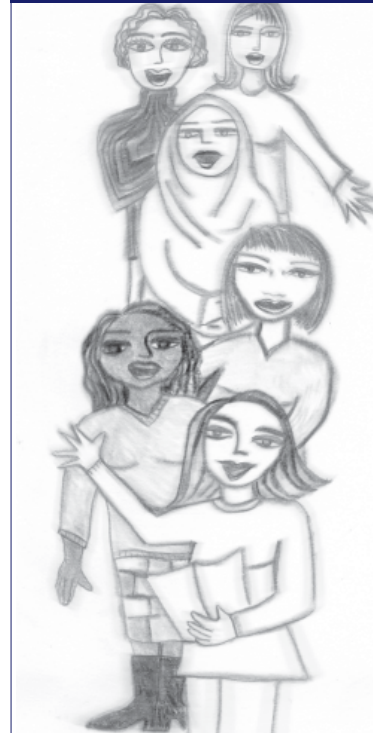


working well
newsletter
march 2009



Issue 15

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



in this issue:

✦ project and
program updates

main feature:

✦ social capital
and social participation
and immigrant and
refugee women

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

Our bodies, our lives,
our choices

MCWH celebrates
30 years

In December last year MCWH celebrated thirty years of programs assisting immigrant and refugee women to make independent and informed choices about their own health and wellbeing.

amharic

arabic

cantonese

croatian

dari

english

farsi

greek

hindi

italian

MCWH started life in 1978 with the humble sum of \$2,000 and an enthusiastic team of twelve peer educators who were trained to deliver family planning education to migrant women in factories. At that time, migrant women were more likely to have abortions than non-migrant women. In response, academics, activists and community workers agreed the time had come to take women's health out of the clinic and into the community. Migrant women needed information so that they could take action on their own health and wellbeing. A series of visits to migrant women's workplaces was initiated and the organisation never looked back.

The MCWH 30th Birthday Celebration took place on the evening of 9 December 2008 at the Abbotsford Convent. Over 100 people joined us in our celebrations; among them past and present members, staff and board members. Proceedings included 1970s film footage, displays of historical photographs, press clippings, annual reports and newsletters. Guest speaker,

Professor Lenore Manderson from Monash University shared her views about multilingual health education via three stories that were symbolic of the feminist and multicultural approach of MCWH.

Guests were entertained by gypsy band Vardos, who inspired much dancing and revelry. A highlight was a surprise performance of Kavisha Mazzella's women's anthem, 'Love, Equality and Justice' by members of the Italian Women's Choir. Equally delightful was the Italian women's impromptu rendition of the partisan classic, 'Bella Ciao', followed by the Chinese version of the same, sung beautifully by our very own Yanping Xu!

We were so pleased to welcome a number of our very early staff and committee members who shared reminiscences about their involvement with the organisation over the late 1970s and early 1980s. Many expressed their pride that the organisation had survived three decades of political, economic and social changes to now deliver programs on a broad range of women's health topics.

From humble beginnings, MCWH is now a nationally-focused organisation with 35 staff, including 22 bilingual health educators who provide health promotion in 20 community languages. Over thirty years, we are pleased to say, MCWH has made contact with over 50,000 women and continues to make thousands of contacts per year.

macedonian

mandarin

somali

spanish

tagalog

thai

tigre

tigrigna

turkish

vietnamese

amharic	Despite the changes over the years, the original focus remains. Immigrant and refugee women continue to ask for multilingual health information delivered by bilingual peer educators. Women still don't have the time or resources to access information themselves—the outreach model means that they can still learn about women's health in their local community or their own workplaces while they take their lunch breaks.
arabic	The MCWH story is one of women's activism, community action, collaboration by workplaces, unions and community groups, and support from state and federal governments over thirty years, all working together for the benefit of immigrant and refugee women's health and wellbeing. It's a unique multicultural success story—and a great example of what immigrant and refugee women can achieve when they have support, resources and opportunities.
cantonese	
croatian	This is a story worth celebrating!
dari	
english	Free copies of the historical MCWH annual report are available—please contact us for yours.
farsi	
greek	dr adele murdolo executive director
hindi	
italian	

