

working well  
newsletter  
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Issue 17

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



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✦ project and  
program updates

main feature:

✦ what can  
'narrative-based  
medicine' offer  
health educators?

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

prevention is the cure:  
mcwh-icepa national  
symposium

MCWH, in collaboration with the Institute for Community, Ethnicity and Policy Alternatives (ICEPA), hosted the national symposium 'Prevention is the Cure: Unpacking Health Realities for Immigrant and Refugee Women in Australia' on 28 October 2009. The symposium gave participants an opportunity to provide feedback to the National Women's Health Policy, with a specific focus on the health and wellbeing of immigrant and refugee women.

- amharic
- arabic
- cantonese
- croatian
- dari
- english
- farsi
- greek
- hindi
- italian

A total of 75 participants from Victoria, the ACT, NSW and Tasmania represented a range of organisations, from community and women's health to multicultural organisations for young people, and people with disabilities. Abla facilitated by Gabrielle Fakhri, discussion was active and passionate, providing much-needed insight into the health realities of immigrant and refugee women.

Professor Hurriyet Babacan (Victoria University) began proceedings by placing the issues for consideration into the context of migration and women's health. Adele Murdolo (MCWH) focused on prevention in reproductive and sexual health contrasting the stories of two women, and how their health was affected by the preventative health policies and practices in their host countries. Associate Professor Bebe Loff (Monash University) spoke on how a human rights approach to health policy impacts on the development of health programs for immigrant and refugee women. Finally, Helen Rankin (Department of Health and Ageing) spoke about the National Women's Health Policy, its

development to date and how delegates could affect its process.

Issues raised by participants included priority issues such as sexual health, occupational health and safety, and mental health. Delegates also spoke about the impact of restrictive immigration policies on health, how inclusion and exclusion at community and national levels can affect health outcomes, and the importance of housing to women's wellbeing. Lack of access to health, settlement, education and welfare services were much discussed. Shortages in appropriate transport and childcare, the unaffordability of private providers, lack of knowledge of the health system, as well as cultural and linguistic barriers and how these factors hinder women's full access to services were all explored. The difficulties of caring for children with disabilities was strongly expressed, with particular focus on the lack of available services, which results in the individualised burden of caring being placed on women including mothers.

Strategies suggested by the participants to improve immigrant and women's health included: coordinating national data collection; conducting national research; coordinating programs that work for immigrant and refugee women; recognising that bilingual educators are an integral part of preventative health; and improving mainstream health service systems to be culturally and linguistically appropriate (and so accessible) to immigrant and refugee women were all widely endorsed.

dr adele murdolo  
executive director

- macedonian
- mandarin
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- tigre
- tigrigna
- turkish
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	<p>diabetes healthy living project</p>
<p>amharic arabic cantonese croatian dari english farsi greek hindi italian</p>	<p>Type 2 diabetes is considered a global epidemic. In Australia, over 700,000 Australians (3.6% of the population) were diagnosed with the disease in 2004-05 (AIHW, 2008). Immigrants and refugees are particularly susceptible to developing this chronic condition due to a host of factors including socio-cultural and political-economic influences (including communication problems), genetic predisposition to the disease, and lifestyle and nutrition changes due to migration. Prevalence rates for Type 2 diabetes in some overseas-born people are higher than in people born in Australia, with rates highest in North African, Middle Eastern, South East Asian, Southern and Eastern European communities (AIHW, 2008). Given these high prevalence rates, culturally-sensitive and appropriate diabetes prevention programs are essential.</p> <p>In 2008, with funding from the Ian Potter Foundation, MCWH implemented the Diabetes Healthy Living Project in collaboration with Victoria University's D2West. This innovative diabetes prevention initiative aimed to increase the capacity of immigrant and refugee women to make healthy lifestyle choices so as to minimise the risk of developing Type 2 diabetes. Project methodology included the establishment of an advisory committee; preparation of a literature review; consultations with key stakeholders (namely health professionals) to determine the information to be included in a culturally-appropriate diabetes prevention program; development and delivery of a two-day narrative-based training program for all</p>

