultural competence across the healthcare system, gaps in service design and communication, stigma around certain health topics, and significant shortfalls in data collection, disaggregation, and use.

The *National Preventive Health Strategy 2021–2030* (NPHS) and a network of adjacent policies recognise CALD populations as priority groups. However, while these policies often acknowledge CALD inclusion in principle as well as specifics, in practice they diverge in scope, depth, and consistency. There is limited cross-policy analysis or coordinated reform effort to ensure CALD health equity is embedded structurally and operationalised in ways that improve service access, experience, and outcomes.

In response, the Migrant and Refugee Health Partnership (MRHP) and The Social Policy Group (SPG) undertook a structured review and consultation process in mid-2025 to explore how Australia's preventive health and chronic disease policy frameworks could be better aligned with CALD community priorities. The process focused on collating high-level insights from experienced multicultural health professionals, service providers and policy actors. As a key part of this work, an integrated Policy Matrix (Appendix 1) was developed, a strategic mapping tool that evaluates 17 current Australian Government strategies with implications for CALD health equity. The matrix highlighted fragmentation, duplication, and inconsistent policy attention to CALD communities, and was used to guide evaluation of policy settings, identify system blind spots, and sharpen reform proposals. It now serves as a key tool for cross-policy coherence and strategic leverage.

The resulting insights and recommendations are situated within growing national and international momentum for equity-driven health reform. This brief contributes to the broader agenda of embedding cultural responsiveness within national systems and complements parallel efforts to address access gaps and structural exclusion. It also aligns with recent national reviews that emphasise the importance of inclusive policy design and systemic change to improve health outcomes for CALD communities. Outputs were oriented toward identifying low-barrier, high-impact actions at a national level.

Approach

The brief focuses on how effectively the health needs of CALD communities are addressed across current national preventive and chronic disease policy frameworks. This includes identifying practical and structural reform opportunities that support equity, access, and culturally responsive implementation.

Consultation across the MRHP followed targeted scoping work to examine how CALD community access challenges are addressed across Australia's preventive health and chronic disease policy settings. A key output of this process was the development of an integrated Policy Matrix, used to assess 17 core national health strategies against a set of CALD access and inclusion indicators. The matrix functioned as a diagnostic tool, highlighting strengths, gaps, and areas for coordination or reform across policy domains.

Key priorities included identifying policy strengths, gaps, and duplications in relation to CALD health access, participation, and outcomes; mapping tensions and blind spots that fragment or dilute CALD health priorities; and consolidating expert insights to guide future policy coordination, integration, and strategic refinement. A critical focus was placed on proposing practical opportunities to improve service coordination, workforce capability, and policy design through lived experience and evidence-led commentary. Findings were synthesised thematically and consolidated into the following strategic insights.

Findings

Across the set of policies evaluated, notable strengths include high-level recognition of CALD communities as priority groups and an increasing commitment to culturally competent care, health literacy, and social determinants of health. Many strategies addressing chronic disease prevention and mental health displayed synergies that offer potential for coordinated equity-centred reform if implemented with stronger cross-policy alignment.

However, several key thematic areas showed inconsistent or insufficient attention. Migration-related health vulnerabilities - including visa-related access restrictions, service exclusions, and pre-migration risks - were inadequately addressed. The specific needs of refugee and asylum seeker populations, shaped by trauma and dislocation, were rarely considered in operational policy terms.

Health risks tied to settlement, such as housing instability, education barriers, and precarious employment, were also underdeveloped. Digital literacy and access challenges for older migrants and new arrivals lacked tailored policy solutions. Intersectional concerns affecting CALD people living with disability, LGBTQIA+ identities, or older age were largely absent. While many policies

acknowledged the importance of co-design, few embedded mechanisms, funding models, or accountability structures to meaningfully include CALD communities in planning and implementation.

From this landscape, **five foundational cross-cutting policy challenges** emerged:

- **Language services and communication** remain unevenly funded and integrated, with limited systemic commitment to ensuring multilingual access through professional translation and interpreting.
- **Cultural competence and workforce capability** are rarely embedded in national training standards, service design, or performance frameworks, undermining culturally safe care
- **CALD data and disaggregation** are often absent or inconsistently applied, weakening the evidence base for effective service planning, targeting, and accountability.
- **Community engagement and co-design** are not robustly operationalised in most strategies, limiting the influence of CALD communities on health system priorities.
- **Migration and settlement factors** - including trauma, exclusion, and visa-related barriers - are insufficiently recognised or addressed, particularly in mainstream preventive health strategies.

