



Submission prepared by the Multicultural Centre for Women's Health as an outcome of:

**A Joint MCWH-ICEPA National Symposium
Prevention is the Cure- Unpacking Health Realities for
Immigrant and Refugee Women in Australia
28th October 2009, Victoria University Conference Centre**

Submission of the Multicultural Centre for Women's Health

to

The Department of Health and Aging, Commonwealth Government of Australia

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1. Introduction

1.1. Executive Summary

On the 28th of October 2009, the Multicultural Centre for Women's Health (MCWH), in collaboration with the Institute for Community, Ethnicity and Policy Alternatives (ICEPA), hosted a national symposium – '*Prevention is the Cure- Unpacking Health realities for Immigrant and Refugee Women in Australia.*' A total of 75 participants from Victoria, ACT, NSW, NT and Tasmania attended the symposium, representing a range of organisations, from the community and women's health sector to multicultural organisations for young people, and people with disabilities. The symposium presented delegates with an opportunity to provide feedback into the development of the National Women's Health Policy, with a specific focus on the health and wellbeing of immigrant and refugee women.

The objectives of this submission are to bring to the fore issues affecting the health and wellbeing of immigrant and refugee women identified at the symposium, and to present the recommendations proposed by participants in contribution to the development of the proposed National Women's Health Policy.

1.2. About the Multicultural Centre for Women's Health (MCWH)

MCWH is a women's health organisation which is committed to improving the health of immigrant and refugee women around Australia. MCWH is for all women from immigrant communities, including refugees and asylum seekers, and women from both emerging and established communities. MCWH provides national leadership and excellence in multilingual health education, advocacy, training, and research with specific expertise in sexual, reproductive, occupational, and mental health.

1.3. About the Institute for Community, Ethnicity and Policy Alternatives (ICEPA)¹

ICEPA is a research and development institute that works towards social transformation and social inclusion. The Institute works to enhance the capacity of individuals and social, educational and economic systems in organisations, communities and nations to meet the challenges of social exclusion resulting from social, cultural and economic inequalities. ICEPA works in the areas of cultural

¹ Source: <http://www.vu.edu.au/icepa> (accessed 24 November 2009).

diversity, international development, social inclusion/exclusion, health and wellbeing and policy alternatives.

1.4. Emerging Themes and Key Recommendations

A range of issues and recommendations were brought up during the symposium and the common themes that emerged during the day are summarised below.

- **Access to Health Services** - Improve access to health care services by addressing barriers such as a lack of gender and culturally sensitive staff, a lack of bi-lingual health workers, limited access to transport and childcare services, and culturally inappropriate health service environments.
- **Health Information Dissemination** - Enhance access to health information and health literacy through holistic health information strategies that provide multi-lingual information beyond a reliance on digital strategies. This can include the increased use of bi-lingual health educators to share health information with women in their own social settings.
- **Preventative Health** - Prioritise preventative health in both policy and action within a holistic framework that addresses other determinants of health such as adequate housing, quality childcare, economic security and freedom from violence.
- **Sexual and Reproductive Health** - Enhance support for preventative health research and programs and increase access to preventative health services by addressing barriers such as limited access to transport and childcare services.
- **Occupational Health & Safety** - Develop strategies that improve availability and access to preventative occupational health services by immigrant and refugee women. In addition, improve working conditions, promote equity in the workplace and encourage immigrant and refugee women's economic participation.
- **Access to Disability and Respite Services** – Enhance availability of resources in the provision of support and respite to patients and their carers, ensuring cultural appropriateness of such services. This ought to be complemented by increased support for people with disabilities to participate more actively in the community.

- **Ageing** - Increase access to gender and culturally appropriate health and recreation services.

- **Research and Data Collection** - Increase national research on immigrant and refugee women's health status and enhance the availability of data disaggregated by gender through encouraging gender and diversity analysis in data collection.

- **Government Policy and Procedure** - Ensure that health and other policies are non-discriminatory and are implemented within a human rights framework.

- **Collaboration and Partnership** - Establish multi-sectoral partnerships within government to ensure a holistic approach to immigrant and refugee women's health. In addition, strengthen collaboration with community service and other organisations, acknowledging the social determinants affecting immigrant and refugee women's health.

- **Funding Opportunities** - Introduce funding models that encourage longer term and more sustainable health education and health promotion for immigrant and refugee women.

- **Coordination of Programs on Immigrant and Refugee Women's Health**
Provide for the development of a national body to coordinate immigrant and refugee women's health programs to enhance the standard of program delivery and the effective use of resources.