mcwh strategic plan	
In late 2007 the MCWH board embarked on a vigorous strategic planning process with the aim of developing a framework for moving our organisation forward to ensure it remains current and continues to support immigrant and refugee women. The process culminated in December 2008 with the completion of a two-year strategic plan.	macedonian
The process was lead by the board's strategic subcommittee with assistance from Adele Murdolo, other MCWH staff, and commercial advisers, Ernst & Young.	mandarin
Importantly, in early 2008, MCWH appointed Dr Santina Bertone to undertake a review of, and report back to the board, on the changing profile of immigrant and refugee women in Victoria.	somali
In particular, the board wanted to understand the areas in which immigrant and refugee women are currently being employed and the changing language and health needs of these women. By way of example, previous research had indicated that as a result of workplace restructuring, deregulation and other economic changes there had been a significant decline in the number of immigrant and refugee women working in the manufacturing industries. As part of this process, Dr Bertone (in collaboration with Adele Murdolo and other MCWH staff) interviewed and consulted a wide range of key MCWH stakeholders.	spanish
	tagalog
	thai
	tigre
	tigrigna
	turkish
	vietnamese

The report's findings formed the basis for the strategic plan as they helped the board to better understand the women MCWH exists to support and how their profile and individual needs differ to those that MCWH has traditionally sought to service.

Although time intensive, the strategic planning process was a rewarding and humbling experience for all those involved. It required the board and management to consider and answer with honesty some fundamental questions about our organisation while remaining true to our vision and mission.

This process led us to reflect on: who we are and who we want to evolve into; who our clients are and what their needs are at present; and what needs we want to be able to meet moving forward and how we can facilitate this process.

The plan's focus is consolidation and growth. It not only seeks to ensure that MCWH continues to link well with its partners and stakeholders (including government, industry, the community sector, health and welfare services, and immigrant and refugee communities) but that it also responds to change—in our country's demographics, the workplace landscape, new research knowledge, and of course, national and local priorities.

MCWH's services will be reprioritized to areas where we can have the greatest impact (without compromising core programs). Our funding strategy will align our service priorities with available government funding sources.

amharic

arabic

cantonese

croatian

dari

english

farsi

greek

hindi

italian

Our governance and management structures and resources will be adapted to ensure they fully support the delivery of our prioritized services.

However, what will not change is MCWH's dedication to immigrant and refugee women and to improving their health and wellbeing together with its commitment to a philosophy that acknowledges and respects immigrant and refugee women's knowledge and expertise.

Although a critical milestone was achieved in December 2008, the hard work is not over just yet! The board looks forward to the successful implementation of the strategic plan in 2009.

tina skliros
chairperson

macedonian

mandarin

somali

spanish

tagalog

thai

tigre

tigrigna

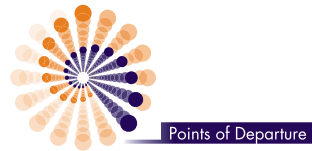
turkish

vietnamese

Pauline Gwatarisa is the MCWH National Project and Advocacy Officer, she is currently engaged in the Points of Departure Project (POD), which seeks to build the knowledge and capacity of NGOs and individuals to advocate on key health issues affecting immigrant and refugee women.

This article is a summary of a Discussion Paper developed for the Project. The Discussion Paper maps key national issues affecting immigrant and refugee women.

issues affecting immigrant & refugee women: social capital & social participation



Points of Departure

Immigrant and refugee women continue to face a myriad of challenges at migration and upon resettlement. The interconnectedness between the challenges faced by women means that these issues cannot be addressed separately. This article offers an overview of some of the key issues affecting immigrant and refugee women and the ways in which they are interconnected. I also discuss at length the issue of social capital and specifically the significance of social networks, their relevance for immigrant and refugee women, and the implications of the loss of social relations on the health and wellbeing of this group.

Immigrant and refugee women face major migration-related issues that make resettlement difficult. Pre-migration factors, such as experiences of war, poverty and inadequate health care facilities; difficulties in finding stable and affordable housing; and the requirement to wait for a two-year period before they are eligible to access social security benefits, are just but some of the factors that combine to make resettlement challenging. This is especially so for newly-arrived refugees, and continues to affect the physical and mental health of immigrant and refugee women.

financial instability

Financial instability among immigrant and refugee women remains a national issue. Financial hardships often result in women borrowing money which they are not able to pay back. Low workforce participation is a major contributor to this financial instability. Recent statistics from the DIC (2008)¹ show that most immigrant and refugee groups have an unemployment rate significantly higher than that of the Australian born, and this is regardless of high education levels. Among women who migrate to Australia on their spouse's visa, failure to find employment upon arrival often means that they have to depend on their spouse's income, which when not availed, leaves the woman in a financially precarious situation. This calls for service providers across the spectrum to be sensitive to the financial circumstances of newly-arrived immigrant and refugee women and to provide the relevant support.

