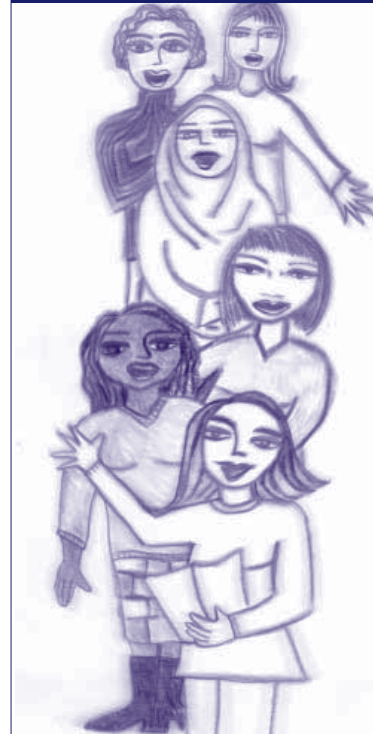


working well
newsletter
march 2011



Issue 21

mcwh: putting immigrant & refugee women's health first!



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✦ project and program updates

main feature:

✦ the 'wich' and the white woman: communicative democracy in action

Multicultural Centre for Women's Health is an immigrant and refugee women's organisation committed to improving the health and wellbeing of immigrant and refugee women across Australia.

amharic arabic cantonese croatian dari english farsi greek hindi italian macedonian mandarin somali spanish tagalog thai tigre tigrigna turkish vietnamese

courageous conversations:
farrep forum report

February 6 is the UN International Day Against FGM. To support this very important international event Victoria's FARREP workers held a panel discussion of prominent speakers, at Melbourne's Multicultural Hub. The aim of the *Courageous Conversations* event was to generate further discussion about female circumcision among those impacted by the practice, as well as among other community members and workers.

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The result was an engaging morning of presentations with active participation from the floor. Invited speakers addressed a number of important issues. Three faith leaders from Muslim and Coptic Orthodox, Somali and Egyptian communities—Shiekh Abdinur Weli, Shiekh Abdelazim Afifi, and Father Samuel—spoke about current theological thinking in relation to female circumcision within those faiths. All three speakers clearly separated out any circumcision practices from the teachings of the Muslim and Coptic Orthodox faiths. They were clear that there was no requirement stated within any of the religious texts that women or girls be circumcised. These practices, the speakers were in agreement, had their origins and cultural continuity, in non-faith-related customs and traditions.

Dr Hiba Rajab, a Sudanese medical practitioner specialising in preventative medicine, and health promotion and community awareness, and now living in Australia, spoke about her work in Sudan with women around sexual and reproductive health care. Dr Rajab spoke about the health impacts of circumcision and about the social pressure on women to arrange for

their daughters to be raised in traditionally prescribed ways, which include circumcision as a central practice. She advocated for community education as a way toward making positive changes in social practice.

One of the major themes of the day was the question of who should lead education campaigns to eliminate the practice of female circumcision and to reduce its impact. Shiekh Abdinur Weli started the conversation by strongly expressing his view that the women affected by female circumcision should be the ones who speak out and educate others about its impact. This suggestion was supported by many participants who added that female circumcision is 'women's business' and so it should be women in the community who lead the campaigns to change community views.

Multicultural Centre for Women's Health strongly supports this position and advocates that a community-based approach to any women's health issue, and especially one that is so politically and culturally sensitive, and impacts so integrally on women's health and wellbeing, is best achieved by putting the power into the hands of those who are most closely impacted. This is the only way that long-term, cultural change can occur without women within that culture simultaneously losing their sense of cultural pride, identity and belonging. Such an approach ensures that women are ultimately empowered to act positively, within a new cultural paradigm that respects their rights, their culture and their wellbeing.

dr adele murdolo executive director & medina idriess farrep community worker

macedonian

mandarin

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tigrigna

turkish

vietnamese

setting the compass:
project report

The 'Setting the Compass' (STC) project (which began in August 2009), is drawing to a close. Setting the Compass has continued MCWH's great recent work in the area of immigrant and refugee women's advocacy—most notably through its predecessor, the Points of Departure Project (POD) project (2008-2009). Indeed, Setting the Compass could be aptly described as an 'off-shoot' of POD. Where POD engaged NGOs across Australia and developed an Advocacy Toolkit, STC engaged a further national audience: grassroots women.

Setting the Compass surveyed national women's NGOs to determine which organisations were working with immigrant and refugee women and which were planning to do so in the future. It also assessed NGO willingness to use the POD Advocacy Toolkit in advocacy work. The survey created an opportunity for dialogue with national NGOs on key advocacy issues for immigrant and refugee women, most of whom acknowledged the Toolkit as a useful resource.