- **Immigrant and Refugee Women's Health Advocacy** – Enhance support for women's health advocacy initiatives aimed at increasing immigrant and refugee's active participation and self-representation in decision making pertaining to public policy and resources allocation in the socio-economic and political spheres.

2. Issues Emerging from the Presentations

2.1. Migration, Women and Health- An Overview of Issues

Professor Hurriyet Babacan, Institute for Community, Ethnicity & Policy Alternatives, Victoria University

The presenter highlighted the use of discriminatory health policies in the immigrant selection process, founded on stereotypes and preconceptions about health risks. For example, the then federal Immigration Minister Kevin Andrews stated that African refugees carry disease and increase crime rates in Australia.² Hurriyet Babacan went on to site the limitations of migration statistics and research findings which tend to suffer from gender blindness.

She also noted the multiple realities faced by immigrant and refugee women - while they may hold skilled and powerful positions at work, they are disadvantaged in other ways such as managing family fragmentation due to migration. Further, migrant women are not present and/or often marginalised in decision making structures, and resources for programs for immigrant and refugee women are often ad-hoc and short term. Other salient factors such as lack of awareness of legal rights, cultural inequality and male dominance in the family, as well as social isolation and discrimination, contribute to negative health outcomes.

The speaker further highlighted some of the barriers to immigrant and refugee women accessing health services. These include limitations in health literacy, lack of culturally and gender appropriate services, limited access to transport, and cultural approaches to health and illness where help is sought at the acute stage. Immigrant and refugee women also carry a disproportionate burden of disease and are at high risk of, inter alia, mental illness, diabetes, hypertension and cardiovascular disease. Research also shows that a higher proportion of immigrant and refugee women have poor sexual and reproductive health experiences and there is a lower uptake of cancer screening services such as mammograms and pap smears in some groups. Discrimination and social exclusion also have a negative impact on immigrant and refugee women's health and evidence has shown that victims of racism and

² See related story, The Australian Broadcasting Corporation, "Hanson supports African refugee reduction," <http://www.abc.net.au/news/stories/2007/10/05/2052376.htm> (accessed 24 November 2009).

discrimination are more susceptible to physical and psychological illnesses including respiratory illnesses, hypertension, anxiety, depression and psychosis.³

Recommendations:

- Access to health services
 - Incorporate gender and culture mainstreaming to improve access.
 - Increase availability of culturally competent and multilingual staff.
 - Provide information on organisational processes and procedure of health services (admission, discharge, etc) and informed consent and choice in languages women understand and are comfortable with.
 - Enhance family involvement and create culturally conducive environments (e.g. in waiting rooms).
- The health needs of immigrant and refugee communities should be analysed using an entitlements approach.
- Develop and implement human rights frameworks for health.
- Promote immigrant and refugee women's equitable participation in decision making at all levels.

2.2. A Human Rights Framework for Considering the Health of Migrant Women

Associate Professor Bebe Loff, Human Rights and Bioethics School of Public Health and Preventive Medicine, Monash University

Bebe Loff gave an outline of human rights principles and norms, highlighting substantive rights (as provided for by international treaties and norms, regional human rights treaties and national law) and procedural rights (processes and procedures for enforcing rights and duties, and obtaining redress). She also gave a synopsis of the human rights-based approach which is based on a broad examination of how people fare in relation to the full range of human rights and is founded on the UNDP's principles of universality and indivisibility; equality and non-discrimination; participation and inclusion; accountability and rule of law.

A rights-based approach demands that attention be paid to safeguarding human dignity, with specific attention to the most vulnerable groups. Using a gender perspective and ensuring equality and freedom from discrimination in programme implementation are also key demands. Moreover, there should be mechanisms in

³ Karlsen and Nazroo (2002), MacKenzie (2003), Babacan et al (2009) and VicHealth (2006).

place that provide safeguards for minority and unpopular groups, promote access to information and respect the right to privacy. In particular reference to health, relevant benchmarks and indicators must be identified with the objective of the progressive realisation of the highest attainable standard of health. The application of human rights standards to health services or evaluation of the realisation of the right to health must consider availability; accessibility (non-discrimination, physical accessibility, economic accessibility, information accessibility); acceptability and quality of health services.

