



**This submission was prepared by the Multicultural Centre for Women's Health  
in consultation with partner organizations**

**SUBMISSION OF THE MULTICULTURAL CENTRE FOR WOMEN'S  
HEALTH**

**TO:**

**THE COMMONWEALTH GOVERNMENT OF AUSTRALIA**

**Written by: Dr. Pauline Gwatorisa**

**Inquiries to:**

Dr. Pauline Gwatorisa

Tel: 03 9418 0915

Email: [pauline@mcwh.com.au](mailto:pauline@mcwh.com.au)

**or:**

Dr. Adele Murdolo

Tel: 03 9418 0923

Email: [adele@mcwh.com.au](mailto:adele@mcwh.com.au)

# A TEMPLATE FOR SUBMISSIONS

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

- The 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 refugee 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. MCWH has been funded by the Commonwealth since the 1980s and also receives Victorian Government Funding. MCWH has considerable experience in migrant women's sexual and reproductive health.
- The MCWH welcomes the opportunity to write a submission for a new national women's health policy. We see this as the most effective way of addressing the health needs of our target population - immigrant and refugee women - both from established and newly emerging communities.
- In this submission, we provide insight from our experience, and that of 7 other community organizations around Australia on health issues for immigrant and refugee women (see appendix i for list of participating organizations).

## 2. Understanding immigrant and refugee women's health in Australia

### 2.1 Importance of including gender as one of the social determinants of health

- Among immigrant and refugee women, recognizing gender as a key social determinant of health is imperative if positive health outcomes for this group are to be realized. We recognise the value of the Discussion Paper<sup>1</sup> making clear the distinction between sex and gender as contributing factors to women's health, and would like this approach to be kept in the final policy.
- In a majority of cases, immigrant and refugee women carry a disproportionate burden of disease, both as sufferers and carers. In many immigrant and refugee communities, the feminization of care-giving is

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<sup>1</sup> Commonwealth of Australia. 2009. Development of a New National Women's Health Policy – Consultation Discussion Paper 2009

apparent. Women take care of their children and husbands/partners, usually at the expense of their own health. Improving women's health will ensure better outcomes in the health and well-being of their families and communities.

- To a greater extent, immigrant and refugee women's ability to participate in social activities is regulated by some gender roles and cultural expectations. This has a negative impact on their mental well-being.

#### **RECOMMENDATION 1**

***The new policy needs to take into account the gender roles and cultural expectations for immigrant and refugee women, and their implications on health seeking behaviour and access to health facilities.***

### **2.2 Importance of recognising diversity among women**

- MCWH recognises that immigrant and refugee women come from diverse backgrounds, and therefore advocates for health services provision that takes into account this diversity. We appreciate the Discussion Paper referring to the MCWH resource: *Multicultural Centre for Women's Health Quality Standards: Multilingual Health Education Programs, Putting Immigrant and Refugee Women's Health First*. The quality standards have allowed for the delivery of health education in a multicultural context. The MCWH highly recommends these standards as a best practice to all organizations involved in immigrant and refugee women's health and well-being.
- Being an immigrant or a refugee woman can pose serious challenges in settling, often with negative mental health outcomes. For instance, immigrant and refugee women are less likely to be in a position to own property or to pay mortgage or rent on time due to limited resources. This often means an over-reliance on credit to buy property or to pay rent, leading to financial insecurity resulting in poor mental health (Poljski and Murdolo 2009).

- Like their Australian-born and English-speaking background counterparts, immigrant and refugee women rely on the provision of health services for the management of their reproductive health, particularly the birthing process, contraception and abortion (Madden (1994) cited in Chang (2000)). Immigrant and refugee women’s reproductive health varies among cultural groups, and compared to Australian-born and English speaking women, immigrant and refugee women’s reproductive health experiences are generally poor.
  
- We believe that the new policy should address the needs of immigrant women as separate from those of refugee women. Due to their circumstances at migration, immigrants and refugees do not always share the same health needs (O’kane 2003). The pre-migration backgrounds and the push-factors for migration for these two groups often results in different health outcomes that in turn require solutions that are tailored to their specific needs.
  
