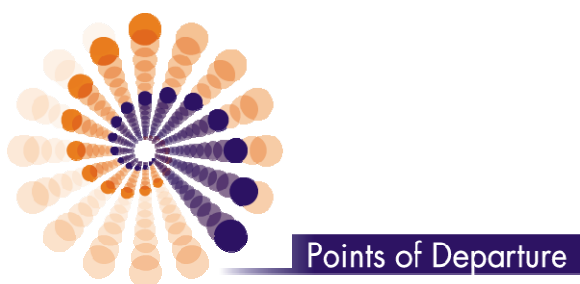


Points of Departure Project



Discussion Paper

National Issues for Immigrant and Refugee Women

Dr Pauline Gwatorisa
National Project and Advocacy Officer
pauline@mcwh.com.au

March 2009

@ Multicultural Centre for Women's Health (MCWH) 2009

Title inspired by Simone de Beauvoir

"Points of Departure" design by 3 Tier Design for MCWH

Contact for all inquiries:

Multicultural Centre for Women's Health
Suite 207, Level 2, Carringbush Building
134 Cambridge Street
Collingwood
Victoria 3066
Australia

Ph: 03 9418 0999

Fax: 03 9417 7877

Email: reception@mcwh.com.au

Website: www.mcwh.com.au

"There are no arrivals anywhere, there are only points of departure." (Simone de Beauvoir)

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	4
LIST OF ACRONYMS	5
INTRODUCTION	6
About the MCWH.....	6
The Points of Departure (POD) project	7
Purpose of the discussion paper	8
1. Immigrant and Refugee Women in Australia	9
1.1 The statistics.....	9
1.2 Introduction to the literature	9
2. Migration and resettlement	10
2.1 Pre-migration factors and resettlement	10
2.2 Challenges in settling.....	11
2.3 Housing	12
2.4 Two year waiting period	13
2.5 Financial issues	14
2.6 Parenting	16
2.7 Social participation	17
2.8 Discrimination and racism	20
3. EMPLOYMENT	22
3.1 Labor force experience	22
3.2 Unemployment and long-term unemployment	23
3.3 International students	25
4. HEALTH AND WELLBEING.....	27
4.1 Sexual and reproductive health.....	27
4.2 Maternal Health	29
4.3 Social capital and mental health	32
4.4 Occupational Health and Safety.....	33
4.5 Violence against women	36
5. IMMIGRATION DETENTION	39
5.1 Immigration detention centres: a policy perspective	39
5.2 Immigration detention centres: recent developments	41
6. WOMEN’S RIGHTS AND REPRESENTATION	42
6.1 The Bill of Rights.....	42
6.2 The Citizenship test.....	43
6.3 Representation.....	44
7. CONCLUSION.....	46
Appendix 1: Details of Expert Advisory Committee.....	47
REFERENCES	48

ACKNOWLEDGEMENTS

The Multicultural Centre for Women's Health is grateful for the funding received from the Office of the Status of Women to undertake the *Points of Departure* project.

We acknowledge the invaluable contributions of the expert advisory committee (EAC) in developing the discussion paper. Many thanks for the resources supplied for the literature review, the written responses submitted, and general contributions via teleconferencing. (Details of the EAC are provided in Appendix 1).

The *Points of Departure* project is the brain child of Adele Murdolo, (Executive Director, MCWH), whose commitment and passion for promoting the well being of immigrant and refugee women over the years is greatly appreciated.

We anticipate that this paper will generate debate among stakeholders and other interested parties, resulting in significant insights which will further shape the arguments made in this paper. Many thanks to all prospective contributors in advance.

LIST OF ACRONYMS

CALD	Culturally and Linguistically Diverse
CLDB	Culturally and Linguistically Diverse Background
CMY	Centre for Multicultural Youth
EAC	Expert Advisory Committee
FGM	Female Genital Mutilation
IDC	Immigration Detention Centres
IWSS	Immigrant Women's Support Service
IWDVS	Immigrant Women's Domestic Violence Service
MCWH	Multicultural Centre for Women's Health
MINC	Mothers in a New Country
MSD	Musculoskeletal Disorders
NESB	Non-English Speaking Background
OOS	Occupational Overuse Syndrome
POD	Points of Departure
PPD	Post-partum Depression
TCF	Textile, Clothing and Footwear
UN	United Nations

INTRODUCTION

About the MCWH

Background

The Multicultural Centre for Women's Health (MCWH) is a community based organization committed to improving the health and well being of immigrant women, including refugee and asylum seekers, around Australia. Providing excellence in multilingual health education, advocacy, training, and research, with specific expertise in sexual, reproductive, occupational and mental health, the organization is run by women from immigrant and refugee backgrounds.

History

In 1978 the organization, then called Action for Family Planning, began with a pilot factory visiting program providing multilingual family planning education to immigrant women factory workers. Throughout the 1990s, the program became a service named Women in Industry and Community Health (WICH), and later, Working Women's Health (WWH), emphasizing the agency's continuing unique expertise in women's workplace health education. By 2006, the WWH became the Multicultural Centre for Women's Health (MCWH), reflecting the organization's comprehensive approach to immigrant and refugee women's health and the continuing commitment to meeting the needs of immigrant and refugee women.

Services provided

The MCWH provides multilingual health education sessions for women in the workplace or women who work as carers, mothers and outworkers. The sessions are conducted by the Centre's Bilingual Health Educators, who are trained to provide high quality multilingual health education in a multicultural context. The services are offered in 21 languages, including Amharic, Arabic, Cantonese, Croatian, Dari, English, Farsi, Greek, Hindi, Italian, Macedonian, Mandarin, Somali, Spanish, Sudanese Arabic, Tagalog, Thai, Tigre, Tigrigna, Turkish, and Vietnamese.

The MCWH offers a range of support services including cross-cultural and other specific training to employers, community workers, and health professionals; and free access to a multilingual library with publications in over 80 languages on health issues affecting women.

The Points of Departure (POD) project

In 2008, the MCWH received funding from the federal Office of the Status of Women to undertake advocacy work on immigrant and refugee women's wellbeing. The project, entitled "Points of Departure" or POD for short, commenced at the beginning of September in 2008. The overall aim of the project is to build knowledge and capacity among NGOs and individuals around Australia to advocate on key social inclusion issues relevant and specific to immigrant and refugee women.

POD is based on the premise that women's lives are marked by constant change. For most immigrant and refugee women, an "arrival" is also a point of departure for a new phase in their lives; in other words, they are always "on the move". Women have to keep pace with these changes: different health care practices, a new language, foreign values and customs, and an expectation by the host country to "integrate" into mainstream society.