Recommendations:

- Government should take into cognisance that in interpreting the right to health, the Committee on Economic, Social and Cultural Rights stated that States have an obligation to respect the right to health “by refraining from denying or limiting equal access - on economic, physical and cultural grounds - for all persons, including... asylum seekers and illegal immigrants, to preventive, curative and palliative health services”.⁴
- Enhanced access to health services for migrants as, according to human rights law, governments have legal obligations in relation to the health of every person within their jurisdiction.⁵

2.3. Sexual and Reproductive Preventative Health

Adele Murdolo, Executive Director, Multicultural Centre for Women’s Health

Through storytelling, the speaker presented the experiences of two immigrant and refugee women in accessing sexual and reproductive preventative health services and information. The story highlighted the social reality faced by immigrant and migrant women upon arrival and after ‘settling’ in Australia. Highlighting the impact of lack of information in colloquial languages and bi-lingual and cultural competent

⁴ Office of the United Nations High Commissioner for Human Rights (UNHCHR), Committee on Economic, Social and Cultural Rights, Substantive Issues Arising In the Implementation of the International Covenant On Economic, Social and Cultural Rights, E/C. 12/2000/4/ , General Comment No. 14-The right to the highest attainable standard of health: 11/08/2000.
[http://www.unhchr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En](http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En) (accessed November 24, 2009).

⁵ World Health Organization, “International Migration, Health and Human Rights,”
http://www.who.int/hhr/activities/en/intl_migration_hhr.pdf (accessed November 24, 2009).

health workers, the narrative brought attention to the barriers in health literacy faced by immigrant and refugee women in accessing contraceptive health services and information. Similar concerns were also raised in terms of immigrant and refugee women accessing and utilising peri-natal information and services; with late presentation for pregnancy health care being more common among migrant and refugee women.⁶ Research also shows that overseas-born women are more likely to develop gestational diabetes than Australian born women.⁷

Occupational health and safety concerns were noted in the narrative, with unemployment, low employment and poor working conditions putting a strain on immigrant and refugee women's health. For example, outworkers are more vulnerable to occupational hazards such as musculoskeletal injuries and workplace violence. Migrant women represent 95% of the approximately 300,000 outworkers in Australia.⁸

In addition to the generally higher incidence of psychological distress among immigrant and refugee communities, the story also illustrated the physical and psychological impact of restrictive family reunion policies on women's health.

Recommendations:

- Preventative health should be a priority in government policy as it can prevent and reduce the risk of:
 - Unwanted pregnancy
 - Dangerous pregnancy
 - Sexually Transmitted Infections (STIs)
 - Infertility
 - Gestational diabetes
 - Type 2 diabetes
 - Occupational injuries and illnesses
 - Child accidents and illnesses
 - Stress and depression
- A preventative health approach must be supported by good social policy. To

⁶ Maria Jose Alcala, *A Passage to Hope: Women and International Migration*, UNFPA State of the World Population 2006 and Manuel Barballo, *International Centre for Migration and Health*, UNFPA-IOM Expert Group Meeting, Geneva, 2006.

⁷ Mardi Templeton and Indrani Pieris-Caldwell, *Gestational Diabetes Mellitus in Australia 2005-06*, AIHW, Canberra, 2008.

⁸ Seaja Chang, *Seamstress: Health Issues of TCF Workers*, Working Women's Health, 2000.

be healthy women need family, community, quality childcare, transport, freedom from violence, economic independence and a voice - representation in the political life of the nation. For immigrant and refugee women, a preventative health approach is the difference between a struggling life, full of daily obstacles, and a better life, characterised by independence, informed and constructive choices, bodily integrity and self-determination.

- A bilingual visiting program for newly arrived immigrant and refugee women should be initiated as part of the process of familiarising women with health and other related services.

2.4. The National Women's Health Policy

Helen Rankin, Director, Gender and Reproductive Health Section, Department of Health and Ageing

The presenter provided a synopsis of the proposed National Women's Health Policy and the national consultation process conducted by the Gender and Reproductive Health Section of the Department of Health and Ageing.

Helen Rankin gave an overview of the aims of the National Women's Policy which are to:

- Improve the health and wellbeing of all women in Australia, particularly women most vulnerable to poor health.
- Promote a health system that is more responsive to women's needs.
- Promote women's participation in health decision making and management
- Promote health equity among women.

She also highlighted the five principles underpinning the National Women's Health Policy- gender equity, health equity between women, a focus on prevention, evidence base and a life course approach.

The following questions were raised by participants:

- How will other determinants of health, e.g. housing, be included in the new policy with regard to other government departments? (Response: There will most likely be a coordinated response, but the focus of the policy will be on addressing the

question: what *should* the National Women's Health Policy try to do?)

- Will extended family members, specifically the role of men, be considered in the policy? (Response: This issue will most likely be addressed within the cultural competency framework and understanding issues within a cultural context.)