- In addition to the different pre-migration factors, immigrant and refugee women bring different values and belief systems from their countries of origin. These, along with linguistic differences and previous exposure to different health systems in country of origin, combine with other socio-economic factors to determine health choices made and the resulting health outcomes, as one Project Worker notes:
 

*“We have found that the vast majority (if not all) refugee women have never heard of well women’s health checks including pap smears, breast checks or asking about their menstrual cycle etc. Experiences of trauma or abuse may also impact heavily upon the woman’s response to various health checks and services offered. Gaining the women’s confidence and subsequent understanding of what is being offered and why can often over come this reluctance – Project Worker – Refugee Primary Health Care Clinic RPHCC)”.*

## **RECOMMENDATION 2**

***In view of the different migration circumstances of immigrants and refugees, health strategies that address the specific needs of each group as different from the other, should be included in the new policy.***

### 2.3 Importance of having specific immigrant and refugee women's health services

- The first NWHP recommended that health service provision for women be a key area requiring action by government in order to improve women's health (Alcorso and Schofield 1991). While funding was made available to develop specialised women's services as a result, the need for special services addressing the 'distinctive' and 'particular' health service needs for NESB women, a priority of the National NESB Women's Health Strategy, has remained unaddressed. It is therefore important that the specific health service needs of immigrant and refugee women be addressed, in order to achieve equity in health. Areas requiring specialised services include the following:
  - **Sexual and reproductive health:** Services tailor made for immigrant and refugee women should be a priority in the new policy. The work undertaken to date on female circumcision/female genital mutilation demonstrates the need for specific services in order to address the particular challenges that come with this practice. Training in cultural aspects of sexual and reproductive health should be considered in the new policy.
  - Evidence suggests that there is a lower uptake of cancer screening services such as mammograms and pap smears in some immigrant and refugee communities. For example, several studies indicate that detection of cervical cancer amongst immigrant and refugee women is later than that for the rest of the population<sup>2</sup>. A long term co-ordinated approach is needed to ensure that immigrant and refugee women are able to access cancer screening services.
  - **Counselling:** In order to improve access to services for Immigrant and refugee women, specific counselling is required. Bilingual counselling services need to be provided in a language women can understand, as this may require the use of communication codes and visual aids in order to get as much information as required to provide the appropriate service.

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<sup>2</sup> 2002. The incidence of Cervical Cancer in South Australia by Country of Birth. Available: [http://www.cancersa.org.au/mc\\_resources/documents/CALDCervix5.pdf](http://www.cancersa.org.au/mc_resources/documents/CALDCervix5.pdf)

- **Disability:** Immigrants with disability face systemic discrimination as they must live in Australia for 10 years in order to be eligible for the Disability Support Programme (DSP), during which period they are unable to receive any allowances from Centrelink or any benefits associated with the DSP, including health services.
- We acknowledge the work of Services working specifically with immigrant and refugee women on health issues, but we also note that currently these are not coordinated and therefore not as effective as they could be. There is a need for coordination of these services at a national level, so that resources may be shared, communication may be enhanced and services are not duplicated. A national coordination program (peak body) would also have the capacity to provide effective advocacy about immigrant and refugee women's health issues.
- We believe that immigrant and refugee women would benefit more by consulting bilingual health professionals and educators in an outreach mode, and therefore funding needs to be made available to support these positions. Women are more likely to attend outreach sessions conducted in their own communities and in their own language. Lessons learnt from the MCWH's multilingual health education program could be replicated to this scenario.

#### **2.4 Relevant examples to understanding immigrant and refugee women's health issues and/or needs in Australia**

- MCWH continues to gather anecdotal evidence of immigrant and refugee women's health experiences from stories told by women during industrial visits and other formal and informal meeting places. These accounts complement research findings and literature reviews in bringing to the fore, key health issues for immigrant and refugee women.