The POD project will be conducted in stages. An Expert Advisory Committee (EAC), whose main role is to guide the project while ensuring the provision of expertise in the range of issues relevant to immigrant and refugee women, was established in October 2008. The EAC has also been instrumental in developing this discussion paper. When completed, the paper shall be circulated for comment among up to 100 key stakeholders. A National Forum to which stakeholders who have viewed and commented on the discussion paper will be invited, is scheduled for April 2009. Participants will use the discussion paper as a guide to identify 5-6 key issues from a list of key social inclusion indicators. Following the National Forum, the Project Officer will conduct a literature review around the identified 5-6 key areas, and afterwards develop a series of papers for circulation among stakeholders who attended the National Forum for final comment.

A major highlight of the project will be the development and launch of an Advocacy Toolkit. This will consist of the 'position and action' papers addressing the 5-6 key issues relevant to immigrant and refugee women, along with supplementary information for use by NGOs and individuals. The Toolkit will be promoted on selected Australian websites.

Purpose of the discussion paper

This discussion paper seeks to map out key issues affecting immigrant and refugee women in Australia. It draws on findings from scholarly research as well as experiences of service providers from different sectors and fields of expertise. Issues are presented with a view to identifying gaps in knowledge and practice. We realize that some of the issues raised in this paper have been raised before, but we also see their recurrence as a matter of concern: these issues are yet to be resolved. At the end of each major section, we pose specific questions, rather than make recommendations, because we are calling for action more than reasoning around issues identified. We anticipate that stakeholders will provide a practical way forward, by providing solutions to questions raised based on their experiences. We are cognizant of the positive strides that the Commonwealth government has made in addressing some of the issues discussed in this paper. We however revisit some of these issues and attempt to highlight certain areas which, in our opinion, require further attention. In reading this paper, stakeholders are expected to relate this to their work and to provide case examples as evidence of challenges faced by immigrant and refugee women. Written responses from stakeholders on issues raised here will guide the development of the advocacy toolkit. This paper is organized as follows:

In the next section I provide some statistics on immigrant and refugee women in Australia, while describing available literature and sources of data used in developing the paper. I move on to describe in turn, key issues affecting immigrant and refugee women. These are not necessarily discussed in order of priority, but are rather organized thematically. I discuss migration and settlement issues in section 2, highlighting challenges faced by immigrant and refugee women during migration and upon resettlement. Part 3 focuses on employment issues, particularly the challenge of long term unemployment. The disparities between educational qualifications and employment are discussed. Health and well being issues are the subject of part 4 of the paper. Factors directly affecting women's mental health, sexual and reproductive health and occupational health and safety, are discussed here. Part 5 is concerned with immigration detention and the debate around the subject. Part 6 discusses women's rights and representation issues. The paper concludes by summarizing key questions for action based on the issues raised in the paper.

1. Immigrant and Refugee Women in Australia

1.1 The statistics

Australia is an ethnically diverse nation, with a population of 19,855,287 according to the 2006 census statistics (DIC 2008). In 2006, 22.2% (4.4million) of Australians were born overseas, with more than half of these born in a non-English speaking country. A further 26% of people who were born in Australia had at least one parent who was born overseas.

Women from non-English speaking backgrounds born overseas or with one or both parents born overseas account for 12 per cent of the total Australian female population. Australia's shifting immigration policies, which increasingly favor admitting high-skilled workers while retaining a focus on family reunification, are leading to greater inflows of women. In 1989-1990, women accounted for approximately 40% of principal applicants for settlement in Australia. This figure climbed to 51.6% by 2002 (Inglis 2003). Several factors have contributed to the rise in Australian population of female immigrants. Some women are eligible to migrate as highly skilled workers. For other women, the economic restructuring and shift away from manual labor has opened more opportunities. The relaxation of traditional constraints on women in countries of origin has permitted some to migrate. Yet others have migrated due to interdependent and spousal relationships with Australian citizens. The introduction of the '204 Women at Risk' visa has also seen an increase in the number of women (particularly single parents), migrating to Australia on their own visas in recent times.

1.2 Introduction to the literature

Immigrant women make up nearly half of the population of the migrant population worldwide, yet national data on their health and well-being is scanty. In Australia, the National Non-English Speaking Background (NESB) Women Health's Strategy (Alcorso and Schofield 1991), launched in 1991 by the Commonwealth-State Council on Non-English Speaking Background Women's Issues, is the main source of data on the pattern of NESB women's health (Shackelton et al 1996). Research on immigration has for a long time focused on the male migrant worker, reinforcing the perception of the migrant woman as only an assistant to her husband. These perceptions have serious

human rights consequences for women, and require that immigrant and refugee women¹ be viewed as individuals to ensure that their rights are understood in perspective, and that they are adequately addressed. Further, some of the data available has not been disaggregated by gender, making it difficult to separate specific issues for women. Research conducted to date shows that immigrant and refugee women face unique challenges upon migration and during resettlement. Resources for this Discussion Paper were obtained from relevant databases, mainly web of science. The Expert Advisory Committee (EAC) members of the Points of Departure (POD) project shared relevant reports from their work which I have cited. In addition, the Paper incorporates EAC members' views on key issues affecting immigrant and refugee women shared at teleconferences held in October 2008 and January 2009.

2. Migration and resettlement

2.1 Pre-migration factors and resettlement

Although immigrant and refugee women share similar barriers and challenges in a host country, it is essential to understand the circumstances within which migration occurs, and how this determines the (re)settlement experience. When refugees flee their countries, they do so in a hurry without time to prepare to leave and often flee in secrecy; do not have time to pack their belongings; do not have time to say goodbye to family and friends; do not have time to prepare themselves mentally, emotionally and financially; do not know their destination or if they do, do not have enough information on what to expect on arrival (O'kane 2003). The pre-migration experiences of immigrants, and the factors pushing them to migrate, are usually different from those of refugees. Immigrants choose to migrate and have time to decide on which country to migrate to; research on their destination; prepare themselves mentally, physically and financially; farewell friends and relatives; and pack their belongings. Immigrants can return to their homes if they need to, which refugees cannot do. The resettlement experiences of immigrant and refugee women are therefore often compounded by their pre-migration experiences and

¹ The Multicultural Centre for Women's Health refers to its constituency as "Immigrant and Refugee women". While I use this term more often in the paper, I do acknowledge the co-existence of alternative terminology, such as Non-English Speaking background (NESB). I use these terms interchangeable, as I have interpreted them to refer to the same constituency. However, I only use the term NESB where it appears in cited references.

for women from a refugee background, their harsh pre-migration experiences often makes resettlement difficult. This has a significant impact on their physical and emotional well being, and often so for many years following (ibid:10).

2.2 Challenges in settling

Overall, immigrants and refugees demonstrate better health on arrival and for some years following than does the Australian-born population. This is explained by the health requirements and eligibility criteria ensuring that generally only those in good health migrate to Australia (AIHW 2002). The health status of immigrants and refugees, however, is known to deteriorate after their arrival in Australia (Alcorso and Schofield 1991), and this is mainly due to the health disadvantages experienced in different areas. For instance, immigrant and refugee women are less likely to take the necessary health related action during an illness due to several barriers. These include lack of information on the health condition, low English language proficiency, other structural barriers, such as poor access to facilities due to mobility constraints.