<p>MCWH bilingual Health Educators; development of diabetes prevention education modules; and delivery of education sessions based on a story-telling methodology for immigrant and refugee women in eight languages: Amharic, Arabic, Italian, Macedonian, Sudanese Arabic, Tagalog, Turkish and Vietnamese. A total of 26 education sessions were delivered, reaching 104 women. Up to three sessions were held per language and one group of women per language (two for Arabic) was recruited to participate. Feedback from the bilingual Health Educators and the participants was overwhelmingly positive, with both reporting a range of benefits, as reported by one observer:</p> <p><i>'This group of women is interesting. They have gone out and bought electric frying pans and have already started to mix in non-traditional cooking to reduce eating a lot of meat and carbohydrates in their meal as a preventive action for diabetes. The messages given have been taken very seriously.'</i></p> <p>The success of the Diabetes Healthy Living Project is being expanded in a newly-funded collaborative venture with the Australian Community Centre for Diabetes. This project will further develop the MCWH diabetes education program for implementation in 2010.</p> <p><b>REFERENCE</b> Australian Institute of Health and Welfare. 2008. <i>Diabetes: Australian facts 2008</i>. Diabetes series No.8. Cat.no. CVD 40. Canberra. AIHW. Retrieved 7 October 2009 from <a href="http://www.aihw.gov.au/publications/cvd/daf08/daf08.pdf">http://www.aihw.gov.au/publications/cvd/daf08/daf08.pdf</a></p> <p>carolyn poljski mcwh health promotion and research project officer</p>	<p>macedonian mandarin somali spanish tagalog thai tigre tigrigna turkish vietnamese</p>
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## What can 'narrative-based medicine' offer health educators?

by Professor Trisha Greenhalgh

The following article is based on a presentation Professor Greenhalgh made at the MCWH Seminar 'Relating to Ourselves: Using Narratives to Improve the Health of Immigrant and Refugee Women' held on Tuesday 28 July 2009.

Professor Greenhalgh's work in narrative-based health promotion has shown the value of story-sharing groups for immigrants and refugees with diabetes, held in their own language and facilitated by bilingual health advocates, to overall patient enablement. Her seminar presentation focused on the use of a narrative-based approach in cross-cultural health promotion, explaining how health professionals can incorporate story-telling in their work with immigrant and refugee women. She also highlighted the barriers to using this approach and how these barriers can be overcome.

“

*...the doctor's advice was often ineffective; what changed their behaviour was a story told to them by another Bangladeshi in an informal setting...*

## Introduction

In every human society, people tell stories. Stories are sense-making devices that allow people to make sense of events and actions and link them with their past experience. Episodes of sickness, for example, are important milestones in the actual narratives of people's lives; the narrative provides meaning, context and perspective for a person's predicament as it defines how, why, and in what way, he or she is ill.

## Narrative frameworks: the holistic approach to chronic disease

Narratives of illness provide a framework for approaching problems holistically and offer the possibility of developing care options that cannot be arrived at by any other means. In the case of a chronic condition such as diabetes, successful management requires that we understand the lifestyle, beliefs and attitudes, and family and social networks, of the patients being treated. Understanding the narrative context of chronic illness can allow for the type of reflection that is often missing from clinical practice. Drawing on examples from a research programme that examined the illness narratives of minority ethnic groups with diabetes, has allowed me to outline in my presentation the benefits of a story-telling or narrative-based approach for the design and delivery of culturally sensitive health education.

Studies of education in self management of diabetes have generally been psychological in perspective (that is oriented towards individual beliefs, attitudes and behaviour). The anthropological perspective (studying the shared values and meaning systems that embed the individual behaviour choices of members of a cultural group), which we used in a study with British-Bangladeshi, aimed to collect the illness narratives of Bangladeshi with diabetes who participated in the study. Rather than rectify 'deficiencies' in knowledge, the study set out to build on the beliefs, attitudes and behaviours already existing in Bangladeshi culture that promote good diabetes control.