#### **RECOMMENDATION 3**

***A national coordination program (peak body) with the capacity to provide effective advocacy about immigrant and refugee women's health issues should be established.***

#### **RECOMMENDATION 4**

***It is recommended that the policy should take into account the ways in which government legislation and regulation (e.g. immigration) may adversely impact on immigrant and refugee women.***

### **3. Principles to underpin the new policy**

- Women's health services participating in this consultation generally agree with the principles in the Discussion Paper, with the following additions:
  - We would like the indigenous knowledge systems of immigrant and refugee women respected and strengthened in the new policy.
  - Women should have a sound knowledge of their rights in order for them to make informed choices of what services to use. Immigrant and refugee women also need not only to be consulted, but to be involved as key stakeholders in critical debates impacting on their health. To a large extent, immigrant and refugee women need to be involved in the legislative processes of government affecting their health and well being.

#### **RECOMMENDATION 5**

***The new policy should respect indigenous knowledge systems and health belief systems of immigrant and refugee women in health care provision. This could be done by engaging older immigrant and refugee women as agents for change in their communities.***

### **3.1. Gender equity in health**

#### **3.1.1 *How women's health issues differ from men's in immigrant and refugee communities***

- Men and women from immigrant and refugee populations have different experiences and outcomes, and this is largely due to the gender inequality and power imbalances, which often makes it difficult for women to make the necessary health choices. Furthermore, immigrant and refugee women are less likely to take the necessary health related action during an illness due to other barriers such as:- lack of information on the health condition, low

English language proficiency, other structural barriers such as poor access to facilities.

- Traditionally in many immigrant and refugee communities, women ensure that men and children are taken care of first, and their own health takes last place. When newly arrived, women are preoccupied with the challenges of resettling and ensuring that their families adjust to the new life. This often leads to late presentation of their health problems.

It is important to conduct health education and health promotion activities in single gender groups, to allow women safe space to express their concerns and ask questions. The Multicultural Health and Support Service (MHSS) (see appendix 1 for organization profile), have successfully used this approach.

### ***3.1.2 Importance of taking into account the broader environments in which women live***

- A social model of health derives from an understanding of the wider socio-economic and political environment's influence on health and well-being. In immigrant and refugee women, pre-migration experiences including the experience of war, torture and trauma, poverty, poor infrastructure, displacement; and challenges at (re)settlement such as finding appropriate housing, employment, access to services etc. are all factors responsible for their poor health, even in the absence any bio-medical condition.

### ***3.1.3 Issues that impact on women's health and wellbeing (e.g. access to services, resources, etc)***

#### **● Labour force participation**

Although NESB migrants are significantly over represented in unemployment and long-term unemployment statistics (Bertone and Leuner 2007), men are more likely to be employed than women. Higher employment levels among men means that they can access health information more easily in their workplaces, which women cannot. Unemployment among immigrant and refugee women lowers their self-esteem and socio-economic status thus contributing to poor mental and emotional health. The new policy should take note of these disparities.

### ● **Low English proficiency**

We are concerned about sentiments made by some health professionals which seem to suggest that immigrant and refugee women do not know their bodies, or body parts referred to during consultations. Many of the women's health problems are a result of communication barriers due to low English proficiency. Some health conditions are best described in the women's own language and failure to find the English equivalent may result in frustration on the part of the woman, and misinterpretation of the condition by the doctor, leading to wrong diagnosis or treatment.

For migrants and refugees with disability it is even more difficult. Language barriers often prevent them from accessing information and communicating with organisations who can assist them. Health professionals need an understanding of communication approaches when treating a person with disability. Extra time is often needed to determine the specific health needs that stem from a person's disability, and that person may or may not have communication and language barriers (i.e. they speak a language other than English, they use Auslan to communicate etc) but the health system does not allow for this.

### ● **Access to transport**

Women also face a major setback when required to use private transport for work purposes due to lower rates of private transport ownership and lack of driving skills (Chang 2000). Women with disabilities often find health services physically inaccessible. For example, X-ray tables and pap-smear facilities are seldom accessible for women with physical disability.

### ● **Interpreter services**

Women are concerned about the gender of interpreters, availability of interpreters and quality of services provided. Some women prefer professional interpreters to relatives due to the sensitivity of issues in sexual health. The scarcity of health interpreters causes frustration in some women, who are left with no choice but to rely on family members. Childcare commitments and other commitments at home make it difficult for women to use interpreters at health centres. In spite of the availability of childcare services, some women may be hesitant to leave their children with people whom they do not know or with whose culture they are unfamiliar. Women are

also concerned about the quality of interpreting offered. They feel interpreters summarize and simplify information.