These challenges, and in addition housing barriers, cultural barriers, unemployment, and discrimination, are the major challenges experienced by immigrants and refugees, and do not only affect their health, but their general wellbeing. Newly arrived refugees are particularly vulnerable due to pre-migration factors – particularly those with a history of brutalization and trauma from years of civil wars and refugee experience. Although it has been noted that the health of immigrants is generally good upon arrival in Australia due to health requirements, the same can not be said for refugees, most of who are from countries where health systems have been disrupted due to civil unrest and are less likely to have found time to undergo health checks before migrating. Poor health and cultural barriers therefore make it difficult to settle. Under the Government Settlement Program, any newly arrived immigrant may be eligible for a wide range of settlement services such as assistance in accessing medical services, Centrelink, employment, and housing.² In spite of this, immigrants and refugees continue to face challenges, such as health providers and other service providers' inadequate understanding of their needs and challenges.

² URL: www.aph.gov.au/library/INTGUIDE/SP/settlement.htm

Questions

How can the training of health professionals and other service providers be improved to accommodate the settlement needs of newly arrived immigrant and refugee women?

What other strategies can be employed in ensuring that the challenges experienced at (re)settlement are addressed?

Are there any case studies on settlement related experiences that can be drawn on in designing these strategies?

2.3 Housing

Stable and affordable housing has been more difficult to obtain in recent times than in the previous three decades (Poljski and Murdolo 2009). Immigrant and refugee women are more likely to find themselves living in outer suburban locations with limited community facilities and public transport, and less likely to be in a position to own their own home on their limited outcomes. Current data suggests that 7.5% of people born overseas who are not proficient in spoken English are unable to pay the mortgage or rent on time compared to 4.6% of people born in Australia. This affects immigrant and refugee women on different levels: on one level women are forced to rely on credit to buy property or to pay rent; on another financial insecurity and uncertain accommodation can result in poor mental health for immigrant and refugee women (ibid).

The Integrated Humanitarian Settlement Strategy (IHSS) is a Federal Government scheme designed to assist refugees into accommodation within the public and private rental market. IHSS case officers have the responsibility to assist with the signing of leases and connecting services such as gas, telephone and electricity (Ethnic Communities Council of Victoria 2008). While the effort of government in this regard is noted, newly arrived home-seekers from an immigrant background who do not have accommodation organized for them upon arrival continue to experience implicit and explicit discrimination based upon language, race, religion and financial circumstances.

While the current housing shortage and the rising cost of living are making it difficult for all home seekers and renters, the situation is worse for people from an immigrant and refugee background, and particularly those from a non-English speaking background.

Low socio-economic status, language barriers, lack of understanding of the housing industry and tenancy laws, all affect immigrant and refugee women's ability and eligibility to negotiate and secure adequate housing, forcing them to accept more marginal housing conditions. The requirements of most housing agents, such as current bank statements, local referees, rental history and longer lease arrangements, do not always favor the circumstances of especially newly arrived immigrants. Crisis/emergency housing for women from a refugee background has also been difficult to secure due to big family sizes. The shortage of housing suitable for high population households is particularly a problem in metropolitan Victoria (ibid:14). Many families living in overcrowded conditions are said to suffer family breakdowns and poor health as a result. Overcrowding also occurs when families are unable to access appropriate housing and end up living with other families.

Questions

How can the problem of overcrowding and housing availability and affordability among immigrant and refugee communities be dealt with (at policy level)?

What case studies on challenges faced by immigrant and refugee women in securing accommodation can stakeholders provide?

2.4 Two year waiting period

The Social Security Legislation Amendment (Newly Arrived Resident's Waiting Periods and Other Measures) Bill of 1996, is designed to impose on skilled and temporary immigrants a two-year waiting period for a range of social security payments. The Bill specifically applies to all categories with the exception of refugees, humanitarian category entrants, and their partners and dependent children. This means that Government expects that new entrants to Australia should provide for their own support during their first two years in Australia. The main reasons given for the passing of the Bill were the high unemployment rate, which in 1996 stood at 8.5%, and a net foreign debt of \$184.8 billion in the same year. This meant that Australia could not afford to have new migrants coming, and immediately drawing social welfare payments, like unemployment benefits (<http://www.apf.gov.au/library/pubs/bd/1995-96/96bd102.htm>). Yet immigrant and refugee groups, particularly skilled migrants, bring in skills which are necessary for economic development.

The impact of the Bill on Family Reunion has been noted, and is a major issue for immigrant women, most of who are motivated by the need to keep their families together when deciding to migrate. Critics of the Bill have argued that a negative impact of the Bill is that it changes the pattern of migration, and disadvantages especially those from poor communities (ibid).

State and Territory consultations held with immigrant and refugee women showed that having to wait for two years for Centrelink payments is seen as a major impediment by immigrants (Commonwealth Office of the Status for Women 2001). Many are said to depend on the family tax benefit as their sole income (ibid:25). The need to find a job for sustenance becomes the main preoccupation, and this often interferes with the quest for other settlement services, such as attendance at English language classes. During the same consultations, women reported that (during the waiting period), if household size swells as a result of other family members joining in, this can result in increased tensions in family households, lending women and children in abusive relationships.

2.5 Financial issues

For most immigrant and refugee women in Australia, financial well being has remained an elusive goal (Poljski and Murdolo 2009). Financial instability often results in the accumulation of unpaid debt and concomitant health outcomes. Conversely, increasing women's financial literacy may lead to improvements in women's health, and also facilitate women's economic participation and social inclusion. The use of credit has increased over the last thirty years. Higher living costs have created a greater demand for credit, but changing community attitudes and lenders' aggressive marketing techniques have also contributed to its growth since the 1980s. Personal indebtedness has escalated with the increasing use of credit. In 1980, the average debt per capita in Australia was \$2,270. In 1996, the figure rose to \$12,033. Today, personal and household debt is higher than before.

Debt is a significant concern for people from culturally and linguistically diverse communities. A project implemented by the MCWH as part of its mission to increase the capacity of women to participate in society, *the Healthy Credit Project* (Poljski and Murdolo 2009), provides an understanding of immigrant and refugee women's credit experience. Immigrant and refugee women arrive in Australia with varying

understandings of credit and debt, as well as varying needs in relation to using debt. Women's migration experiences and socio-economic status determine their need for credit, and the ways that women access credit and their capacity to repay loans. For instance, women who arrived in the immediate post-Second World War period had better employment opportunities compared to immigrant and refugee women coming to Australia in recent times. According to Bertone and Leuner (2008), immigrant and refugee women have an unemployment rate of 8% compared with the 5.5% national average.