These structural issues frame the focus of the consultation and form the basis for proposed strategic reforms. The Integrated Policy Matrix is attached as an appendix to support further analysis and inform future planning and alignment efforts.

Key Insights & Recommendations

The insights are structured around common themes that reflect recurring access and equity issues across Australia's health system. The analysis identifies priority reform areas and presents recommendations to strengthen CALD-inclusive health policy and service delivery.

1. Foundational Barriers to Equitable Access

Despite broad policy commitments to inclusion, CALD communities face persistent access barriers linked to cultural dissonance, health system literacy, and inadequate service responsiveness. These foundational gaps manifest across health settings and disproportionately impact those with complex needs.

Trust breakdowns between CALD communities and health services are common, driven by fragmented care, language disconnects, and culturally incongruent communication. Many consumers are unfamiliar with system navigation or deterred by fear, stigma, or prior poor

experiences. These challenges are magnified for individuals facing low literacy, mental health issues, chronic illness, or intersecting marginalisation.

Recommendation 1: Establish and fund cultural liaison models and bicultural health workforce programs to build trust and broker care access. Examples might adapt from the model of Aboriginal Liaison Officer programs in hospital environments, and federal scaling of community Local Health Districts (LHNs) bicultural health networks.

Recommendation 2: Embed CALD-centred health literacy initiatives tailored to cultural context, navigation, and patient empowerment.

2. Interpreter and Translation System Reform

Language services remain a critical enabler of equitable healthcare access for CALD communities. However, the current interpreter and translation system is marked by inconsistent availability, variable quality, and operational inefficiencies - particularly in low-resource settings and for less common languages. Structural issues include underfunding in key areas such as antenatal care, limited billing mechanisms, and cost barriers to entering or remaining in the profession.

There is an urgent need to revitalise specialised interpreter training and expand pathways to NAATI accreditation. AI-enabled translation was noted as a complementary technology, but cannot substitute for qualified human interpreters in complex or sensitive health interactions.

Policy reform should also focus on elevating the professional standing of interpreters as a specialised and essential workforce. Strengthening workforce recognition - including improved skilled migration pathways and long-term residency options for qualified interpreters - would support system stability, meet growing demand, and attract skilled practitioners.

Recommendation 3: Fund a national health interpreter workforce strategy, including subsidies for interpreter training, reinstatement of health-specialised training, and standards for interpreter use in care.

Recommendation 4: Expand professional recognition pathways for qualified interpreters, including improved access to skilled migration and permanent residency options, to support long-term workforce development and sector stability.

Recommendation 5: Strengthen interpreter availability and billing parity in primary and community care, including for time-intensive consultations.

3. Community-Led Models and Leadership Investment

Community leadership remains one of the most effective yet underutilised levers for improving health access and outcomes among CALD populations. Evidence consistently shows that community-driven models foster trust, strengthen engagement, and enhance cultural legitimacy in service delivery.

Successful models, such as Queensland's Mater Health Advisory Group, demonstrate the value of bicultural engagement, embedded co-design, and local leadership in shaping responsive care pathways. These initiatives improve both the quality and credibility of data collection, enhance cultural communication, and support the development of context-specific solutions.

National policy frameworks should prioritise investment in replicating and scaling such models across jurisdictions. This includes sustained funding for bicultural workers, community health education, and CALD-led program design and governance. Embedding community leadership within health system architecture would move engagement from ad hoc participation toward genuine co-ownership and partnership in health reform.

Recommendation 6: Support national scaling of bicultural community advisory structures, including funding to integrate these into local health networks and clinical governance.

Recommendation 7: Invest in bicultural workforce and community health worker initiatives to drive localised engagement and culturally responsive service connection.

4. Strengthening Co-Design and Consumer Voice

There remains a significant gap between stated commitments to co-design and the quality of implementation across health policy and service delivery. Engagement processes are often critiqued as superficial, tokenistic, or performative, with limited influence on program design or outcomes.

Genuine co-design requires sustained engagement, informed consumer representation, and clear feedback mechanisms that ensure contributions shape decisions. However, many CALD community members currently involved in engagement processes lack adequate training, support, or compensation to participate meaningfully. This undermines both the inclusiveness and the effectiveness of engagement efforts.