3. Issues Raised During Discussion

3.1. Access to private health services

- One of the participants (a refugee nurse) noted that health services such as radiology and pathology are largely inaccessible and expensive for asylum seekers. The participant inquired as to whether the proposed women's health policy would improve access to private health services by immigrant and refugee women. In response, it was suggested that although it was too early to predict the impact of the policy, it is hoped that the policy will propel positive change in areas other than health.

3.2. Advocacy

- One of the speakers highlighted that community organisations and individuals can make use of UN monitoring and reporting mechanisms through the submission of shadow reports to relevant UN convention committees. This is a naming and shaming process, through which UN committees can make recommendations for change to the relevant state parties. Another speaker suggested that the proposed women's health policy explicitly acknowledge the impact of other policies on women's health and facilitate the provision of resources for advocacy initiatives, such as the writing and submission of shadow reports. She also called for increased advocacy highlighting the impact of other policies (immigration, education, etc) on health.

3.3. Strategic Coordination of Resources

- A participant suggested that a possible solution to meeting the needs of immigrant and refugee women is to support lead organisations that have a strategic role in refugee health. There should also be increased and long-term funding for community participation initiatives; mental health (using an approach that respects the way refugee women express, present and understand mental health); and research and data collection (including identifying refugee status in health services).

3.4. Exclusion/Inclusion

- The concept of exclusion/inclusion was raised in relation to how the exclusion of children, whether implicit, explicit or (un)intentional, can contribute to the cyclical nature of exclusion. A participant provided the example at her child's crèche where children of Vietnamese and North African backgrounds often did not participate fully in special crèche activity days. It was suggested that, perhaps like all parents, the transitory nature of crèche drop-offs was a contributing factor for parents' misinformation, but it also begs the question as to why immigrant parents and their children were less likely to participate in extracurricular activities.
- A representative from the Australian Women's Welfare Vietnamese Association commented that English proficiency was often a barrier to participation and that learning English was not a priority for some Vietnamese women—some women often relying on other family members to communicate for them in English, in much the same way as 'producing a credit card', when needed. It was suggested one way to change women's thinking—especially older women—about the importance of English was that it can help connect them with their (grand)children.
- Another participant, who arrived in Australia as a refugee, responded with an account of her childhood. She suggested that it was less a case of not understanding and/or English proficiency, but more to do with a mistrust of Australian society in general as to why her parents did not allow her to participate in extracurricular school activities. Her parent's concern as to what others in their community might think or say about their parental guidance was another factor.
- Comments were made about the challenges parents and carers face in relation to the individualistic nature of Australian society coupled with the rhetoric of the work/life family balance, which can impact on parents and children to actively and fully participate in school and community life.
- The notion of inclusion, as one participant commented, is one that is too narrowly defined within the confines of 'Australianness'. The continued use of the immigrant and refugee and NESB acronyms are indicative of exclusionary criteria that is based on cultural deficiency and lack, rather than that of inclusiveness and respect of, for example, the maintenance of languages other than English.

- One participant commented on the number of services providing assistance to refugee and immigrant groups and asked why some women still did not seek help. It was suggested that it is not a question of choice, but one of inability. Service providers should continually question the reasons for women's inability to seek assistance and focus on what can be done to enable women to seek help.

3.5. Women as carers

3.5.1. Disability

- A question was put forward as to whether there were any bilingual and culturally appropriate interventions and/or institutions that address the needs of migrant women who care for disabled family members.
- Both the symposium MC and one of the speakers, who each care for a disabled child, spoke of the constant battle and challenges of receiving appropriate care for children with a disability as well as respite for the carers. The consequences of lack of support for both carer and child can be profound: murder-suicide.
- 'If mental health is the poor relative of public health, then disability is the poor relative of mental health': this statement was provided by Professor Loff to illustrate the low policy priority given to people with disability and their carers. She suggested the government's inaction on the disability issue—if inaction can at all be excused—could only be made ethically palatable on the grounds that governments perhaps do not and could not fully understand the lived reality of disability; otherwise, governments should be deemed irresponsible.
- One participant with a disability welcomed the various perspectives being discussed in regard to disability support. She commented that making sense of disability, both as a condition and as a policy issue, requires more work and awareness-raising. Support for people with disabilities and their carers should be underpinned by an acceptance and understanding that disability is a fact of life. She also called for increased disability awareness-raising within government and by government, enhanced support for organisations such as ADEC and the National Ethnic Disability Alliance (NEDA), that advocate for the rights of people with disabilities and their carers. She noted the need for more meaningful government support for people with disabilities to participate in society, as well as recognition of their valuable contribution in the community.