Service providers who provide financial counseling, budgeting assistance, financial assistance, and legal support lack the expertise in issues specifically impacting immigrant and refugee women. These issues comprise knowledge of the nature and impact of informal debt on this group, including relationship debt – i.e. influence from partners and immediate family to take out formal loans without having an accurate understanding of their responsibilities. In addition, services tend not to be culturally or linguistically appropriate, or accessible to women who may have transport difficulties or limited access to internet facilities.

Poljski and Murdolo also note that immigrant and refugee women accumulate formal debt by signing documents that commit them to debt on behalf of others, without realizing the power of their signature. Their access to knowledge on credit is generally limited, and is impacted by their experiences in their country of origin.

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. There have been reported cases of abuse amongst women who migrate to Australia on their spouses' visas. When they fail to find employment upon arrival, they become dependent on their spouses income, and sometimes are unable to escape violent relationships. In most cases, this income is not availed leaving the woman in a financially precarious situation. Newly arrived women's financial situation is particularly precarious during the two-year waiting period discussed above. An added disadvantage for these women is that due to financial constraints, they are unable to enroll in English classes and educational programs, which further limits their employment opportunities, thus perpetuating financial dependency.

Questions

What strategies should be put in place to safeguard women from incurring debt?

What case studies can stakeholders provide for an informed response to the financial challenges faced by immigrant and refugee women?

2.6 Parenting

In November 2008, the Victorian Immigrant and Refugee Women's Coalition organized a series of theatrical performances entitled "*How will the System Listen to Us?*" performed by immigrant and refugee women. A scene performed by a group of Sudanese women showed the challenges faced in raising children in a foreign country. There is often deep concern over the erosion of culture and values, as children tend to adopt a more Western lifestyle: dressing, smoking, drugs, refusal to go to school, talking back to parents etc.³ Parents express a sense of failure and defeat, and request for any form of assistance in raising children in line with their culture is not uncommon. These sentiments are shared in a report prepared for Immigrant Women's Support Service (IWSS) by Gatbonton (1992). She notes that many parents of non-English speaking background fear that their children will become too Westernized and lose the important values and traditions of their original culture and as a result, strive to inculcate the customs and traditions they themselves grew up with into their children. This often results in conflicts between the two parties, with children from NESB being caught up in "a balancing act" (Gatbonton 1992), in other words, trying to negotiate the two worlds.

Questions

What form of assistance can be offered to parents facing challenges in raising their children in a new country? In what form should this assistance be provided?

Are there any case studies on challenges faced in parenting?

³ While the women's experiences cannot be ruled out, as they indeed enacted real life experiences, the risk of stereotyping the behavior of Anglo- Australian children need to be guarded against, if sustainable solutions to immigrant and refugee women's parenting challenges are to be found.

2.7 Social participation

People whose first language is not English face challenges in participating in some social activities. This in turn dictates the amount of support one can anticipate in times of need. In 2006, almost one in seven people born in countries other than Australia or main English speaking countries reported that they had no source of support during a time of crisis (ABS 2008).⁴ For immigrant and refugee women, 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 speaking countries had higher attendance rates (71% and 70%) than those from other countries (57%). The leisure venues surveyed included Cinemas, Zoological gardens and aquariums, popular music concerts etc. For most immigrant and refugee women, caring duties, financial constraints and other commitments at home restrict their participation in these and similar activities. Some families from an immigrant and refugee background do not attend certain social activities due to lack of transport. In some cases too, it is important to understand that leisure activities are culturally based. Most African families would prefer attending or participating in traditional dancing, cultural festivals/events, cultural fashion and food fare, and the like, than going to the cinemas or to see opera music.

A lack of English language proficiency also presents a barrier to participation in leisure, cultural and sporting activities. This is true for all age groups, but particularly so for older women, who are often forgotten in discussions on social participation. 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 of Australia 2001).

Questions

What programs /assistance can be offered to increase immigrant and refugee women's participation in social activities? What are the critical issues to consider in designing programs?

What case studies can be used to illustrate the restricted social participation of immigrant and refugee women?

2.7.1 Participation of women with a disability

The Australian Bureau of Statistics defines disability as " a limitation, restriction or impairment, which has lasted, or is likely to last, for at least 6 months and restricts everyday activities" (cited in the Report of the Evaluation of the Commonwealth Disability Strategy (2006)). There are many types of disability including sensory (e.g. hearing or vision loss), physical disability including restriction in the limbs and developmental disability such as autism. Mental illness, such as schizophrenia and bipolar disorder, also fits the above definition.

While some people with disability can function independently most of the time, others rely on carers to assist them with important tasks such as eating and showering. Carers are often female, a family member, a relative or a close friend of the person living with a disability, and do not receive payment for their work. People with disability and their carers are valued members of the Australian community. Support is usually available in the form of equipment and services. Legal protection is also provided for people with disability under the Disability Discrimination Act (1992). Likewise, the Carers Acts, administered by most of the Australian States and Territories, safeguard the rights and entitlements of carers.

Consequently, as a result of support systems and legal protections, quality of life is slowly improving for all Australians with disability and their carers. However, progress for some groups of people with disability, such as women from Non English Speaking Backgrounds (NESB), is slower and more challenging than others.

Women and girls with disability from NESB are one of the most vulnerable groups in Australia, and often face discrimination on different fronts. In a study conducted by Pane

(1994), participants noted that to be an NESB woman with a disability means “you have three disabilities i) disability ii) ethnicity iii) a woman”. In general too, when talking or writing about the experience of disability for people, it’s often the disability that is referred to first, and not the person, yet this should be the other way round.

Labor force participation for women with a disability remains a big challenge, in spite of the fact that employment is the most effective pathway to social inclusion for all Australians. A major impediment to participation for women with disabilities is that of mobility. Women with disabilities require assistance in accessing, not only workplace environments, but also other social and learning environments. Mobility limitations often imply that immigrant and refugee women cannot participate fully in social life.

While it is essential to ensure that immigrant and refugee women participate actively in the labor force, attention also needs to be paid to the conditions and environments within which they work. Workplace disabilities are quite common among immigrant and refugee women, and as Strong (2001) notes, the pain associated with a workplace disability often generates chronic irritability and depression, which are further exacerbated by poverty and social isolation.

Broadly, people from NESB with disability face significant barriers to accessing government funded support services. For example people born in a non English speaking country are approximately 4 times less likely to access a government funded disability support service than their peers born in an English speaking country (Australian Government Productivity Commission, *Report on Government Services 2009*). People with disabilities are only eligible for a disability pension after 10 years of residence in Australia (Commonwealth of Australia 2001). This undermines the contribution of people with disabilities to the national economy. Poor access to support services will increase barriers to participation for women from NESB with disability.