Strategic investment in consumer representative capacity building is essential, alongside clearer integration of co-design expectations into policy funding contracts, program implementation stages, and performance accountability frameworks. Embedding community voice into the full policy and program cycle will strengthen legitimacy, responsiveness, and system equity.

Recommendation 8: Develop funded CALD consumer participation frameworks, including training and sustained involvement through strategy lifecycles.

Recommendation 9: Embed co-design requirements in commissioning models, with clear definitions, mechanisms, and accountability metrics.

5. Overlooked Migrant Subpopulations and Service Gaps

Specific migrant cohorts - particularly temporary visa holders, Pacific Australia Labour Mobility (PALM) workers, and dependents of skilled migrants - remain critically underserved in national health policy frameworks. These groups are frequently excluded from Medicare eligibility, face private insurance limitations, or fall between jurisdictional and service mandates.

Health access pathways for visa-based populations are often fragmented and poorly integrated. For example, pre-arrival tuberculosis screening for certain migrant groups is not consistently linked to domestic health systems, such as My Health Record, creating discontinuities in care. Likewise, families and dependents accompanying primary visa holders are often overlooked in both policy design and service planning, despite facing unique and compounding barriers to care.

Addressing these gaps requires more inclusive health policy development that explicitly accounts for the structural and migration-related determinants shaping access, eligibility, and continuity of care for all migrant subpopulations.

Recommendation 10: Undertake cross-jurisdictional review of migrant cohort health access, with inclusion of temporary visa holders in Medicare alternatives or subsidised services.

Recommendation 11: Integrate visa-based pre-screening health data into primary care systems, including My Health Record.

6. Policy and Data Coordination Gaps

CALD communities are frequently acknowledged across national health strategies, yet structural coordination challenges persist. Weak inter-policy alignment, siloed implementation, and fragmented data feedback loops continue to undermine systemic progress on equity and inclusion. The absence of shared data indicators, limited integration of migration-related variables, and inconsistent program evaluation standards all contribute to reduced accountability and strategic drift.

A further limitation is the failure to capture and respond to intersectional factors—such as disability, LGBTQIA+ status, and older age—within CALD population groups. These dimensions are rarely incorporated into policy frameworks, leading to homogenised treatment of CALD communities that obscures diverse and compounding access barriers. Most strategies treat CALD needs as a broad or static category, without the nuance required for equitable planning and targeted implementation.

Recommendation 12: Develop a national CALD equity coordination framework, aligning cross-policy accountability, reporting, and shared indicators.

Recommendation 13: Build CALD and intersectional disaggregation into data infrastructure, including performance monitoring and public reporting.

Conclusion

This brief highlights shared recognition of the practical, cultural, and structural barriers that continue to shape inequitable health access for CALD communities and span the policy ecosystem. It consolidates grounded perspectives that underscore the need for strengthened cultural responsiveness, improved interpreter systems, more robust CALD data frameworks, and greater investment in community leadership and co-design.

The findings aim to inform future policy refinement and integration, reinforcing commitments to equity, responsiveness, and inclusion across national health strategy. They are intended to support ongoing dialogue and joint action between government, services, and CALD communities to embed practical, systemic reforms that improve access, participation, and outcomes.

Aligning CALD Health Access Priorities with Australian Government Policies

Appendix 1 - Policy Matrix

This matrix evaluates the extent to which key Australian national health policy strategies address critical CALD (culturally and linguistically diverse) priorities, needs, and issues. Each row corresponds to a distinct thematic area representing known structural, service, or community dimensions affecting CALD population health outcomes. The presence, strength, or absence of policy attention in each cell reflects the outcome of a targeted review of strategy documents, searching for explicit or implicit commitments, initiatives, or operational measures.

Below is a guide to what each matrix row (issue area) signifies:

CALD recognition as priority population
Whether the policy explicitly identifies CALD groups as a target or priority population deserving tailored interventions, resourcing, or outcome tracking.

Culture-bound characteristics of the mainstream system
Whether the policy acknowledges that dominant health systems, norms, and assumptions may create structural exclusion or invisibility for CALD communities.

Diversity within CALD populations
Whether the policy recognises heterogeneity across CALD groups (e.g., by ethnicity, language, migration background, religion) rather than treating CALD as a monolith.

Language barriers
Whether the policy identifies language barriers as a factor impeding access to services, information, or participation in health programs.

Translation and Interpreting services

Whether the policy commits to or supports the integration of high-quality language services (interpreting, translation) across health system settings.