access to services

Inability to access services is yet another challenge faced by immigrant and refugee women. Access to services is by and large hampered by women's low English proficiency, which often makes it difficult for them to articulate their concerns or request specific services. Mobility constraints represent another barrier to accessing services, as immigrant and refugees are more likely to find themselves in outer suburban locations with limited community facilities and public transport. Lack of knowledge about where to find information in their own language also limits the amount of information immigrant and refugee women have on available services, hence affecting access. Therefore, although services such as interpreting and child-care are available in hospitals, immigrant and refugee women may still express concerns around these issues due to the foregoing.

immigration

Immigration issues for immigrant and refugee groups continue to feature in public debate, thus making it a key national issue that warrants advocacy and lobbying. Of specific concern is the treatment of immigrant and refugee groups in immigration detention centres (IDCs), and the conditions within them. Available literature points to this approach as being directly responsible for the increasing incidence of mental illness and self harm amongst asylum seekers. Indeed, there have been breakthroughs in reviewing Australia's immigration detention. However, there is a need to keep track of future developments regarding new legislation on detention. Non-governmental organisations and other service providers could play a critical role in influencing a shift in detention policy.

social capital

Turning now to the widely discussed subject of social capital: the concept is defined as various factors that contribute to wellbeing, and these include voluntary associations, community and other informal networks, and extended family support. Immigrant and refugee women often have testimonies of the support they either received or offered to their networks in their home countries. This was marked by frequent visits to neighbours as a way of 'checking on each other', noticing areas of need, and providing assistance as appropriate. This kind of support, immigrant and refugee women say, is missing in a new country.

Apart from the fragile social ties, networks are often eroded at the family level. Because migration is a movement between places, it is often treated as a movement between social relationships.² At point of

departure to a host country, many people are separated from their families, and relatives are often lost or dispersed across international borders. Among refugee women, this is particularly distressing because of the urgency to leave the home country, which often leaves one no time to farewell friends, pack up belongings and make inquiries about their destination. Often, there is a mismatch between their perception of the host country, and the reality on the ground, resulting in culture shock, and difficulty in adapting.

The impact of this loss of social capital is manifest in different areas. In childbirth, for instance, women have expressed the desire to have extended family members' support during the post-natal period. Most immigrant and refugee women see childrearing as the role of the family, and not of the State. As a result, new mothers experience a deep sense of isolation and lack of support, and isolation is intensified when problems occur with the baby; women also long for social relations during the post-partum period.³

Loss of social capital is also experienced in care-giving. In older immigrant and refugee women, the need for constant care from family and relatives becomes greater with age. Yet the notion of placing the aged in aged-care facilities, which is common practice in the West, is considered alien and un-cultural by most immigrants, especially from most African cultures, but also from other parts of the world, such as India. So for instance, placing an older relative in an aged-care facility is seen as 'un-African' by African immigrants, or 'un-Indian' by Indian immigrants. Being able to 'take care of your own' in a home setting is a much valued practice among immigrant populations, and failure to do so is said to bring a bad omen on the family. However, in a new country, continuation of such practices is put to the test. People's busy schedules, that is the challenges of resettling—finding accommodation, looking for employment, registering for support of all sorts,

takes away from the time available to dedicate to such support and practices. Immigrant and refugee women often place their sadness, loneliness and depression within a framework of lost social ideals and relations. This sadness and loneliness, and the subsequent loss of family interaction, are major issues impacting on immigrant and refugee women's mental health. Good mental health derives directly from positive relationships that enhance self-acceptance, personal growth, trust, safety, and reciprocity.

Participation in social activities is one way in which these positive relationships could be created and enhanced, yet in immigrant and refugee women, low social participation has been noted. The inability to participate in social activities is exacerbated by some gender roles and cultural expectations which regulate their movements. For instance, a survey by the ABS (2008) on migrant groups' attendance at cultural or leisure venues shows that those born in Australia and main English countries had higher attendance rates (71% and 70%) than those from other countries (57%).⁴ The leisure venues surveyed included cinemas, zoological gardens and aquariums, and popular music concerts. For most immigrant and refugee women, caring duties and other commitments at home restrict their participation in these and similar activities. In addition, immigrant and refugee women may prefer to participate more in cultural events and festivities, rather than visit cinemas and aquariums. There is therefore a need to design programs aimed at increasing immigrant and refugee women's participation in social activities. Cultural appropriateness and women's preferences should be taken into account in designing these programs, in order to ensure increased participation.