Apart from the isolation and discrimination that women might experience from English speaking / Anglo Celtic cultures, women from NESB with a disability also face barriers within their own communities. People in many NESB cultures regard disability with shame and fear, and women with a disability are considered to be incomplete and sometimes even non-sexual (Meehan and Hanson 1999). Women and girls with a

disability are also considered to be very vulnerable in some cultures and they are heavily protected by often well-meaning family members, to the point where they are restricted from employment, socializing with friends and participating in community events. This can lead to greater isolation and exclusion from one's ethnic community and the wider Australian society.

Questions

What is the uptake of services designed for immigrant and refugee women with a disability? What strategies can be put in place to increase the social participation of women with disabilities and those under their care?

Can stakeholders provide case studies on challenges faced by people with a disability?

2.8 Discrimination and racism

Immigrant and refugee women tell appalling stories of how they are discriminated in different spheres of life. Because they are visibly different from mainstream Australians in terms of skin color, culture, accent, or type of dress, they are more vulnerable to discrimination and vilification.

Workplace discrimination

Immigrant and refugee women attribute their exclusion from employment to their visibility. (Ethnic Communities' Council of Victoria 2009). Reports show that some employers prejudice NESB women and make assumptions about their abilities. As a result, immigrant and refugee women tend to conceal their ethnic identity in order to secure a job, and some do so by imitating a different accent from their own, and others by not revealing their ethnicity (POD Teleconference 2009). On-the job discrimination continues to be a reality for immigrants. There may be a need for immigrant women who have been on their jobs longer, to act as mentors to their fellow immigrant women upon commencement of employment.

Discrimination in the housing sector

As noted earlier, discrimination is also experienced in the area of housing. Newly arrived immigrants and refugees often find it difficult to interpret certain tenancy laws, leaving them vulnerable to exploitation and discrimination by their landlords. Exploitation has

been known to occur not only when tenants are in private accommodation, but also when they are ending a lease. Many tenants from an immigrant and refugee background quite often find it difficult to recover their bond, as landlords penalize tenants for the whole amount of their bond for minimal damage, pre-existing poor conditions or damages which the landlord is obliged to repair (Ethnic Communities' Council of Victoria 2008). Due to lack of knowledge on rental policy, recourse and fear of a bad reference, tenants find it difficult to challenge decisions of landlords.

Religious discrimination

Immigrant and refugee women also face discrimination in different circles on the basis of religion. Those who follow the Islamic faith are most vulnerable, and face an additional barrier if they wear the headscarf, hijab or burqa, which makes them even more visible (Ethnic Communities' Council of Victoria 2008). Most women of the Islamic faith face some difficulty in negotiating appropriate cultural clothing in the workplace, with some women reporting that they have been discriminated against in the recruitment process and on the job because of their religious attire. In general, higher levels of prejudice against Muslim and Arab Australians have been generated by geopolitical, international media coverage, and general fears and concerns which have resulted in heightened levels of "Islamaphobia" (Dunn et al 2007). Events such as the terrorist attacks of September 11, 2001 have been linked to the discrimination experienced by those from an Islamic background (Islamic Women's Welfare Council of Victoria 2008; Human Rights and Equal Opportunity Commission 2004).

Questions

How can immigrant and refugee women be assisted in overcoming racial-related challenges? What do they need to know in order to prepare themselves?

What sort of preparation is required, who provides this information, and in what form?

In what ways can service providers influence policy on racism and discrimination?

What case studies can be provided as evidence of the extent of racism and discrimination?

3. EMPLOYMENT

3.1 Labor force experience

NESB migrants are significantly over represented in unemployment and long term unemployment statistics. In 2006, people who were born in Australia and those born in main English speaking countries were more likely than those from other countries to be employed (78% and 80% compared with 68%). Men were more likely to be employed than women. Among people born in non-English speaking countries, 79% of men compared with 57% of women, were employed in 2006 (ABS 2008). In the same year, as Bertone and Leuner (2007) note, immigrant and refugee women had a substantially higher unemployment rate (8%) than the national average (5.5%), and a proportionately higher unemployment rate than Australian-born women (4.8%). A higher proportion of immigrant and refugee women were not in the labor force (52%), compared to Australian-born women (39%).

Immigrant and refugee women with low English proficiency, and newly arrived in Australia have the highest rates of unemployment compared with other overseas-born women and men (Alcorso and Schofield cited in Chang 2000). Due to a lack of recognition of educational qualifications obtained in their home countries, as well as their limited English skills, women from NESB are often situated at the lower end of the labor market, mostly as laborers or in non-skilled and blue collar jobs. The Adult Migrant English Program (AMEP) is a service offered by the government to allow those with low English proficiency to improve their English skills. Up to 510 hours of English classes are offered to migrants entering Australia as a part of the humanitarian scheme (ECCWA 2009). It has been noted that a high percentage of AMEP students complete the program without acquiring functional English (ibid:9). As a result, completion of the AMEP does not guarantee employment for immigrant and refugee women, as they may still lack the necessary English skills.

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). Unemployment among immigrant and refugee women lowers their self-esteem and socio-economic status thus contributing to poor mental and emotional health.

These outcomes, as Bertone (2000) notes, have been a result of major industry restructuring, triggered by globalization and government policy. Some authors (e.g. Williams and Batrouney cited in Bertone 2000) show how in the 1970s for instance, unemployment rates for Australian born and migrant workers were equally low, but in the 1990s, the overseas born, and particularly, NESB have higher unemployment rates. According to the same authors, recent migrants had unemployment rates of 20%, and some ethnic groups, such as Indochinese and Africans even higher. There is therefore increased structural poverty amongst people from NESB, particularly women.

3.2 Unemployment and long-term unemployment

The unemployment of people from NESB needs to be understood in its proper historical perspective. In Australia, economic restructuring and cyclical downturns had a disproportionately adverse effect on migrant workers in the 1990s. Migrants, especially those in the textile, clothing and footwear (TCF), public transport and manufacturing industries, bore the costs of enterprise bargaining and workplace change, such as loss of low skill jobs and resulting unemployment, hence NESB migrants continue to experience higher unemployment rates compared to Australian born people and ESB migrants. Immigrant and refugee women in particular, generally have a low level of participation in Australian-based education and training initiatives (Stephens and Bertone 1995), and many, especially those who have migrated to Australia in the post-war period and/or who are refugees, also arrive in Australia with few formally recognized qualifications.

Statistics that are more recent show a similar trend in employment participation across nationalities with different educational levels. Table 3.1 below, based on statistics from the 2006 Census, details the percentage of people with Bachelor degree or higher for selected communities. These statistics show higher unemployment rates from people of NESB in relation to Australian born, and this is regardless of educational qualifications. Women who arrive in Australia under skilled migration programs tend to have a high educational attainment on arrival in Australia (Department of Immigration and Citizenship (2008). Immigrants from India for example have the highest educational attainment, with 52.5% of the community holding a Bachelor degree or higher (compared with 14.7%

among the Australian-born).⁵ Unfortunately, in the case of immigrant and refugee women, high educational attainment tends not to lead to well-paid positions in a chosen field. Difficulties in having overseas qualifications recognized in Australia, often leads to even highly-qualified women finding it difficult to work in their chosen field, or finding a job at all (Department of Immigration and Citizenship 2007).