Culturally competent services

Whether the policy addresses the need to provide health services adapted to CALD communities' cultural practices, expectations, and norms.

Workforce competency in culturally competent care

Whether the policy emphasises training, upskilling, or supporting the health workforce to deliver culturally competent, responsive, and respectful care.

Health communication (multilingual, multicultural)

Whether the policy promotes culturally adapted, linguistically appropriate public health messaging, campaigns, and educational materials.

Stigma

Whether the policy addresses how stigma (social, cultural, or institutional) affects CALD community health behaviours, service use, or health outcomes.

Health systems barriers

Whether the policy identifies and proposes solutions to systemic barriers in health system design, funding, or governance that disproportionately affect CALD populations.

Mental health support

Whether the policy acknowledges the specific mental health needs, risk factors, and service access barriers experienced by CALD communities.

Preventive health and health literacy

Whether the policy integrates strategies to promote preventive health engagement, screening, and health literacy within CALD populations.

Social determinants of health

Whether the policy incorporates attention to social, economic, and structural factors shaping CALD health outcomes, such as employment, housing, education, and discrimination.

Data collection and evidence-based policy

Whether the policy supports the collection, disaggregation, and use of CALD-specific data to inform performance monitoring, evaluation, and continuous improvement.

Migration-related health vulnerabilities

Whether the policy acknowledges how visa status, Medicare access, temporary migration, or migration pathways affect CALD population health access and vulnerability.

Refugee and asylum seeker health and trauma needs

Whether the policy recognises the specific health and trauma needs of refugees and asylum seekers, including trauma-informed care, resettlement stress, and access barriers.

Settlement and integration barriers

Whether the policy addresses challenges faced by newly arrived migrants in navigating the health system, establishing community connections, or integrating into local services.

Multigenerational household health risks

Whether the policy considers how household structures (e.g., larger or multigenerational CALD households) influence disease transmission, caregiving burdens, or access to services.

Digital health access and digital literacy

Whether the policy accounts for CALD community access to digital health platforms, tools, and information, and recognises disparities in digital literacy.

Community engagement and co-design mechanisms

Whether the policy includes mechanisms to meaningfully involve CALD communities in the design, delivery, and governance of health programs and policies.

Intersectional impacts (gender, disability, LGBTQI+, CALD)

Whether the policy addresses the compounded or overlapping health disadvantages experienced by individuals with intersecting identities, such as CALD women, CALD people with disabilities, or LGBTQI+ CALD individuals.

Key policies

Area of Address	National Preventive Health Strategy 2021–2030	Men's Health Strategy 2020–2030	Women's Health Strategy 2020–2030	Children & Young People Health Plan	Mental Health and Suicide Prevention Plan	Strategic Framework for Chronic Conditions	Strategic Framework for Rural and Remote Health	Health and Climate Strategy	Obesity Strategy 2022–2032
CALD recognition as priority population	Explicitly included under Equity Lens.	CALD males identified as priority.	CALD women identified as priority.	Mentions CALD youth, limited detail	Identified as a vulnerable group.	Listed as a priority population.	Acknowledged in rural/remote context.	Mentions vulnerable populations; limited CALD focus.	Notes inclusivity but lacks depth.
Culture-bound characteristics of the mainstream system	Addresses structural cultural barriers.	Acknowledges cultural norms in male health.	Addresses cultural and gender-specific barriers.	Notes cultural adaptation, minimal detail	Addresses cultural stigma and system barriers.	Highlights culturally safe models.	Focuses more on geographic barriers.	Notes resilience, little cultural integration.	Acknowledges but lacks operational depth.
Diversity within CALD populations	Emphasises CALD heterogeneity.	Acknowledges diversity among CALD men.	Recognises diversity within CALD women.	Recognises diverse youth needs	Highlights cultural diversity in mental health.	Notes diverse risk profiles.	Limited focus.	Limited elaboration on CALD diversity.	Lacks detailed CALD differentiation.
Language barriers	Explicitly addressed, multilingual resources.	Recognised as an access barrier.	Recognised, calls for support.	Recognises accessible youth communication	Highlights language barriers.	Notes interpreter need.	Mentions interpreter needs.	Notes inclusive communication; lacks CALD-specific plans.	Recommends culturally appropriate campaigns.
Translation and Interpreting services	Promotes quality access.	Supports culturally adapted services.	Supports interpreter services.	Limited mention	Supports translated mental health materials.	Supports interpreter use.	Notes interpreter needs.	Mentions inclusive communication but lacks CALD focus.	Advocates tailored communication, limited operational detail.
Culturally competent services	Emphasises system-wide cultural competence.	Advocates male-centred cultural competence.	Highlights culturally competent women's services.	Endorses culturally responsive youth care	Prioritises culturally competent mental health care.	Stresses cultural competence in chronic care.	Encourages cultural responsiveness, limited detail.	Suggests culturally competent climate response.	Suggests need but lacks depth.
Workforce competency in culturally competent care	Prioritised training and redesign.	Recommends cultural competence development.	Supports workforce training.	Acknowledges need, lacks CALD detail	Advocates cultural competence in mental health.	Emphasises training.	Encourages workforce competence strengthening.	Recognises workforce challenges, limited CALD detail.	Suggests readiness but lacks strategy.
Health communication (multilingual, multicultural)	Culturally adapted campaigns.	Supports tailored communication.	Advocates multilingual tailored communication.	Supports adapted youth messaging	Highlights culturally sensitive mental health messaging.	Supports adapted communication.	Notes local needs, less cultural focus.	Mentions inclusive strategies.	Recommends culturally adapted campaigns.