conclusion

The issues affecting immigrant and refugee women listed in this article are by no means exhaustive. Newly-emerging communities come with new challenges, which in turn require that service providers be sensitive to emerging challenges in order for them to provide relevant support. Indeed, issues raised here are not new, and this raises critical questions: Why do these issues keep recurring in literature and at public fora? What does this say of national response to these issues? Where have we gone wrong? What can be done differently? The diversity of the population of interest (that is immigrant and refugee women), and the complex challenges they face require combined efforts from all stakeholders.

dr pauline gwatirisa
national project and advocacy officer

For more information on the POD Project or the Points of Departure National Forum on the 8th of April 2009, please contact us. The Forum will seek to explore the issues raised in this article and the Discussion Paper on which it is based. Please call MCWH on: 03 9418 0999 or send an email to: pauline@mcwh.com.au

Footnotes

1 Department of Immigration and Citizenship (2008) 'The People of Australia: Statistics from the 2006 Census.' Commonwealth of Australia.

2 McMichael, C. and L. Manderson (2004). 'Somali Women and Well-Being: Social Networks and Social Capital among Immigrant Women in Australia.' *Human Organization* 63(1): 88 - 99.

3 Small, R., P. Liangputtong Rice, et al. (1999). 'Mothers in a New Country: The Role of Culture and Communication in Vietnamese, Turkish and Filipino Women's Experiences of Giving Birth in Australia.' *Women and Health* 28(3): 77 - 101.

4 Australian Bureau of Statistics (2008). 'Australian Social Trends, 2008.' www.abs.gov.au/AUSSTATS/abs@nsf/Lookup/4102.0Chapter42022008. Accessed 20 January 2009.

mcwh bilingual health education at mushroom exchange	
	2008 was a year of great productivity and dedication in the Industry Visits Program (IVP), which visited a number of workplaces including Mushroom Exchange a mushroom picking and packaging factory at Mernda.
amharic	<p>Nine of our health educators ran a total of 128 sessions between September and November with women from 13 different groups including Arabic, Chinese, Indian, Liberian, Macedonian, Papua New Guinean, Somali, Sri Lankan, Sudanese, Thai, Turkish, Vietnamese and English. We made 535 contacts with women during these visits and distributed hundreds of copies of useful information in the women's preferred languages. Topics covered included reproductive and sexual health, OH&S, and mental health and wellbeing.</p> <p>Women raised issues related to their work which involves repetitive movements, stretching, twisting and lifting, which in turn can result in pain or soreness of the arms, fingers, shoulders, neck, and back. Other issues included stress due to the uncertain nature of casual work and issues relating to the bonus system.</p> <p>Reproductive and sexual health is always a subject which women are interested to talk about. Prior to our sessions some of the women workers at Mushroom Exchange had had little if any access to education relating to sexual health:</p> <p>'I have a tumour in my ovary; the doctor told me to have a baby but didn't give me any treatment for my tumour. Will my pregnancy help to cure my ovary tumour?' (participant)</p>
arabic	
cantonese	
croatian	
dari	
english	
farsi	
greek	
hindi	
italian	

	<p>Women said that participating in our sessions encouraged them to take action regarding their health and wellbeing. One woman experiencing menstrual issues reported the information provided had motivated her to see a doctor straight after work. She was now awaiting medical results. Other feedback, reflected similar positive impacts on participants' health and wellbeing:</p> <p>'Next time, when I go to see a doctor I am going to ask him to explain everything to me. I will make a list of what I have to ask him before I go. I will ask my male doctor to introduce me to a female pap-test practitioner.' (participant)</p> <p>Feedback also reflected that this often extends to family and friends, increasing its value:</p> <p>'Give me another set of Vietnamese written information; I need to send it to my sister in Queensland. I talked about your visit and she wants me to send resources to her.' (participant)</p> <p>One the brightest examples of the difference our programs make came during these sessions. A newly-arrived pregnant woman unable to find permanent housing reported that she had been greatly supported by the agency she had been referred to via the support and assistance of our educators. She was soon moving into her own apartment, and a social worker was also assisting her with hospital arrangements and essential baby goods.</p> <p>amira rahmanovic manager education & training programs</p>
macedonian	
mandarin	
somali	
spanish	
tagalog	
thai	
tigre	
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 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.

✦ 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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