In the meantime, refugee women have benefited from the most outstanding achievement of the Setting the Compass project (so far), that is the development of an advocacy training program for bilingual women. The women themselves have taken action: by participating in training based on the Advocacy Toolkit.

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A one-day training program was developed, using the Toolkit as its base. Key topics included: writing letters to politicians; how to launch a campaign; and writing submissions for legislative change. The program was delivered as a series of 'advocacy skills development' sessions.

Sessions were advertised to relevant stakeholders and stakeholder websites, across Australia. Participants were a mix of immigrant and refugee women themselves, and representatives of women's organisations. A total of eight sessions were delivered, one in each State and Territory, and 122 women attended. Most participants were from the ACT and South Australia. Certificates of participation were awarded to the women, while co-organisers' received certificates of appreciation.

A major expectation of the training is that the women participants will pass on the skills they acquired to other women in their communities, in women's preferred languages.

On the whole, the response to the training was quite high; in their feedback, participants noted the relevance and timeliness of the program. We continue to receive requests for this training, which means further funding is needed to continue our efforts in this area.

For further information please visit the MCWH website: www.mcwh.com.au For assistance using the Advocacy Toolkit call 1800 656 421.

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the 'WICH' and the White Woman

Edited highlights of a paper and presentation
by Dr Regina Quiazon at the 2010 MCWH AGM



This feature brings together two interconnecting metaphors: the 'witch' and the 'white woman' and their place in MCWH's story-telling approach to health education.

But this is no fairy tale: the image of the witch and the white woman have important insights in relation to the ways immigrant and refugee women can have control over their bodies and health and wellbeing.

Introduction

The term 'WICH' is a neat reminder of one of the MCWH's earlier monikers, 'Women in Industry Contraception and Health' and later, 'Women in Industry and Community Health'. Of course, it also conjures up the image of the other 'witch' and might even remind us of that infamous moment in history, the Salem Witchcraft Trials of the 1600s when there was a strong belief in the devil and witchcraft was punishable by death. What can we take from this particularly gruesome and misogynistic episode in history?

Metaphorically at least, the figure of the 'witch' continues to represent the hysteria, prejudice, injustice and disregard for civil liberties experienced by those who are perceived to be causing harm. In relation to women especially, we might even reflect on the ways women are portrayed in rape trials

and so-called media sex scandals. The term witch-hunt can also be applied to treatment of asylum seekers and refugees: the hysteria about queue jumping; immigrants and refugees taking jobs away from Aussies; the disease they will bring; and the burden on our economy. These are the political issues highlighted by the witch.

The 'WitCHes' of MCWH

Before making the connection of the 'witch' with the 'white woman', it's worth considering the history of MCWH's 'WICH'.

MCWH's first incarnation as Action for Family Planning (AFP) in the 1970s came out of the growing democratic ideal of citizen participation. The community health movement, the women's movement and trade unions put pressure on governments to focus on social welfare. This mobilised direct action based on wider issues of inequalities and oppression.

In Australia, the Whitlam Government (1972-75) set policy thinking and practice patterns for participation in public health. Along with other policies which focused on participation, the Whitlam Government's Community Health Program aimed to provide integrated primary health care in addition to preventive and advocacy services. The debate about multiculturalism in Australia had begun to shift from integration to equality of access and opportunity.

The emergence of AFP met the practical—cultural and language—needs of immigrant women, but it also contributed to an equally important need for all women to regain and exercise control over their bodies. MCWH's various incarnations since AFP (WICH, Working Women's Health) have all built on these beginnings. Fast forward to 2010: the focus on 'consumers' instead of 'patients'—for better or worse—has also meant people should take responsibility for their health and the choices they make. Theoretically, at least, because the number of choices one has available depends on where you are on the socio-economic ladder.

If we look at the current health promotion landscape, we can see how such 'choices' are being shaped and managed. Take, as example, a selection of words currently being used by government, policy makers and funding bodies: 'empowerment', 'capacity building' and 'participation'. What meaning or value do they have for individuals who are disadvantaged and marginalised?

Take participation as an example, how can we 'empower' an immigrant or refugee woman, with very little English, working 60 hours a week as an outworker and who wants to return to school? How can we 'build the capacity' of a newly-arrived woman, with two young children, who is homesick and depressed, how should she help herself in ways in which are meaningful and significant for her particular life circumstances? How do we do those things while knowing that, in comparison to the Australian-born population, there are more immigrant and refugee women unemployed, more immigrant and refugee women who have higher incidence of ovarian cancer, perinatal and neonatal mortality, maternal deaths, more who have diabetes and die from diabetes-related deaths, more who use women's refuges? These are the challenges MCWH faces every day, but is so often understood—not incorrectly—but simply as 'health education' or 'health promotion'.