Area of Address	National Preventive Health Strategy 2021–2030	Men's Health Strategy 2020–2030	Women's Health Strategy 2020–2030	Children & Young People Health Plan	Mental Health and Suicide Prevention Plan	Strategic Framework for Chronic Conditions	Strategic Framework for Rural and Remote Health	Health and Climate Strategy	Obesity Strategy 2022–2032
Stigma	Recognises cultural stigma.	Highlights stigma in male help-seeking.	Addresses stigma in reproductive and mental health.	Mentions youth stigma, limited cultural lens	Central focus on stigma in mental health access.	Notes stigma limits engagement.	Less explicit.	Minimal stigma focus.	Mentions weight and behaviour stigma, lacks cultural detail.
Health systems barriers	Identifies systemic barriers.	Recognises system barriers for CALD men.	Recognises system barriers for CALD women.	Notes youth access gaps, minimal CALD focus	Identifies systemic exclusion in mental health.	Calls for systemic equity improvements.	Focuses on geographic gaps, limited cultural aspects.	Addresses resilience but little cultural integration.	Highlights barriers to obesity prevention.
Mental health support	Promotes culturally safe access.	Emphasises CALD male support.	Highlights CALD women's needs.	Includes culturally appropriate youth support	Core focus on CALD mental health.	Addresses as comorbidity needing adaptation.	Less emphasised; general rural focus.	Recognises climate mental health impacts, limited CALD content.	Notes as comorbidity, lacks CALD elaboration.
Preventive health and health literacy	Culturally adapted preventive care.	Advocates improving male health literacy.	Supports improving women's health literacy.	Supports preventive youth health, limited CALD tailoring	Supports CALD mental health literacy.	Highlights preventive approaches.	Encourages health literacy, less cultural detail.	Notes preventive climate adaptation, limited cultural framing.	Advocates culturally relevant prevention and literacy.
Social determinants of health	Addresses socioeconomic, cultural, structural determinants.	Highlights intersectional determinants.	Focuses on social and cultural determinants.	Acknowledges social drivers, including culture	Emphasises determinants shaping mental health.	Notes determinants in chronic burden.	Highlights rural determinants, less cultural focus.	Notes determinants shaping climate impacts, limited CALD detail.	Acknowledges determinants, lacks CALD elaboration.
Data collection and evidence-based policy	Calls for disaggregated data and evaluation.	Highlights data gaps on CALD men.	Identifies data gaps on CALD women.	Calls for improved youth data, includes CALD	Calls for improved CALD mental health data.	Supports better CALD data monitoring.	Encourages local data, lacks CALD disaggregation.	Identifies need for better data, limited CALD focus.	Notes data gaps, limited CALD monitoring.
Migration-related health vulnerabilities	Limited; NPHS and Mental Health minor mentions.	Rarely addressed.	Rarely addressed.	Limited mention	Minor attention through trauma-informed care.	Absent.	Not addressed.	Absent.	Absent.
Refugee and asylum seeker health and trauma needs	Underexplored.	Absent.	Absent.	Not addressed	Partial mention (trauma-informed care).	Absent.	Absent.	Absent.	Absent.
Settlement and integration barriers	Indirectly touched on; social determinants.	Absent.	Absent.	Limited mention	Absent.	Absent.	Absent.	Absent.	Absent.
Multigenerational household health risks	Virtually absent.	Absent.	Absent.	Not addressed	Absent.	Absent.	Absent.	Absent.	Absent.