Establishment of women's health centres with female service providers would increase frequency of women accessing available services. Special attention need to be paid to the gender of interpreters at health facilities, as this influences women's decisions and choices. The new policy needs to pay attention to the preference of most women to see health professionals of the same gender because of the need for privacy around sexual and reproductive health issues.

### ● **Mental health services**

The mental health of people with disability is also an important issue and should be considered in the broader health agenda. People with a mental illness who also have a disability are often referred to as having a 'dual diagnosis' or co morbidity issues. A person with a disability can not have their mental health needs adequately addressed from the mental health services sector as it does not have the resources, understanding or expertise to accommodate disability. There are an insufficient number of mental health practitioners with specialist skills or accreditation for treating people with disability. Likewise, the disability sector does not have the resources, understanding and expertise to address a person's mental health needs.

It is well documented that:

- Migrants and Refugees miss out on generic and psychiatric support services
- language and cultural barriers present significant obstacles for immigrant and refugee groups in gaining access to mental health services
- Immigrant and refugee women are often unaware of the range of services and supports available and lack the knowledge necessary to access appropriate services
- family members and caregivers of immigrants and refugees with mental illness do not have the opportunity to express their problems, frustrations and views about care-giving within a structured and appropriate environment.

## RECOMMENDATION 6

***A multi-sectoral approach to addressing mental health issues among immigrant and refugee women should be adopted. Relevant sectors could include: the mental health, disability, and ethnic sectors.***

### 3.2 Health equity between women

#### 3.2.1 ***Particular groups of immigrant and refugee women that are at increased risk of poor health and wellbeing outcomes and their needs***

- Among immigrant and refugee women, some groups are more vulnerable and at risk of poor health and wellbeing than others. Women's experiences in accessing and utilizing health care services vary, with some groups facing more disadvantages than others. The disparities in employment opportunities between English Speaking Background (ESB) and Non-English Speaking Background (NESB) women where the latter have lesser employment opportunities, is just one example of the factors contributing to poor mental health outcomes for immigrant and refugee women. The new policy should also address the inequities between different groups of immigrant and refugee women as follows:

##### **- Women with a disability**

As noted above, women with a disability face unique challenges in accessing and utilizing health services. Systematic discrimination and stigma attached to disability are some of the challenges faced. This often results in isolation and can lead to significant mental health issues which often also lead to poor physical health.

##### **- Older women**

Loss of social capital among immigrant and refugee women has been mentioned quite frequently as the most important cause for poor mental health (Miller et al 2004; McMichael and Manderson 2004). Isolation and loneliness which often result from migration is more prevalent among older, than younger immigrant and refugee women (Alcorso and Schofield 1991). Social isolation is often a problem for older women as they are unable to communicate well outside of their family circle. Boredom and a sense of isolation can lead to high incidence of gambling, a problem that may lead to poor mental health and guilt (Commonwealth Office of the Status of Women

2001). The new policy should take into account migration experiences of older immigrant and refugee women in designing health services.

#### **- Young women**

The MCWH recognises the amount of work and research that has been undertaken in a bid to understand the health and well-being of young immigrant and refugee women. This, along with our regular training sessions with young immigrant and refugee women, shows that the main issues affecting this group revolve around their sexuality. Reproductive health services that are specifically designed for young immigrant and refugee women should therefore be made a priority in the new policy. Specific health services will also ensure that traditional practices impacting on young immigrant and refugee women are adequately addressed.

#### **- International students**

International students face numerous challenges during the time of study and upon completion, often compromising their health and well-being. Living expenses for international students are exceptionally high due to lack of concessions (e.g. on transport and health insurance), and the exorbitant fees they are required to pay for their tuition. The need to have cash in hand to pay for their fees and to meet their general living expenses, forces most students to accept non-skilled work in the informal sector, usually tolerating extremely poor conditions (ECCV 2008). The occupational health and safety and mental health needs of international students should be adequately addressed in the new policy.