3.5.2. Ageing

- The issue of elderly women carers was raised in the context of an ageing community: what is the broad infrastructure support for women who have a carer role? In this regard, the implementation of a life course approach through practical initiatives was highlighted. It was pointed out that for some cultures; residential care is not an option. One suggestion is for a 'hub' model where care and support could be easily accessible by public transport and where services such as childcare, seniors support groups and respite-care is provided.

3.6. The Evidence base

3.6.1. Funding/Funding Models

- The imperative to be 'innovative' in order to receive project funding was criticised as being detrimental to community efforts. Longer-term approaches and opportunities for funding are considered beneficial for sustainability.
- Research and data collection needs to incorporate identification of ATSI and immigrant and/or refugee status.
- Further research is required on the relationships between emotional and mental health and physical symptoms.
- Funding models should change, especially in regard to what is deemed to be a 'health' concern. Comment was made that 'Public Health' has a tendency to colonise all issues. The proposal to ban junk food advertising was cited as an example of the ways in which the legitimacy of others to the obesity debate is excluded. Different disciplines tend to see solutions according to their own discipline and, as such, questions should be asked in relation to how issues are characterised in order to deal with them properly.
- Funding bodies also need to be made accountable for the types of projects funded.
- Duplication of research/projects is an issue.

3.7. Addressing knowledge gaps

- One participant noted that knowledge gaps were exacerbated by low English language proficiency levels. There is therefore a need to re-examine how women access health and wellbeing information to ensure that such information is culturally accessible and appropriate.

- Health information strategies work best if holistic. Ideally women, and especially young women, would get better health information and health services if strategies were based in relationship based models i.e. if women could get information from people who could convey some sense of caring for the women. Reliance on technology and digital strategies cannot replace women getting health information & support from people such as health workers and community members.

4. Issues discussed during the Breakaway Groups

4.1. 'What knowledge gaps exist in relation to immigrant and refugee women's health?'

- More research and data collection should be conducted on particular communities in relation to specific health conditions i.e. prevalence rates and disaggregation of data according to gender, ethnicity and condition.
- Knowledge was also discussed in terms of information that is provided and that has been transformed by the women for their own use. In this regard, the importance of information-provision should be seen as part of the process of empowering women to make their own decisions about their healthcare: women could then make choices as a matter of *prioritising for themselves* rather than information merely as a process of practical communication.
- A project with the Sudanese community was cited in relation to language barriers (Women's Centre for Health Matters, ACT). Interviews and focus groups conducted with 40 Sudanese women revealed that women were less likely to give birth at a hospital because of the perception that doctors would force them to have caesarean births.

4.2. 'What are the critical health issues for immigrant and refugee women?'

In responding to this question, it was noted that there is a need to take into cognisance immigrant and refugee women's understandings of health. Group members noted that their family's health and wellbeing, including their children's education and spouse's employment were, in most cases, given precedence over the individual woman's health. Another participant noted that preventative health was not a priority, with women only seeking health service at the acute stage.

The issues identified were:

- Lack of knowledge of Australian health systems
- Lack of access to health systems and services
- Inappropriate and inadequate housing, primarily characterised by overcrowding
- Family disintegration and low English proficiency which culminate in isolation and poor mental health. Participants suggested that increasing accessibility and availability of bi-lingual health educators could help address this.
- Lack of culturally appropriate facilities and limited opportunities for physical exercise.
- Low levels of health literacy imply that women are ill-informed to initiate and ask GPs for tests. For example, a woman suspected she had Hepatitis B but was not confident enough to ask the GP for a test, and only managed to do so 6 years on after encouragement from a bi-lingual health educator. Participants also called for increased bi-lingual information on breast cancer, pap smears and contraceptives.

4.3. 'How can information about immigrant and refugee health be collected and collated?'

- 'Information' is currently collected in hospitals and/ or medical centres about patients in regards to status or geographical area when they first provide details about themselves. There could be a question provided within this data collection that could include immigrant or refugee status as long as the question does not identify the individual(s) concerned and maintains confidentiality policies.
- Collecting and collating information does not always have to be in a clinical or health environment. Some cultures respond better to questions in a less formal, more social setting. There is a lot of information exchange and sharing during conversations in social settings.
- Better collaboration between organisations as some organisations may already have information relevant to another organisation.
- When collecting information, people are not always going to be so forthcoming when responding to questions. It is important to be patient, develop a rapport, and develop trust and confidentiality and to respect the fact that some people do not want to talk about certain issues or may not be ready to talk.