Area of Address	National Preventive Health Strategy 2021–2030	Men's Health Strategy 2020–2030	Women's Health Strategy 2020–2030	Children & Young People Health Plan	Mental Health and Suicide Prevention Plan	Strategic Framework for Chronic Conditions	Strategic Framework for Rural and Remote Health	Health and Climate Strategy	Obesity Strategy 2022–2032
Digital health access and digital literacy	Briefly acknowledged; mainly Digital Health Strategy.	Absent.	Absent.	Notes digital inclusion for youth	Absent.	Absent.	Absent.	Absent.	Absent.
Community engagement and co-design mechanisms	Broadly endorsed, limited CALD-specific mechanisms.	Endorsed, minimal detail.	Endorsed, minimal detail.	Supports youth engagement, minimal CALD detail	Endorsed, minimal detail.	Endorsed, minimal detail.	Not emphasised.	Not emphasised.	Endorsed, minimal detail.
Intersectional impacts (gender, disability, LGBTQI+, CALD)	Some attention.	Some attention.	Some attention.	Highlights youth intersections	Some attention.	Minimal.	Minimal.	Minimal.	Minimal.

Additional policies

Area of Address	Oral Health Plan 2015–2024	Alcohol Strategy 2019–2028	Drug Strategy 2017–2026	Action Plan for the Health and Wellbeing of LGBTIQA+ People 2025–2035	Disability Strategy 2021–2031	Diabetes Strategy 2021–2030	BBV and STI Strategies 2018–2022	Cancer Control Plan
CALD recognition as priority population	Recognises disparities, less explicit CALD focus.	Acknowledges cultural diversity, broad focus	Minimal CALD attention; broad focus on harm reduction.	Recognises intersectionality, limited CALD-specific focus.	Addresses CALD-disability intersections but mainly disability-centric.	Acknowledges CALD diabetes burden, limited tailored measures.	Explicit CALD priority group in sexual health.	Recognises CALD disparities but lacks tailored plans.
Culture-bound characteristics of the mainstream system	Focused on general access, limited cultural adaptation.	Limited cultural adaptation focus	General systems-level focus, limited cultural specifics.	Addresses heteronormative bias, limited CALD-cultural specifics.	Addresses disability barriers in systems, limited cultural focus.	Limited adaptation of mainstream systems for CALD groups.	Addresses cultural barriers in HIV/STI care.	Acknowledges system gaps but lacks cultural adaptation detail.
Diversity within CALD populations	Absent; general population focus.	Acknowledges broad cultural differences	Minimal attention to cultural diversity nuances.	Recognises LGBTQI+ diversity, less on CALD intersections.	Recognises disability diversity, minimal CALD nuance.	Limited acknowledgment of CALD subgroup differences.	Recognises diversity across affected populations.	Limited CALD subgroup exploration.
Language barriers	Limited language services focus.	Mentions tailored outreach, minimal language focus	Mentions need for adapted communication.	Focus on inclusive language, minimal multilingual services.	Emphasises accessible formats, limited language adaptation.	Acknowledges language barriers, minimal implementation detail.	Strong multilingual focus for risk communication.	Acknowledges communication barriers, minimal language strategy.
Translation and Interpreting services	Minimal mention.	Minimal focus	Mentions adaptation but not elaborated.	Minimal, focused on inclusive language not translation.	Accessible communication, less interpreter emphasis.	Limited translation/interpreting provisions.	Emphasises high-quality translation and outreach.	Limited interpreter focus.
Culturally competent services	Minimal attention.	Notes need for cultural adaptation	Minimal elaboration.	Emphasises LGBTQI+ cultural competence.	Focused on disability competence, minimal CALD integration.	Lacks detailed CALD cultural competence strategies.	Promotes culturally safe BBV/STI services.	Emphasises person-centered care, limited CALD cultural lens.
Workforce competency in culturally competent care	Workforce recommendations general.	Mentions cultural awareness, lacks depth	Minimal elaboration.	Focused on LGBTQI+ cultural training.	Focused on disability competence, minimal CALD specifics.	Lacks detailed CALD workforce measures.	Strong emphasis on workforce cultural training.	Limited focus on cultural upskilling.
Health communication (multilingual, multicultural)	General health literacy focus.	Recommends culturally tailored campaigns	Mentions drug education but lacks detail.	Inclusive messaging, not focused on multilingual needs.	Accessible materials, minimal multilingual tailoring.	General prevention messaging, minimal CALD focus.	Strong culturally tailored communication.	General public health messaging, limited CALD tailoring.
Stigma	Little stigma focus.	Addresses alcohol stigma, minimal cultural detail	Addresses drug use stigma, minimal cultural tailoring.	Strong focus on LGBTQI+ stigma.	Addresses disability stigma, limited CALD layers.	Mentions diabetes stigma but lacks cultural depth.	Strong focus on stigma in HIV/STI contexts.	Mentions stigma in cancer, lacks cultural tailoring.