### Diabetes and personal connections: family and friends

Interviews conducted with British-Bangladeshis during this study revealed the desire to understand and explain the onset and experiences of the illness was often strong; however, it tended not to lead to the search for professional or scientific explanations, but rather to a reflection on personal experience and the experiences of friends and relatives. In terms of positive behaviour change within this group, the doctor's advice was often ineffective; what changed their behaviour was a story told to them by another Bangladeshi in an informal setting:

*'I heard about a woman who came to that clinic, and they gave her insulin and her baby died, so I won't go to that clinic and I won't take the insulin'.*

Other stories are prefaced and conclude in a similar way:

*'I heard about a man who smoked and had his leg cut off, so I gave up smoking'.*

Another participant reflected:

*'I heard about a woman who kept finishing off the food the children left, and she got very fat, so I started to measure the portions of my food'.*

### The 'sharing stories' model of peer education

Following the research conducted with Bangladeshis with diabetes, story-sharing groups with the British-Bangladeshi community were developed over seven years. This action research was based on the development and evaluation of group based story-telling interventions, which included: a group based learning set for bilingual health advocates, in which stories about clients with diabetes formed the basis for learning; and advocate led support and education groups for people with diabetes, which used personal stories as the raw material for learning and action. We trained facilitators who ran story-telling groups in Gujarati, Punjabi, Urdu, Somali, Bengali, English (for African-Caribbeans) and Tamil.

The 'sharing stories' model of peer education is based on three key characteristics: firstly, the story-sharing is spontaneous, informal and unstructured—people tell whatever stories they want about their diabetes, in whatever order, with no rules about what is 'important' or 'legitimate'. Secondly, there is non-directive facilitation by a bilingual health advocate or volunteer trained in the model; and, perhaps most importantly, the input of clinical professionals must be a response to the stories shared by group participants, rather than a 'standard spiel'.

### Research findings

One significant finding of the study suggests that the mechanism by which group participation might achieve positive outcomes is not principally through the acquisition of knowledge (although this is clearly important), but by providing a forum in which participants can negotiate the meaning of knowledge and by prompting knowledge. Although it is often assumed that education occurs by the transmission of knowledge from an educator to learners, the finding from both the advocate learning set and the user group was that knowledge was repeatedly discussed, reframed and challenged by the group, and only then made meaningful for the participants.

### Sharing stories model versus standard education: comparative impact

The impact of this sharing stories model was tested in a comparison with 'standard education' consisting of nurse led structured group education with an interpreter. The findings of the quantitative data revealed the story-sharing groups were better attended (85% compared to 35%) and associated with better 'enablement' (a subjective measure of confidence in looking after one's illness) scores. The findings also found the story-telling were equivalent in terms of biomedical outcomes. Although people's condition did not fare better, people attending the groups nevertheless *felt* better.

In addition to the collection of quantitative data such as glucose and cholesterol levels, the study also gathered about 300 stories that had been told in the story-sharing groups. These stories were analysed thematically and narratively. The thematic analysis revealed seven practical issues—such as knowledge ('facts'), diet, exercise, and medication—which are typically found in any data analysis of stories of people with diabetes. The narrative analysis, however, was far more illuminating in that it gives meaning to the practical issues. Examining the stories narratively involved analysing the story as a whole for its literary features including scene setting; characterisation, emplotment and consideration of the story's audience. This narrative analysis revealed eight key storylines or plots: entering the kingdom of the sick; rebuilding spoiled identity; becoming a practitioner; living a disciplined and balanced life; balancing a care network; negotiating across a power gradient; managing the micro-morality of lifestyle 'choices'; and taking collective action.