- Communication does not always have to be based on questions and answers. For instance, through storytelling many people are able to share and provide information in an environment that is less threatening.
- Information can be gathered through focus groups and involving community or cultural leaders in these discussions so people may feel more comfortable about what they are talking about.
- When collecting and collating information it is useful to include referrals such as counselling or immigrant and refugee services that have on-going contact with the community at the grassroots level.
- It is important to be respectful of people, their culture, and their experiences when gathering information. Training should be provided to workers who may be collecting information, emphasising the code of confidentiality.
- Using bilingual health educators from within the community can be an effective way of gathering information. These workers (bilingual health or peer educators) should be paid and trained to this work in facilitating information gathering.

5. The National Women’s Health Policy

5.1. Identified Priorities and Possible Actions

In light of the National Women’s Health Policy Consultation Forum, the contributions below were provided by participants in response to a call to identify immigrant and refugee women’s health priority areas and suggestions for possible actions. These contributions were provided in light of the five policy principles⁹ identified by the Gender and Reproductive Health Section, Department of Health and Aging.

What are your priorities?	What could be done about these?
▪ Health information dissemination	
Access to information for immigrant and refugee women.	Employment and training of bilingual health educators to facilitate processes wherein women receive and share information in a language they can understand.
Increased information sharing through the use of narrative storytelling.	Use research based methodology to transfer health information to women in languages they are comfortable with.
▪ Aging	
Access to appropriate physical activity services.	Development of culturally appropriate physical education programs that encourage women’s participation, for example, having women only swimming sessions.
Increased research in aging and migrant women- beyond reproduction/menopause.	In collaboration with government departments, funding should be provided to organisations working with immigrant and refugee women to conduct research and advocacy on preventative health care for older women.
Access to healthcare by elderly women from non-English speaking backgrounds.	More training and education for ethno-specific health professionals and development of more ethno-specific elderly health services (nursing homes, seniors’ groups, clinics, etc)
Social inclusion and recreation for the elderly.	Specific social engagement activities for the elderly so that they are not, and do not feel, redundant in society.
▪ Language	
Increased delivery of health services in languages other than	Increase training for counsellors, clinicians and patients on the use of interpreters aimed

⁹ The five principles are gender equity, health equity between women, a focus on prevention, evidence base and a life course approach.

English.	at creating an environment in which women feel more comfortable to disclose their health concerns.
Providing health information that caters for the needs of women with low literacy levels.	Improved use of radio and ethnic newspapers, as well as increased funding for professional translators in the health sector. Information must be provided using different media as not all women can read, even in their native language.
Addressing English language barriers as this impacts on women's ability to communicate, and consequently has a negative impact on their access to health services.	Encourage women to interact in English e.g. have time in playgroups to speak to their children in English and have English conversation time during friendship group meetings.
<p>▪ Cultural sensitivity and awareness</p>	
Promoting cultural diversity awareness.	Promote cultural and gender diversity awareness at every level, not only amongst health workers and general managers. There must also be inter-cultural exchange amongst women so they have a better appreciation of other cultures.
Improved provision of culturally specific services in hospital.	Training of bi-lingual workers to attend medical appointments with clients as well as providing patients with a medical record with information that is relevant to the client's illness/medical condition in easy to understand language. In addition, health professionals need to be provided with education and training on effective cross-cultural communication, possibly including such training in the university curriculum for medical students.
African immigrant women face multiple discrimination as women, as black and as Muslim and this is a pertinent issue that needs to be addressed as it limits their participation.	Promote a non-discriminatory and non-judgemental approach to women's health through education and awareness-raising for health service providers and the society at large.
<p>▪ Preventative Health</p>	
Prioritization of preventative healthcare by immigrant and refugee women as many preventative health needs are not taken up because more pressing issues about migration, housing, care-giving for young children or sick adults are deemed more important. Where women do make the time to access preventative health services, culturally appropriate programs do not exist.	Research on the preventative health care needs of immigrant and refugee women, barriers to accessing health services, as well as best practice on providing culturally appropriate health services. There should also be further support for refugee women and their families after the Integrated Humanitarian Settlement Strategy (IHSS) support ceases. In addition, funding models should be adjusted to support more long-term projects. Further, government programs and community organisations currently working with immigrant and refugee women must encourage women's participation in