The 'W2W' Approach

The woman-to-woman' (W2W) approach is a cornerstone of MCWH's health education delivery model. MCWH sessions are conducted according to a participatory, peer model which means our Bilingual Health Educators act as equals (not as teachers) and the women are acknowledged and respected for the knowledge they already have. Women who participate in MCWH sessions are active participants not mere passive consumers.

This fits in quite well with what is now called the 'narrative' approach in academic thinking. Or, you could put that another way: close to 30 years later, universities have only now, fairly recently if you consider the field of health promotion, come up with a name for the ways in which MCWH education sessions are conducted. Whether it's one or the other, it's important that our work can now be looked upon more seriously by researchers.

Storytelling: Not Just Women Chatting With One Another

MCWH health education sessions are not just about women swapping stories. To think they are only that, completely misses the point of why MCWH exists and why it continues to play a vital role in the community and in the lives of immigrant and refugee women. No, it is not only about storytelling: it is also storytelling which possesses socio-political value and is therefore a form of 'communicative democracy'.

As the feminist social theorist Iris Young describes it, communicative democracy is 'where arguments about policy or action depend on appeals to need or entitlement, narrative provides an important way to demonstrate need or entitlement'. (1) Young comments that while other ways of communicating often privilege the dispassionate and the educated, the use of narrative is more egalitarian 'because everyone has stories to tell, with different styles and meanings, and because each can tell her story with equal authority, the stories have equal value in the communicative situation'. (2)

More often than not, the stories given and recounted in MCWH sessions are less about sharing health problems and information—although this is clearly an important aspect—than about sharing the socio-political context from which health issues arise.

Communicative Democracy in Action

In a MCWH health education session, one woman spoke of her fears about raising STI testing with her husband as she was sure he had been sleeping with other women.

One of the younger women in the group suggested that she use a condom as a precaution prior to asking her husband to undergo a test; another older woman in the group pointed out the husband might accuse his wife of being unfaithful.

The woman who was seeking advice was well aware of the health risks but, of more significance to her, was that she needed advice in relation to negotiating three very complex territories: family, culture and sexual politics. After listening to the other women, she made her decision: she would not ask her husband to wear a condom, but would find a way to broach the issues with her husband in her own time.

The issue here of health risk was not related to the woman's health as such, but to her relationship with her husband. Health problems and conditions don't exist in a medical vacuum, but always co-exist with the conditions of daily life.

If we look closer at this example of woman-to-woman communication from an education perspective: we can say, that it allows women to speak across their own differences and perspectives; and, interpreting particular encounters and experiences through storytelling becomes the context for learning. Bilingual health educators and participants engage in dialogue, interpreting the meaning and significance of experiences, which cultivates interpretive thinking as well as bringing about a sense of social wisdom. To quote Young:

'Narrative exhibits experience and values from the point of view of the subjects that have and hold them; it also reveals a total social knowledge from the point of view of that social position. Each social perspective has an account not only of its own life and history but of every other position that affects its experiences. Thus listeners can learn about how their own

position, actions and values appear to others from the stories they tell. Narrative thus exhibits the situated knowledge available of the collective from each perspective, and the combination of narratives from different perspectives produces the social wisdom not available from any one position.' (3)

Given the democratic possibilities of a storytelling mode of communication, MCWH uses case studies (stories) in education sessions, which serve both as an introduction and a focal point for discussion. More importantly, stories allow women to more freely voice their opinion about issues.

The 'White' Woman

Where does the 'white woman' fit into such a model of health education? The 'white woman', to be more precise, refers to the *language and practices* of Western knowledge. It is not uncommon for cultures, especially those affected by colonisation, to refer to the 'white' as shorthand for the unequal relations brought about domination and subordination. How can the 'white woman' make us understand the political value of MCWH's education sessions? An anecdote told by Victoria Lolika, our Sudanese Educator completes the story:

'I arrived to conduct a session with a group of Sudanese women. They were still chatting away to each other even after I walked into the room and sat down to begin the session. Still the women continued to chat amongst themselves. Then one woman approached me and asked me 'When is the *kawaja* [white woman] arriving?' I gave her a big smile and told her, 'I am your white woman!'

From WICH to White Woman, the Multicultural Centre for Women's Health continues to be an organisation where immigrant and refugee women—educators and participants—actively exchange information as opposed to being passive 'consumers' of health information.

REFERENCE:

Young, Iris Marion (1997) *Intersecting Voices: Dilemmas of Gender, Political, Philosophy, and Policy*, New Jersey: Princeton University Press.

mcwh health
education program
at dame phyllis frost

In October last year we conducted our Health Education Program with women at Dame Phyllis Frost Prison (Deer Park). Hoang Nguyen, the prison's Multicultural Liaison Officer asked us to run our program for 50-60 immigrant and refugee women.