### **RECOMMENDATION 7**

***The new policy should have a tool that considers the disadvantages faced by these particular groups on the basis of their gender, age, geographical location and capabilities.***

### **3.3 A focus on prevention**

#### ***3.3.1 Enhancing preventative health among immigrant and refugee women***

- We consider preventative health very important for immigrant and refugee women as they are currently missing out compared to other groups and we see the consequences. Immigrant and refugee women are under-represented

in preventative health services and over-represented in the acute and crisis end of health and welfare services. This includes in mental health, and refugees. There is evidence to show that immigrant and refugee groups access General Practitioners more than any other service. Yet GPs may not have the requisite skill and expertise to work with immigrant and refugee women across the board, including those with a disability.

Ageing migrants are overrepresented in some diseases such as diabetes and vitamin D deficiency<sup>3</sup>. There is also a lower uptake of breast screening services in immigrant and refugee women<sup>4</sup>.

- Information is key in preventative health, as evidenced in the quote below:

*“As the women worker for settlement services I became aware that many new migrants are not aware of health services available to them, they don’t seem to understand preventative health such as routine health tests, risk factors such as diabetes in emerging communities, oral health and maintaining general wellbeing. As a result following a consultation with the women, a series of workshops were conducted with the help of a health interpreter to deliver interactive information on several health topics. The positive aspects of this mode of delivery is that more families learn about what is health services, what is available, how to maintain a healthy life in general. Basically, it would be a positive approach for health services to work in outreach such as Migrant Resource Centres where the clients can be reached and programs can be developed for the target group. In this way we can ensure that new migrants are informed early in their settlement years and so that they are more likely to use prevention health services – Women Worker – St. George Migrant Resource Centre.”*

However, services have an increasing tendency to provide only web-based information, which is inaccessible to immigrant and refugee women. Telephone calls are answered by automated voice machines, and not by a real person. In addition, there is reduced availability of multilingual material. Production has not kept up with demand, especially in the context of changing population demographics.

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<sup>3</sup> FECCA Health Policy: [http://www.fecca.org.au/Policies/2007/policies\\_2007009.pdf](http://www.fecca.org.au/Policies/2007/policies_2007009.pdf)

<sup>4</sup> FECCA: Migrant and Refugee Women’s Health Statement to DIAC, 2009.

- People with disabilities whose first language is not English, face double disadvantage when it comes to access to health information. This is compounded by the fact that some messages are not produced in alternative formats such as Braille, audio, large print or Easy English. As women tend to be the main care givers for family members who are aged or have a disability, they would be most likely to seek and benefit from the information.
  
- The MCWH has responded to some of these needs by, for instance, using a woman to woman approach in providing health education to immigrant and refugee women. Trained Bilingual Health Educators provide high quality multilingual health education and information in a multicultural context. This approach is well suited for immigrant and refugee women, and has proved to be the best way to wellbeing, and an effective way of enhancing preventative health.
  
- There is scientific evidence to show that peer education and support facilitated by bilingual health advocates/educators has more effective results than other methods of health promotion. A 2008/09 randomised control trial conducted by Trisha Greenhalgh in the UK has found that health promotion story telling group sessions held in ethnic minority participants' own languages and facilitated by bilingual health advocates tend to be better attended (85% compared to 35%) and produce higher patient enablement scores than standard education sessions (Greenhalgh et al 2009).
  
- Existing women's health services, and especially those that are specific to immigrant and refugee women, are well-placed to continue to provide these services, with an increased capacity from government to meet existing and future demand.
  
- We recommend that there be an increase in the provision of educational resources such as pictures showing female anatomy and physiology in the women's languages. Wherever possible, sessions should be conducted by females.
  