	preventative health education programs and enhance interaction between women and health workers.
Enhancing preventative health behaviour among immigrant and refugee women.	Commitment of funding for research into understanding women's health seeking behaviour and barriers to health seeking behaviour (e.g. cervical screening). Only once there is greater understanding of women's health seeking behaviour (including attitudes and approached to health) can we begin to address the issues.
<p>▪ Policy and procedure</p>	
To address discriminatory practices in the migration process.	Amendment of migration policies that exclude those who have serious medical conditions as well as increased focus on health (including preventative health) in the IHSS process.
Gender and diversity analysis must be incorporated into all government policy and programme development.	Drawing on the example of the Department of Human Services' Cultural Diversity Plan and Gender and Diversity Lens for Health and Human Services, there needs to be capacity building for government departments' staff to undertake gender and diversity analysis as well as development of similar plans across all departments.
Raising cultural awareness among young people.	Social inclusion and cultural awareness to be part of education system from high school to university level.
<p>▪ Collaboration and Partnership</p>	
Establishment of a holistic, multi-sectoral approach to immigrant and refugee women's health.	The proposed National Women's Health Policy should be made applicable to other government departments and policies e.g. education, immigration, economics, justice, housing. Further, government should set up a whole of government committee to implement strategies from the National Women's Health Policy. For example, the Preventative Health Taskforce should incorporate a gender and diversity working group. This should be done through a process that also encourages cooperation between government departments.
A cross-sectoral approach to addressing immigrant and refugee women's health issues	Increased collaboration between government and other sectors such as community service organisations and the business sector, including forums that allow all sectors to contribute and be part of the solution. Collaboration needs to create meaningful partnerships with government that recognise and validate the social determinants of

	healthy communities (families, individuals, women, men, children, etc).
Promote action and collaboration on women's health associations, bodies and services.	-Start a GP/Divisions of Practice working group on women's health -Start an Allied Health Workers consultative body to focus on women's health -Start a bilingual health workers group on women's health.
▪ Participation	
Promoting the rights of asylum seekers and facilitate their participation as part of civic society	-Submitting shadow reports to relevant UN treaty bodies to promote the rights of asylum seekers -Increasing access to services, especially investigative tests and specialist services as these are often expensive and inaccessible.
Community action to break the barrier among refugee women to participate in health education and information programs.	Incorporate a family based approach (to also include men in the family) when discussion women's participation in order to gain the family's support for women's participation, as well as increase access to participation by immigrant and refugee women in decision making to address issues of concern as identified by the women.
▪ Data Collection	
Regulation of research and statistics.	Development of policies that ensure all populations are included (or not excluded) such that the suggested facts are incorrect or discriminatory.
Updating of research on immigrant and refugee women's health.	Fund national research projects to benchmark immigrant and refugee women's health and to identify best practice in health service delivery to immigrant and refugee women
Advocacy and education to address discriminatory attitudes and practices within the health sector in regional areas.	There is a need for further gender and diversity analysis in regional areas- not only in respect to data gathering but raising awareness about cross-cultural matters pertinent to women's health and health service delivery.
▪ Sexual and Reproductive Health	
Starting a sexual and reproductive health strategy and regular national status report about contraceptive use, STIs, termination of pregnancy.	Develop a national sexual reproductive health strategy and common data collection standards regarding sexual and reproductive health. In addition, conduct focus group discussions with women from different cultural backgrounds and design short and long term sustainable sexual and reproductive health programs.
Increasing 2 yearly screening rates for migrant and refugee	Providing childcare and transport services to enhance access to health services coupled

women.	with greater consultation with women as to the best way to communicate reproductive health information to them.
Protection from discrimination for breastfeeding mothers.	More private facilities for women to breastfeed when in public areas while simultaneously raising the public's awareness on breastfeeding as women should have the freedom to breastfeed in public free from discrimination and sexism.
Addressing myths around health within newly arrived communities e.g. about breastfeeding, not letting children play outside for fear they will get sick, etc.	More education programs and information on health by bi-lingual health workers in the community.
Better access to sexual health information for young migrant and refugee women.	Provide culturally appropriate information that equips young women with skills and support to negotiate greater control over aspects of sexual health. This needs to be done within a relationship framework.
▪ Violence against Women	
Reducing family violence in resettlement	Enhancing support and integration of comprehensive and broad social support services to assist resettlement, for happier, healthier family units and prevention of violence, in addition to empowerment and capacity building for civic participation, including jobs and economic empowerment for women and their families.
▪ Occupational Health & Safety	
Develop health strategies regarding women and work	-Work with the Department of Education, Employment and Workplace Relations (DEEWR) and Fair Work Australia to develop strategies to improve women's working conditions, economic participation and health at work. -Fund a research project on equality at work/home and the gender pay gap. -Promote strategies to encourage family friendly policies and practices.
▪ Care and Respite	
Mental health issues surrounding the patient and family of all citizens in society.	An overhaul of the mental health system (restructure, deconstruction thereof) and promotion of family and open participation.
Support for women as carers.	-Social activities (especially for the mentally ill) and respite for carers and family members