Table 3.1 Percentage of people with a Bachelor degree or higher

Country of Birth	Bachelor degree or higher	Unemployment rate	Workforce participation
India	52.5%	7.2%	72.3%
Malaysia	43.2%	5.7%	67.3%
Hong Kong	36.1%	6.6%	63.3%
Philippines	35.7%	5.2%	73.1%
Korea	33.7%	9.5%	51.8%
China	31.9%	11.2%	56.3%
Sri Lanka	31.8%	6.4%	70.9%
Viet Nam	15.8%	11.4%	61.9%
Lebanon	7.4%	12.1%	45.5%
Croatia	6.2%	5.6%	45.9%
Greece	4.7%	4.7%	33.6%
Italy	4.1%	3.2%	35%
Australia	14.7%	4.9%	67.1%

Source: Department for Immigration and Citizenship (DIC): 2008

All of the above groups, except the Greece and Italy-born, which have ageing populations, have an unemployment rate significantly higher than that of the Australian born (4.9%). Similarly, workforce participation rates are generally lower than those for the Australian-born (67.1%) with the exception of people from India, the Philippines and Malaysia. The figures for people not in the workforce include pensioners, women who

⁵ Please note that gendered figures are not available. However these whole-of-community figures, while not accurate for women's educational attainment, may be seen as indicative of women's educational attainment. We would surmise that women's educational attainment would be lower in each of the communities analyzed.

are caring for families, as well as people who have given up on finding employment - women make up the majority of people not in the workforce.

Watson (2000) investigated the reasons for this disparity between educational qualifications and employment and notes the following barriers amongst highly educated migrants:

- lack of local knowledge - i.e. the different kinds of “cultural capital” which migrants bring to the workplace – for instance migrants from former colonial countries who have been oriented towards more hierarchical workplaces are less preferred in the more egalitarian Australian workplaces.
- Highly qualified migrants face the paradox of taking any job offer in order to (i) avoid long-term unemployment (ii) hold out for a job at an appropriate skill level and facing an increased risk of protracted job searching. Each option has its own repercussions. Option (i) condemns immigrants to under employment, while the 2nd option means longer unemployment periods. In either case the highly educated immigrant loses touch with their area of expertise and lose credibility with prospective employers.

Immigrants and refugees who have spent long periods working in jobs that are below their level of skill and qualification commonly report a decline in confidence and sense of disillusionment. A commonly given example is that of the highly educated and skilled taxi drivers, whose qualifications are not recognized in Australia.

Kennedy and McDonald (2006), in studying the relationship between immigrant mental health and unemployment, found a relationship between adjustment strategies of migrants and skills recognition. They argue that more highly educated immigrants have more pronounced adjustment phases compared with less educated immigrants, and that this may relate to delays or difficulties in employer recognition of skills and training obtained overseas.

3.3 International students

International students face numerous challenges during the time of study and on completion, often compromising their employment opportunities and application for permanent residency for those who choose to stay in Australia upon completing their studies. During the time of study, most international students are on a type of visa that

allows them to work a maximum of twenty hours a week. 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). International students tend to work extra hours in order to break even. Most are involved in “shift work” on an “on call” basis - an employer calls them as and when a shift becomes available. Students tend to accept any offer for a shift, for failure to take a shift when “called” compromises one’s chances of being called again in future. Students also accept any shift offered, regardless of when it is offered, as they do not know when the next shift will become available. This has serious implications on their general well-being. The “on call” system means that students cannot effectively plan their academic work, neither are they able to concentrate, as they are constantly anticipating a call from the employer (Personal communication). Failure to acquire “shifts” is a cause for poor health amongst students, which in turn affects their general academic performance.

Failure to secure professional jobs during their time of study limits students’ opportunities for acquiring the skills required by employers upon completion. This, coupled with the requirements for permanent residency status when applying for many local jobs, effectively rule international students out of many local employment opportunities in Australia (ECCV 2008). Yet long periods of unemployment, and/or under employment, has negative consequences for international students with an Australian qualification intending to apply for skilled migration visas in Australia. One of the visa requirements for this category of migrants is that they should have at least one year working experience in Australia. Most students fail to qualify for this visa due to the disadvantages they face in the labor market.

Questions

What do the major players in the job market, i.e. employers, employees, immigration authorities and others, need to know about immigrant and refugee women? How best can they offer assistance? What form of assistance can be anticipated from prospective employers and immigration authorities? How can the different sectors work together to ensure the participation of immigrant and refugee women in this area?

What key education-related challenges should immigrant and refugee women know (i) before migrating (ii) upon settlement? In what form should this information be provided?

Are there any case studies to be drawn on to illustrate the challenges experienced in labor force participation?

4. HEALTH AND WELLBEING

4.1 Sexual and reproductive health

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.

Immigrant and refugee women's reproductive health varies among cultural groups. For instance, a report by Madden (1994) cited in Chang (2000) shows that a large proportion of women from Europe and USSR have had hysterectomies (14.2%), whereas those from Northern America (4.3%) and South East Asia (4.8%) have the lowest proportions. However, immigrant and refugee women's reproductive health experiences are generally poor compared to Australian-born and English speaking women. Some authors, e.g. Naksook (2000); Small (1999), note that some of the barriers experienced by immigrant and refugee women in accessing reproductive health services include:

- Gender of health professional: most women prefer to see health professionals who have the same gender as them because of the confidentiality of sexual and reproductive health issues.
- Cultural/linguistic backgrounds: women prefer to see doctors from the same cultural/linguistic backgrounds as this allows for better communication and longer consultation times

- Communication barriers: many of the women's problems are a result of communication barriers. 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
- Interpreter problems: 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. Relatives are used when there are shortages of professional interpreters and leaving them no option. Yet other women preferred relatives as interpreters because they would help them remember the discussions.
- The scarcity of health interpreters causes frustration in some women, who are left with no choice but to use family members. The problem has been partially solved by providing interpreters at health centres at a certain day of the week. Women have faced problems with this because of their commitments at home, and especially child-care and other commitments. 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.

Questions

What can be done to reduce the barriers faced by immigrant and refugee women in accessing sexual and reproductive health services? What are the gaps in existing systems? What needs to be changed? How can the different players be involved in bringing about change i.e. the affected women, women's formal and informal networks, health professionals?

What case studies can be referred to in designing strategies to address challenges faced?

4.2 Maternal Health

Barriers in maternal services provision

Studies that have been conducted at State level to explore women's views of maternity care include:- the Statewide Ministerial Review of Birthing Services (1988-90); Survey of Recent Mothers (1989), conducted in conjunction with the Ministerial Review; Survey of Recent Mothers (1993). Small et al (1999) note that, notwithstanding, the views of immigrant and refugee women have been underrepresented in all these studies, and even though women from CALD backgrounds were consulted, the numbers involved were too small.