### Stories: giving self management meaning

Without a story, the concept of 'self management' has no meaning. Take, for example, the following storyline of 'rebuilding spoiled identity':

*'My [diabetic] mother was in Saudi eating and eating, inside doing nothing, watching TV all day. She wasn't well, and then she returned home to Somalia and walked a lot to visit her sisters and she ate less and lost weight and was happier'.*

In this instance the core storyline of identity-rebuilding in diabetes is one of being 'indoors, inactive and introspective' to one of being 'out of the house, active and linking with others', thereby highlighting the identity struggle inherent in the sick person. Another storyline, such as living a disciplined and balanced life, also suggests that diabetes self-care behaviour, of looking after the body and following a set of rituals, could be aligned to religious beliefs. A fatalistic attitude from one group member ('I'm going to die anyway so why bother doing the tests or following a healthy life?'), drew strong criticism from other

group members, who saw great religious value in taking control over one's diabetes and achieving balance. (In a previous study, focus groups of Bangladeshi religious leaders confirmed the strong alignment of the teachings of the Quran and diabetes self-management behaviours).

This type of story-work converts 'self-care behaviours' to acts of meaning. The storylines give the practical issues social meaning and moral worth and hence are the mechanism by which 'self management' comes to make sense for the person. In this regard, strengthening the link between story-sharing groups (the story-work component) and individual care clinical care planning (the self-care behaviour component) needs further work. Nevertheless, the main findings of the story-sharing groups study suggests the group experience can lead to improved diabetes outcomes. A common response offered by patients was that of gaining motivation and confidence in self-care. Patients also described positive changes in diet, activity levels and self-management regimes after attending the story-sharing groups.

### Further Reading

Greenhalgh, T. & Hurwitz, B. (1999) 'Why study narrative?', *BMJ*, Vol. 318, p. 48-50.

Greenhalgh, T., Helman, C. & Chowdhury, A. (1998) 'Health beliefs and folk models of diabetes in British-Bangladeshis: a qualitative study', *BMJ*, Vol. 316, p. 978-983.

Greenhalgh, T., Collard, A. & Begum, N. (2005) 'Sharing stories: complex intervention for diabetes education in minority ethnic groups who do not speak English', *BMJ*, Vol. 330, p.628-633.

Greenhalgh, T., Collard, A. & Begum, N. (2005) 'An action research project to develop group education and support for bilingual health advocates and elderly South Asian patients with diabetes', *Practical Diabetes International*, Vol. 22(4), p.125-129.

### About Professor Greenhalgh

Professor Trisha Greenhalgh is a GP in North London and Professor of Primary Health Care at University College London. She has published over 100 papers in peer-reviewed journals, is the author of seven academic textbooks, and was awarded the OBE for Services to Medicine in 2001. Her research interests include service development for chronic disease management, with a focus on the provision of culturally-appropriate services for immigrants and refugees.

women's health connect project	
	Education sessions for hotel housekeeping staff were delivered as part of the Women's Health Connect Project, which aimed to build the capacity of immigrant and refugee women living, working and studying in the City of Melbourne. Along with the hospitality services sector, the project also allowed MCWH to focus on female international students for the first time.
amharic	Both the health of female international students and the health of immigrant women in the accommodation service industry are relatively new areas of concern. The 2008 City of Melbourne International Student Survey reveals that only 44% of students accessed general health services. This figure demonstrates the need to specifically reach students in educational institutions, in their preferred community settings and using their preferred media through an outreach model. The MCWH Industry Visits Program was also found to be particularly relevant for immigrant women working in the accommodation service industry. Recent research suggests that more immigrant women are now working in accommodation and food services (9%) compared to the manufacturing industries (5%) (Bertone and Leuner, 2008).
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	The Langham Hotel education sessions were delivered to 178 female housekeeping employees from various migrant backgrounds, including Chinese, Filipino, Indonesian, Thai, Indian and Sri Lankan. The education sessions, were conducted during the women's lunch break, allowing the women to speak openly about their health concerns and receive further information that they could pass on to family and friends.