- We believe that the most effective way to enhance preventative health among immigrant and refugee women would be to tap into their indigenous

health belief systems – find out what they know, see how it relates to modern ways of knowing, and strategise on how to synthesize these two world views

#### **RECOMMENDATION 8**

***We recommend capacity-building for mainstream services to enable them to work more appropriately with immigrant and refugee women, and to build cultural competency.***

#### **3.3.2 How should the Policy address violence against women?**

- The Policy should address the breadth of settings where violence against women occurs, including in the home, the workplace, and public settings such as public transport.
- Strategies to prevent violence are key to reducing the occurrence of violence against women and should be the focus on how the Policy addresses violence against women. The Policy should develop culturally and linguistically appropriate strategies to engage immigrant and refugee women in the prevention of violence against women.
- We believe that men should be actively involved in efforts to reduce violence against women. Effective culturally-specific strategies engaging men in preventing violence against women should be developed, implemented and evaluated.
- The full extent of family violence against women and others with disabilities is not known. Immigrant and refugee women are often left out of research studies and are less likely to report family violence for various reasons. Women with disabilities experience violence at higher rates and more frequently than other women, particularly from carers in institutional and residential settings (Healey et al 2008). The new policy should address the different levels at which violence is perpetrated.
- Financial distress amongst migrant couples/families is an issue of concern: most victims of domestic violence cite household expenditure and other financial issues as the major bone of contention with their partners. MCWH

has evidence to support the need for financial counselling budgeting assistance and legal support for immigrant and refugee women (Poljski and Murdolo 2009). The mental health implications of debt and financial insecurity on this group should be addressed in the new policy.

- Women escaping domestic violence often report mental and other health problems incurred from repeated incidences of abuse. Many refugee women are exposed to gendered violence prior to migration and this can have an impact on their physical and emotional well-being and their ability to access health services. Yet some groups of immigrant and refugee women, especially those from patriarchal societies, often cite certain community values, especially religious and cultural values, which are seen to oppose the presence of domestic violence in the community. The new policy needs to pay attention to the cultural meanings attached to domestic violence, as these have serious implications on incidence reporting and uptake of services.

#### **RECOMMENDATION 9**

***The cultural interpretation and stereotypes around domestic violence in immigrant and refugee communities need to be addressed, as these can impede efforts to stop violence against women.***

#### **3.3.3 *Examples or experiences from your organisation relevant to prevention in relation to immigrant and refugee women's health***

- The MCWH has been active in advancing the social inclusion agenda for immigrant and refugee women. In our work, we have identified some key social inclusion indicators against which the social inclusion of immigrant and refugee women in all spheres of life could be measured. These include:- labour force participation, health and well-being status, parenting, access to services, discrimination, housing and homelessness, and representation. Our advocacy work has focussed on how these indicators contribute to the social exclusion of immigrant and refugee women, which in turn lead to poor health outcomes. The new policy should complement the government's social inclusion agenda in increasing the participation of women.

### **3.4 A strong and emerging evidence base**

#### **3.4.1 *Current gaps in knowledge, research and data about immigrant and refugee women's health***

- National data on the health and well-being of immigrant and refugee women is scanty. The National Non-English Speaking Background (NESB) Women Health's Strategy (Alcorso and Schofield 1991) is the main source of data on the pattern of NESB women's health.
- Research into the issue of culture, disability and health is virtually non-existent. There is very little research undertaken on the lives of CaLD women with disability. Although some studies have been conducted at organizational level (for example the work of the Multicultural Disability Advocacy Association (MDAA) in NSW and the Ethnic Disability Advocacy Centre (EDAC) in WA), very little has been done on a national scale.
- We are concerned that Government is not utilising already existing immigrant and refugee women's knowledge and resources. We recommend that the new policy takes local knowledge into account in service provision, as this also helps preserve immigrant and refugee women's cultural identity while reducing social isolation.

#### **3.4.2 *New gender focused research and/or data collection***

- The need for gendered disaggregated data is essential for effective service delivery, due to the gender differentiated needs of men and women. Most of the data available for immigrant and refugee women has not been disaggregated by gender, making it difficult to separate specific issues for women.