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Health systems barriers	Focuses on general barriers.	Identifies system barriers broadly	Recognises barriers but minimal cultural depth.	Highlights systemic exclusion, less CALD detail.	Addresses systemic disability exclusion.	Acknowledges access gaps, minimal cultural solutions.	Notes system-level exclusion in BBV/STI care.	Identifies access barriers, limited cultural adaptation.
Mental health support	Little mental health focus.	Mentions comorbid mental health, minimal CALD	Addresses drug use and mental health, minimal cultural depth.	LGBTQI+ mental health focus, limited CALD overlay.	Mental health within disability context, little CALD focus.	Mentions mental health comorbidities, lacks CALD specifics.	Addresses mental health in HIV/STI care.	Mentions psychosocial care, lacks CALD focus.
Preventive health and health literacy	General literacy focus, minimal cultural tailoring.	Broad prevention, minimal cultural detail	Supports harm reduction literacy, limited elaboration.	Focused on LGBTQI+ health empowerment.	Focused on disability health literacy, minimal CALD tailoring.	General diabetes prevention, lacks CALD literacy strategies.	Strong preventive health education.	General cancer prevention, minimal CALD-specific literacy.
Social determinants of health	Acknowledges determinants, minimal cultural elaboration.	Notes SDOH broadly, minimal CALD focus	Addresses determinants but minimal cultural specificity.	Strong focus on LGBTQI+ SDOH.	Strong focus on disability SDOH.	Acknowledges SDOH links, minimal cultural nuance.	SDOH central to risk contexts.	Recognises SDOH but lacks CALD-specific framing.
Data collection and evidence-based policy	Recognises data needs, minimal CALD elaboration.	Notes data needs, minimal CALD disaggregation	Encourages evidence use but limited CALD data detail.	Highlights LGBTQI+ data gaps.	Focused on disability-disaggregated data, limited CALD layers.	Calls for improved data, minimal CALD detail.	Emphasises CALD-disaggregated surveillance data.	Calls for better cancer data on vulnerable groups.
Migration-related health vulnerabilities	Absent.	Absent.	Absent.	Minimal attention.	Minimal attention.	Weak or absent.	Highlights migrant/refugee HIV/STI vulnerabilities.	Minimal migration-related focus.
Refugee and asylum seeker health and trauma needs	Absent.	Absent.	Absent.	Limited; some LGBTQI+ refugee mentions.	Not addressed.	Not addressed.	Recognises trauma among migrant/refugee BBV/STI-affected groups.	Largely absent.
Settlement and integration barriers	Absent.	Absent.	Absent.	Not addressed.	Not addressed.	Not addressed.	Partially addressed in migrant BBV/STI contexts.	Not addressed.
Multigenerational household health risks	Absent.	Absent.	Absent.	Not addressed.	Not addressed.	Not addressed.	Not addressed.	Not addressed.
Digital health access and digital literacy	Absent.	Absent.	Absent.	Limited mention, emerging issue.	Limited mention.	Limited mention.	Limited mention.	Limited mention.
Community engagement and co-design mechanisms	Not emphasised.	Recommends partnerships, minimal CALD co-design	Not emphasised.	Strong LGBTQI+ co-design focus.	Strong disability community engagement.	Minimal co-design detail.	Strong community partnerships in HIV/STI work.	Early-phase co-design emerging.
Intersectional impacts (gender,	Minimal.	Minimal.	Minimal.	Central to LGBTQI+ approach.	Strong disability-gender intersectional framing.	Minimal intersectional framing.	Recognises intersectionality in risk.	Emerging intersectional awareness.

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disability, LGBTQI+, CALD)								

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