Educational programs on mental health and disability support for women for immigrant and refugee women	Support for disabled and their families and carers that allows respite and domicile if necessary so that women and family can live their lives as well as the disabled person.
Education on children's rights and protection from discrimination	-Education and training of support service providers on the impact of children's health on women's health as well as cultural sensitivity in the delivery of health services. Action has to be taken by government, local authorities as well as immigrant and refugee communities

5.2. What effective health services would you identify as models for others and why?

- Outreach and support groups increase access to health services by immigrant and refugee women who would otherwise be excluded.
- Western Region Health Centre and Doulla Galla Refugee Health teams employ bilingual workers, culturally competent doctors and refugee health nurses and this has proved very effective for women accessing health information and services. The Multicultural Centre for Women's Health's use of bilingual health educators and the woman to woman approach is also an effective way of increasing women's knowledge of health and related services, particularly in the promotion of preventative health.

5.3. Comments on the Principles underpinning the National Women's Health Policy

Based on a holistic approach, an articulation of the significance of diversity in developing effective health policy should be included as health equity between women relies on recognition of how diversity affects women's health services. There is also a need for quality qualitative studies funded to find out what marginalised, minority groups of women need in terms of preventative health care.

5.4. Other comments and suggestions?

- Physical activity and mental health with women from the Horn of Africa, especially the aged, needs research and attention to ensure women receive culturally sensitive and appropriate services.
- Funding for programs, evaluation and research needs to be long term. Good qualitative studies need to be funded to get information from the community about what their needs are.
- There needs to be more discussion around the construct of 'class' as well as around the fact that racism is 'alive and well' in Australian society without people made to feel that they are 'rocking the boat' if the issue is discussed.
- There needs to be less labelling and categorizing of people e.g. LOTE/NESB/immigrant and refugee- as we are all Australians.
- More community activities that encouraged interaction between different cultures are needed in an effort to increase cultural sensitivity and reduce discrimination.

Appendix 1

List of organisations represented at the MWCH and ICEPA national symposium on immigrant and refugee women's health

Keynote Speakers

- Professor Hurriyet Babacan, Director of the Institute for Community, Ethnicity and Policy Alternatives, Victoria University, Melbourne.
- Associate Professor Bebe Loff, Head of the Human Rights and Bioethics Unit in the School of Public Health and Preventive Medicine, Monash University.
- Dr Adele Murdolo, Executive Director, Multicultural Centre for Women's Health
- Helen Rankin, Director of the Gender and Reproductive Health Section, Department of Health and Aging.

Organisations

Australian Multicultural Education Services (AMES), VIC
Australian Vietnamese Women's Association, VIC
Cancer Council Victoria, VIC
Cardinia-Casey Community Health Service, VIC
Centre for Culture, Ethnicity & Health, VIC
Centre for Multicultural Youth, Carlton, VIC
City of Darebin, VIC
Cornerstone Contact Centre, Dandenong, VIC
Darebin Community Health, Darebin, VIC
Deakin University, VIC
Department of Health and Families, NT
Department of Health Services, VIC
Department of Immigration and Citizenship, VIC
Doutta Galla Community Health Service (DGCHS), VIC
Family Planning Victoria (FPV), VIC
Hanover Welfare Services, VIC
Institute for Community, Ethnicity and Policy Alternatives (ICEPA), VIC
Jean Hailes Foundation, Clayton, VIC
Key Centre for women's Health in Society, University of Melbourne, VIC
Melbourne Youth Justice, VIC
Monash University, VIC
Multicultural Health & Support Service, North Richmond Community Health Centre, VIC
Multicultural Health Service - South Eastern Sydney and Illawarra Area Health Service, NSW
Migrant Resource Centre North West Region, St Albans, VIC
National Breast Cancer Foundation, VIC
National Ethnic Disability Alliance, NSW
Northern Melbourne Institute of TAFE (NMIT)
Relationship Australia, TAS
South East Healthy Communities Partnership, Dandenong, VIC
South West Health Care, VIC
Victorian Equal Opportunity & Human Right Commission, VIC
Victorian Multicultural Commission, VIC
Western Region Health Centre, VIC
Women's Centre for Health Matters, ACT
Women's Health Loddon Mallee, VIC

Figure 1:

Aggregation of Organisations Represented at Symposium