Critical issues affecting immigrant and refugee women emerge from Small et al's Mother's in New Country (MINC) study. Low English proficiency was seen to impact negatively on women's attitude towards certain aspects of maternity care. Lower English usage has been seen to be a significant predictor of depression. Language barrier impedes access to and utilization of health facilities. Access to interpreters remains a major challenge for women – a member of the POD EAC noted that women still deliver babies in the labor wards without interpreters. As a result, hospitalization becomes an alienating experiencing for women, who always express fears of being “laughed at” when using a new language (English). In some cases, women do not understand the procedures being carried out on them (Nahas et al 1999), and some feel intimidated to ask. This probably explains the raised rates of Caesarean births for NESB women, as noted by Small et al in the MINC study. A similar observation was made by participants at a recent symposium “Giving Birth in Victoria” that was held in Melbourne in October, 2008, showing that while previous studies may have identified certain issues of concern for immigrant and refugee women, little has been done in practice to address these concerns, hence their recurrence at different fora.

Childbearing practices and support

Most studies around immigrant women's experiences with childbirth in a foreign country have shown that there is a range of traditional practices that are at odds with Western style maternity care (Small et al 1999;2003; Nahas et al 1999; Choundhry 1997; Liamputtong 2002;2000). For instance, Nahas et al (1999) show that amongst the Lebanese, breastfeeding practices often conflict with the childrearing advices from nurses and midwives.

Most women see childrearing as the role of the family, not the State. As a result, women in ante-natal clinics experienced a deep sense of isolation and lack of social support, and that isolation was intensified when problems occurred with the baby, and they longed for social relations during the post-partum period. Lack of social support is also seen to determine the choice of certain practices, such as breastfeeding. In a study on Vietnamese immigrant women's experiences with breastfeeding Rossiter (1997) noted that women in her study lived in a nuclear family structure and did not have the same support from the extended family as they had in Vietnam. After birth, these women not only lacked time to observe traditional postnatal ritual, but also faced the challenge of caring for the baby on their own. In a separate study, Manderson and Matthews (1981), found the same challenges amongst Vietnamese women, and note that in order to not to further jeopardize their own health, many resorted to bottle-feeding.

Some societal expectations amongst some cultures, e.g. some Arabic cultures, compromise the health status of women, especially soon after delivery. For instance, a woman is expected to continue performing her gendered role of taking care of her husband and children, and that she should not complain about her hardships and inability to cope with the baby. If she does then she is labeled a "bad wife" (Nahas et al 1999). It is therefore imperative to identify areas where conventional or western knowledge systems conflicts with traditional beliefs of immigrant and refugee populations.

Religious beliefs in maternal health

Immigrant and refugee women may hold specific health and religious beliefs that are discordant with conventional medicine or might combine traditional beliefs and modern medical knowledge, which in turn has implications for access to and utilization of professional health care. Manderson and Allotey (2003), in writing about the role of storytelling and gossip among immigrant women and how these fuel women's suspicions of the host country's medical services, cite a case of "Amina", who became apprehensive at the thought of having a Caesarean section, because she did not want to be given Heparin, which was found to be made from the gut of pigs. In Muslim communities, pig is considered unclean, and Amina's fears would have been based on the "pollution" that comes with getting a "pork injection".

Some authors (e.g. Nahas et al 1999), have noted the need for midwives to consider certain traditions, ethnic practices and religious beliefs when caring for specific groups. For instance, childbearing women from the Islamic culture may the need to fast during Ramadan, to cover their hair in the presence of a man, to pray five times a day, and to wash before prayer. Appropriate support needs to be extended to these women when needed. Some of these women, because of high parity (Nahas et al 1999) find it difficult to wait long hours before being seen in the antenatal clinic when they have children to care for at home. Nahas et al (1999) suggest that health care providers could consider home visits to these women in order to get around concerns such as availability of childcare facilities. It is also emerging that women, especially from Africa communities, are not well informed on legislation around child safety. This is an area that needs to be addressed.

Post-partum depression

Women's sexual rights concern not only women's health, but also their dignity and freedom. In a study conducted among women from Arabic cultures, the major causes for postpartum depression (PPD) were pre-migrations factors such as marital problems, life events, previous psychiatric problems, occupational status, and lack of social support (Nahas et al 1999). Women from the same study also expressed a lack of knowledge of PPD. This, coupled with the stigma around mental illness in some cultures, can interfere with women's access to health services, and needs to be treated with caution.

However, PPD is increasingly caused by migration and the reasons for migrating, and these cause added pressures on women (Nahas et al 1999). It is therefore important to understand the migration of immigrant and refugee women, their environment since migration, their cultural, religious, and family values. The POD toolkit should include culturally sensitive information on specific issues such as PPD. In fact women in this study requested information in the form of childbirth classes and Arabic "how-to" books that are compatible with Middle Eastern customs. The MCWH is well placed to provide the latter from its resource library, while liaising with other migrant resource centres.

Questions

How should health professionals deal with the conflict between traditional practices and modern practices? What form of support should women be afforded? How feasible and sustainable are home visits?

How should health professionals respond to women's religious beliefs?

What needs to be done differently, and how?

What case studies can be used to illustrate the challenges listed above?

4.3 Social capital and mental health

Social capital has been defined as various factors that contribute to well-being. The focus is usually on how people use and gain from voluntary associations, interactions with others in their neighborhoods, and the contacts that friends and relations provide (McMichael and Manderson 2004). Good mental health derives directly from positive relationships that enhance self-acceptance, personal growth, trust, safety, and reciprocity. Poor social networks are associated with poor health. Immigrant and refugee women who do not have either immediate or extended family or community support often experience isolation, and this is a major cause for depression, as I discuss below.

Loss of social capital as a cause for depression

Depression is one of the most serious health problems experienced by immigrants (Miller et al 2004). Because migration is a movement between places, it is often treated as a movement between social relationships (McMichael and Manderson 2004). In their countries of origin, women frequently visited each other. This interaction is vital as a source of support, as it allows community members to mingle and to "check on each other". Members who are in need of support are noticed quickly during these informal visits and relevant assistance rendered. This, most women say, is missing in a new country, because people are too busy with resettlement issues to think of the next person. Women often place their sadness, loneliness and depression within a framework of lost social ideals and relations.

Pre-migration factors such as health care inadequacies, social disruptions and political instability continue to affect physical and mental health for immigrant and refugee women. For example, Miller et al (2004) found that immigrants from the Former Soviet

Union (FSU) were reluctant to leave their homes when they came to Australia, but had to come for the sake of the children – so that the children may have a better life and a future. The fear of being left behind alone in the homeland also drove some women to travel with their families.