### **RECOMMENDATION 10**

***National level gender disaggregated data on the health needs of immigrant and refugee women from both established and newly emerging communities should be prioritized in the new policy.***

### **3.5 A life-course approach**

#### **3.5.1 *Ways in which immigrant and refugee women's health issues change over the lifespan***

- For immigrant and refugee women, it would be appropriate to identify specific health services needed in particular periods of their physiological development such as: puberty, pre-natal stage, pregnancy, post-natal stage, menopause (40 – 50 years), older women (65+ years). Major health changes occur in women's sexual and reproductive health. We recommend engaging older immigrant and refugee women in health education and health promotion activities in their communities. Building the capacity of grassroots women in imparting information on safe practices will ensure that the occurrence of harmful practices, such as FGM, is minimized.
- A life-course approach inclusive of immigrant and refugee women's experiences would take into account significant life stages relating to migration and re-settlement.
- A change in the nutritional habits of immigrant and refugee women is yet another determinant of their health and well-being (Australian Institute of Health Welfare 2005.) These changes occur more during the migration process than over the lifespan. Unavailability of some staple foods and other preferred food products leaves one with no option but to use locally available products, which may have detrimental effects to health (for example Willis et al 2007; Barnes and Almasy 2005.) There is anecdotal evidence to suggest that the risk of Diabetes in immigrant and refugee women for instance, is associated with changes in their nutrition.

#### **3.5.1 *Ways in which health issues or needs of immigrant and refugee women missed in health policy***

- Priority health issues facing immigrant and refugee women often differ from those facing other women. The National Non-English Speaking Women's Health Strategy found that the key priority issues facing immigrant and refugee women are sexual and reproductive health, mental health and occupational health and safety. While these concerns are shared among all women, the ways in which these health concerns manifest are often specific

to the experiences of immigrant and refugee women. For example, immigrant and refugee women's concentration in blue-collar employment makes certain occupational health and safety issues more pressing. These include occupational overuse syndrome, effects of dust and noise, and manual handling.

- Immigrant and refugee women, both young and old, have a wealth of information which could be useful for designing strategies and formulating policy. This information is often missed because of linguistic differences. Women use certain colloquial terms to refer to private body parts – rarely are the actual terms e.g. vagina, penis etc used in consultation or any other form of communication. Where actual terms are used, women often feel embarrassed and ashamed, often curtailing any further discussion. Sensitivity to these issues is highly recommended.

#### **4. Priorities of a new Policy**

##### **4.1 Key priorities to be included in the new Policy.**

- There is need for gender disaggregated data on immigrant and refugee population's health and well-being.
- Social inclusion of immigrant and refugee women in all spheres of life should be made a priority.
- Funding should be made available to build the capacity of immigrant and refugee women to take up leadership roles in their communities. Projects that are designed to facilitate this outcome should be supported.
- Government should ensure that sufficient funding is available for specific projects in the area of women's health. An assessment of the distribution of immigrant and refugee women's health services will ensure that other under-serviced areas such as the Northern Territories are well resourced.
- Multilingual health education and health promotion should be well supported and well funded.
- Programs supporting and promoting immigrant and refugee women's health and wellbeing should be nationally coordinated by a peak body that also has advocacy capacity.
- Training in cultural competence in health institutions will ensure improved access to, and increased utilization of health services by immigrant and

refugee women. This could be integrated into ongoing health education and other training programs.

- Funding for ongoing community development programs that can assist better integration within the wider community should be made available on a recurring basis.

## **5. Building on the 1989 National Women's Health Policy**

### **5.1 Examples from the MCWH regarding the National Women's Health Policy**

- Our work at the MCWH has by and large been driven by the priorities set in the first NWHP. In 2003 for instance, the MCWH hosted a national meeting with the aim of collaborating with other organisations around Australia to run a national advocacy and awareness campaign on a women's health issue of significance for immigrant and refugee women around Australia. This event opened more opportunities for networking and discussion on a range of issues of importance to immigrant women. The MCWH has continued to gather evidence on key issues affecting immigrant and refugee women. It is interesting to note the recurrence of the key priority health issues identified in the first NWHP in current literature and in the narratives shared by women.
- The MCWH notes that a lot remains to be done to address gaps in knowledge around occupational health and safety, mental health and reproductive health, as noted in the first NWHP. Evidence-based information on the health status of immigrant and refugee women is required if effective strategies to address their health needs are to be formulated.