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 - cantonese
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 - hindi
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- The majority of the women interested in our program were of Vietnamese origin, so we conducted the sessions in Vietnamese. Introduction to women's health; reproductive health and sexual health; and mental health and wellbeing were all covered during these sessions. The last session, evaluation and feedback, gave us an opportunity to thank the women for their participation and contributions, share some traditional food, and award certificates of participation.
- The women had requested green mango as a refreshment at one of the sessions and could not believe it when their request was fulfilled. Our Educator knew the importance of and the desire for this very culturally-specific treat and brought it along to the last day of evaluation. *'We asked for green Thai mango, but we didn't think that our wish will come through!' one woman said.*

It was an extremely successful program and will be remembered for many things including the women's enthusiasm which was reflected in their commitment to it throughout.

One of the major reasons women so enjoyed the discussion and information sharing was the sessions being in Vietnamese—talking in the

language you know best means being able to fully understand and ask questions with confidence. The women said this was a real plus. It was the first chance for many of the women to discuss their issues including sexual and reproductive health, stress, depression, and insomnia. They were also happy to learn techniques for relaxation and to deal with pain and insomnia.

'We gained a lot of knowledge and information during these visits. This program impacted on our attitude towards life and health. We would like to have more sessions in the future because this knowledge will help us to participate in outside society better.'

Vietnamese woman

When asked why they came each week, women replied sessions were not only educational, but also fun and informative, relevant to their life right now, and easy to understand. It was a chance to meet, talk, share. Usually they would only wave to each other. As one prison official said our program brought many benefits to the women participants including smiles on their faces.

MCWH has been asked to run our program with all of the 250 women at Dame Phyllis Frost, including the non-immigrant women, who make up about 75% of the prison population. Hopefully additional funding will allow us to fulfil this request in 2011.

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education & training
programs manager

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- tigre
- tigrigna
- turkish
- vietnamese

health education program:
adding new languages

<p>amharic</p> <p>arabic</p> <p>cantonese</p> <p>croatian</p> <p>dari</p> <p>english</p> <p>farsi</p> <p>greek</p> <p>hindi</p> <p>italian</p>	<p>Multicultural Centre for Women's Health (MCWH) stays up-to-date with the health and language needs of immigrant and refugee women through regular evaluation and review of our health promotion practice and resources. This means reviewing the composition of the Bilingual Health Education Team every 2-3 years to evaluate the extent to which the languages covered by the program have kept pace with those spoken by newly-arriving women.</p> <p>This year we undertook our review process and found that there were a number of new languages that were in demand in the programs, but that MCWH was not in a position to offer in bilingual health education. These 11 languages were Assyrian, Chaldean, Dinka, Indonesian, Karen, Khmer, Nuer, Punjabi, Sinhalese, Swahili and Tamil.</p> <p>We also found that in the case of three further languages—Arabic, Hindi and Vietnamese—our program would benefit from the addition of extra team members to keep up with the demand within the larger populations. Our third consideration in reviewing the team composition was to take into account the loss of staff members. During the previous period, we are proud to say that some of our Bilingual Health Educators moved into other demanding roles in the community sector. Sadly though,</p>
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this meant a meant a loss of valuable team members for us and of the languages Amharic, Mandarin and Tagalog to the team.

During the review process a further need emerged: for bilingual educators who were trained to work with younger immigrant and refugee women in our community. Younger women are a group that we have catered for in bilingual health education in the past, but we increasingly felt that if we were to offer 'peer' education to younger women, we need to think about the impact that age has on women's experiences of their culture and health. This led us to the decision to also recruit for a young women's bilingual health educator for the first time.

Once we had identified the skills and languages that we wanted to add to the team, we started recruiting for six new members. Unfortunately we are working within a limited resource allocation, so we cannot fill all of our gaps at once. However, adding six new members to our team will bring us yet another step closer to better meeting the needs of women in our community.

Our recruitment process is now underway and we look forward to welcoming our new recruits to the team in May this year.

dr adele murdolo
executive director

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If you would like to be well read about immigrant and refugee women's health contact us for a mcwh publications catalogue. For research reports on a wide range of immigrant and refugee women's issues including resettlement, sexual and reproductive health, occupational health and safety, alcohol and other drugs, credit and debt issues, and diabetes prevention.

✦ access multilingual health information

Become a MCWH Member and borrow resources from the Multilingual Library. We also have a comprehensive Resource Collection if you are looking for information in your language. Over 14,000 items and 90 languages.

✦ enhance your work with immigrant & refugee women

MCWH provides cross-cultural and other specific training for employers, community workers, service providers and health professionals—we specialise in intensive training programs for bilingual community workers. MCWH will customise our training to your needs.

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If you are interested in immigrant and refugee women's health and wellbeing, become part of MCWH, contact us for a MCWH membership form.

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