	The international student component of the project has involved research and education. As working with female international students is new territory for MCWH, extensive consultation with key stakeholders (agencies, organisations and institutions providing health and welfare-related services to students), has been undertaken to determine the key health issues for students and to assess how to reach students with the MCWH model of education. Female international students have also been consulted in the research process, in focus groups and in pilot education sessions on sexual health and mental health. To date, the consultation has involved 14 key informant interviews and two focus groups with 29 professional participants. Three focus groups and seven education sessions have also been conducted with 35 students. Consultation findings will be used in the development of a culturally-appropriate health promotion program for female international students. Additional funding has been received from the Lord Mayor's Charitable Foundation and more education sessions will be delivered to students in 2010.	
	<b>REFERENCES:</b> Bertone S and Leuner B. 2008. <i>Immigrant women in the service industries</i> . Multicultural Centre for Women's Health internal report. March 2008. City of Melbourne. 2008. <i>City of Melbourne International Student Survey October 2008 (Summary and Data Report)</i> . Melbourne: City of Melbourne. Retrieved 08 December 2009 from <a href="http://www.melbourne.vic.gov.au/CommunityServices/ForYouth/InternationalStudents/Documents/International_Student_Survey_2008.pdf">http://www.melbourne.vic.gov.au/CommunityServices/ForYouth/InternationalStudents/Documents/International_Student_Survey_2008.pdf</a>	
	carolyn poljski and regina quiazon mcwh health promotion and research project officers	macedonian mandarin somali spanish tagalog thai tigre tigrigna turkish vietnamese

farrep in rural and regional victoria	
	The number of people from FARREP target communities who are living in Victoria's rural and regional areas is increasing. MCWH has conducted a small project to investigate the need, and potential, to deliver a statewide service to FARREP target populations.
amharic	The project had three aims: to find out more about the locations, numbers and ages of FARREP target populations in rural and regional Victoria; to find out more about the health needs, with a specific focus on sexual and reproductive health, of women from FARREP target populations, and match these with FARREP statewide capacity; and to promote FARREP statewide services to service providers and communities in rural and regional Victoria.
arabic	
cantonese	MCWH consulted with key stakeholders in Greater Shepparton, Greater Geelong, Colac/Otway, Warrnambool, and Mount Alexander, to discuss their understanding of demographic factors related to FARREP communities and also to better understand the issues they were addressing in their work with these communities.
croatian	
dari	In Greater Shepparton the priority health issues identified included obesity and diabetes; diet and nutrition; sexual health and STIs; family planning; contraception; domestic violence; and mental health. Our research found service providers required further education about reproductive and sexual health needs and that women also required further education about their own health and wellbeing.
english	
farsi	
greek	
hindi	
italian	

	In Greater Geelong, Colac/Otway and Warrnambool the priority health issues identified included contraception; unplanned pregnancy; relationships; sexual health and STIs; mental health; domestic violence; FGM; and pregnancy. Some communities in this region expressed concern about health issues and low use of services, indicating that service providers have an opportunity to improve their work with these communities. Hospital staff may benefit from a greater understanding of FGM.
macedonian	In Mount Alexander priority health issues were pregnancy; contraception; limited maternity resources for women with high-risk pregnancy; health assessment and health checks; vitamin D, healthy eating and diabetes (for women and children); and cultural issues, such as women rarely caring for themselves.
mandarin	
somali	Research recommendations include: FGM training and education programs for service providers; the holding of women's health days; language-specific health education for women on issues including FGM, reproductive and sexual health, and general health; raising the awareness of services providers about FARREP and MCWH; and offering providers cross-cultural training. Consultation is to be conducted in other rural areas of interest as identified by the project to determine the health issues of their FARREP communities.
spanish	
tagalog	These findings will assist MCWH and statewide FARREP workers to gauge their capacity to support these communities. If you would like a copy of the research report which includes statistical analysis and population data please contact MCWH.
thai	
tigre	medina idriess farrep worker and anna volpe publications & promotions coordinator
tigrigna	
turkish	
vietnamese	

#### ✦ subscribe to working well

'Working Well' is the Multicultural Centre for Women's Health newsletter. Keep up-to-date with projects and programs and the issues affecting immigrant and refugee women's health and wellbeing. Contact us and we will put you on the mailing list.

#### ✦ be well read about immigrant & refugee women's health and wellbeing

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 and the impact of gambling on immigrant and refugee women.

#### ✦ 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 12,000 items and almost 70 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.

#### ✦ join mcwh

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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