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## Appendix i

### List of organizations participating in the MCWH submission process

Organization	Background
St. George Migrant Resource Centre	St George Migrant Resource Centre is a community based organisation, providing settlement assistance and community care services to local migrants, refugees and people in culturally and linguistically diverse communities, with a focus on newly arrived, families, women and older people. The mission statement is to ensure equitable access to services to migrants especially from NESB backgrounds so they can participate equally in the social and economic opportunities available to other Australians. The over-riding principles of the centre is to provide service in a community based focused and that migrants and refugees have the right to participate in the community without discrimination; have the right of access to user-friendly service; have the same right to support, information and community services as other members of the community; special needs which require specific strategies in service delivery.
National Ethnic Disability Alliance (NEDA)	The National Ethnic Disability Alliance is the national peak organisation representing the rights and interests of people with disability from CaLD backgrounds, their families and carers throughout Australia. NEDA is funded by the Commonwealth Department of Families, Community Services and Indigenous Affairs (FACSI) to provide policy advice to the Australian Government and other agencies on national issues affecting people with disability from CaLD backgrounds, their families and carers. NEDA actively promotes the equal participation of people with disability from CaLD backgrounds in all aspects of Australian society. It manages a range of projects relating to CaLD and disability communities and works closely with its state and territory members to ensure that its policy advice reflects the lived experiences of people from NESB with disability.
Refugee Primary Health Care Clinic (RPHCC)	The RPHCC opened its doors in March 2007 based at the Launceston Migrant Resource Centre. Services provided by the clinic are bulk-billed and include: <ul style="list-style-type: none"> <li>• Refugee Health Assessment (MBS item No.714)</li> <li>• Catch-up immunisations for all arrivals</li> <li>• Referral to specialist services e.g. Mantoux clinic</li> <li>• Women's health checks, including contraception and cervical smears.</li> <li>• Assistance in relocating to mainstream GP practices, once the assessment, subsequent treatments and immunisation schedules have been completed.</li> </ul>
Relationships Australia Tasmania	Relationships Australia Tasmania (RA Tas) is leading provider of relationship support services and is a community-based, non denominational, not for profit organisation that provides a wide range of counselling, mediation and educational services for individuals, couples and families on relationship and other issues such as family or social difficulties, separation, family violence, sexual abuse, gambling addiction, property settlements, parenting plans and children's contact arrangements. RA Tas also provides support and information specifically for men. Offices are in Launceston and Devonport as well as Hobart.
Multicultural Women's Advocacy (MWA)	Multicultural Women's Advocacy, Inc. (MWA) is an advocacy, advisory, and lobby group that focuses on the needs of women from culturally and linguistically diverse (CaLD) backgrounds. MWA provides information, referral and support to CaLD women seeking opportunities to further develop their capabilities and to achieve their goals. As the peak body representing a united voice for women of culturally and linguistically diverse backgrounds (CaLD) and

	<p>their children in the ACT region, MWA continues to advocate, exchange information, and cooperate with other community groups, businesses and government agencies, to address issues of access and equity for CaLD women in the ACT. MWA also initiates, and provides access to, activities and programs that support CaLD women in reaching their full potential.</p>
<p>Multicultural Health and Support Service (MHSS)</p>	<p>Multicultural Health and Support Service (MHSS) is a state-wide service that aims to achieve better health outcomes for culturally and linguistically diverse (CALD) communities in relation to blood-borne viruses (BBV) and sexually transmissible infections (STI).MHSS currently works with individuals, families and communities from Arabic-speaking, Southeast Asian and African backgrounds. MHSS also works with mainstream service providers in relation to access and culturally sensitive service provision.</p>
<p>Federation of Ethnic Communities Council (FECCA)</p>	<p>FECCA is the national peak body representing Australians from culturally and linguistically diverse (CaLD) backgrounds. FECCA works collaboratively with its members, policy advisory committees and constituents across Australia to promote multiculturalism, community harmony, social inclusion and the rejection of all forms of discrimination and racism. FECCA's primary role is to provide advocacy and develop policies for Australians from diverse linguistic and faith backgrounds.</p>