Apart from the fragile social ties, networks are often eroded at the family level. 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. The sadness and loneliness that often follow from this, and the subsequent loss of family interaction, are major contributors for immigrant and refugee women's mental health.

Questions

***How can immigrant and refugee women be assisted in creating social capital?
Are there any case studies to be used in understanding the effects of loss of social capital on health and well-being, and strategies to address challenges faced?***

4.4 Occupational Health and Safety

Occupational Health and Safety (OHS) statutory legislation within Australia comprises of 10 OHS statutes made up of 6 State Acts, 2 Territory Acts, a Commonwealth Act covering Commonwealth employees, and a Commonwealth Act covering the maritime, Each of the OHS statutes impose duties of care upon persons to ensure health and safety at the workplace (www.workplacehealthandsafety.com.au/servlet).

The types of jobs and industries in which immigrant and refugee women are employed in are responsible for their occupational morbidity and mortality. Immigrant and refugee women are over-represented in occupations and industries characterized by extremely high rates of occupational injuries and diseases (Strong 2001). These occupations include cleaners, trades assistants and factory hands, machine operators, sales assistants and agricultural laborers and related work. Women working in market gardens within the Sydney Basin (Strong 2001), for instance, were seen to undertake labor intensive jobs such as hand chipping and packing, while 30% of spraying was done by women, often with limited training on safe use of pesticides.

The work of Alcorso and Schofield (1991) (cited in Strong 2001) showed that proportion of disabilities resulting from accidents at work varied amongst the different groups of employees as follows:

Table 4.1 Proportion of disabilities by cultural group

Group	Proportion of disabilities %
CALD	29.7
Australian-born	10.0
English-speaking background	24.9

Adapted from Alcorso and Schofield (1991) (in Strong 2001).

Immigrant and refugee women therefore have a history of higher rates of injury at work. Some of the reasons for susceptibility to work-related injury and illness include, as already noted above, the concentration of immigrant and refugee women in dangerous occupations and industries, and also lack of English proficiency, lack of training and workplace orientation as new workers, and difficulty in obtaining information on potentially dangerous drugs (Strong 2001).

The textile, clothing and footwear (TCF) industry is a major employer of people from non-English speaking background in Australia. It is reported that 30% of TCF workers are based in the textile, 62% in the clothing, and 8% in the footwear industry. Among these, 65% are women, and 75% are NESB immigrants with low English proficiency. TCF workers have the second highest incidence of work-related injuries/disease in the manufacturing sector (Stephens and Bertone 1995). Due to significant changes in the industry from the mid-1980s, many TCF industries have changed from factory-based production to outwork, with outwork now central to TCF production, in particular, to clothing manufacturing.

The average injury/disease ratio in the textile industry is higher than the average ratio in all Australian industries. Types of injuries suffered include fractures, sprains and strains of joints and adjacent muscles, dislocations, intracranial injury, internal injury of chest, and amputations. These injuries are mainly caused by manual handling. Women also

cite dust and fluff as hazards, although Occupational Overuse Syndrome related Musculoskeletal Disorders (OOS-related MSD) was found to be the major cause of injury/disease (ref). As MSD is mainly attributed to repetitive job tasks and sustained work postures, financial pressure from the piecework payment system and time pressure can be the main source for outworkers' work-related injuries.

Questions

Does OHS handling training address language and cultural barriers? In what form is training conducted? What are the underlying causes for injuries in the workplace? At what frequency do injuries occur? Are incidence protocols in place and being used?

What case studies can be used in designing materials to address OHS challenges faced by immigrant and refugee women?

Workplace violence

A study conducted by the MCWH in conjunction with URCOT, an independent, not for profit, applied research centre affiliated with RMIT University, revealed that violence against women is a significant problem in most workplaces (URCOT 2005). A strength of the research is its focus on specific groups of women, i.e. immigrant, lesbian and indigenous women, rather than a general outlook on women's experience. According to the UN (2006), a serious obstacle to progressing the elimination of violence against women has been the inadequate and uneven data on various forms of violence against women and how they affect different groups of women. URCOT investigated different forms of violence and how they impact on different groups of women, hence addressing this gap. Consistent with other studies on barriers experienced by immigrant women, this research found that women experienced language barriers that impeded their access to vital services and information. However, the study does not make recommendations that are tailored to the specific challenges faced by immigrant women in the workplace. This gap in knowledge needs to be addressed.

4.5 Violence against women

Domestic violence

Section 11(1) of the Domestic Violence (Family Protection) Act 1989 (amended 1993), defines domestic violence as any of the following:

- a) Willful injury
- b) Willful damage to the spouses property
- c) Intimidation or harassment of the spouse
- d) Indecent behavior to the spouse without consent
- e) A threat to commit an act mentioned in items a to d

The above definition recognizes that in a broader sense, violence can take the form of physical assault, sexual abuse, verbal abuse, psychological or emotional abuse, economic abuse, social abuse, and spiritual abuse. Violence against women occurs across all cultures. Like the rest of Australian women, immigrant and refugee women are victims of different forms of violence. Understanding that violence against women pervades all cultures can allow women to speak openly about their experiences without fear of stigmatization (Braaf and Gangully 2002). However, the experiences of immigrant and refugee women are unique, as I discuss below.

A study by Cultural Perspectives (2000) outlines some of the possible causes of domestic violence among people from culturally and linguistically diverse backgrounds. These include financial pressure and insecurity; unemployment, which results in low self-esteem, depression, and boredom; misunderstandings between parents and children; alcohol and gambling; and differences in gender roles in Australia and the country of origin. For most immigrants and refugees from Africa and indeed some Asian countries, violence emanates from the cultural expectation that a virtuous woman or a good wife is one who is submissive (e.g. Njovana and Watts 1996), and violent behaviors such as wife-beating can be condoned if a wife fails to submit. These perceptions around wife-beating have been found to be largely influenced by a patriarchal ideology, as revealed in some studies: among Turkish students (Sakall 2001), and Palestinian women (Haj-Yahia 1998). Violence against women is therefore rooted in gender and power imbalances and structural inequalities embedded in society. Immigrant and refugee women often cite certain community values, especially religious and cultural values, which are seen to oppose the presence of domestic violence in the community. 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. The introduction of the '204 Women at Risk' visa category (mentioned earlier), is an acknowledgement of the vulnerability of refugee women and the challenges they face in settling in a new country.

Among immigrant and refugee women, it is not unusual for certain behaviors prevalent in the countries of origin to carry over as part of the migration process and continue in Australia. Among women from African cultures particularly, the incidence of rape and other sexual abuses continue to be perpetrated, regardless of their new environment. Most of these cases go unreported due to a number of reasons. For instance, women are too frightened to report the perpetrators of this violence, for fear of escalating violence. Community members are also known for covering up for each other, so as to keep face. Other barriers to disclosure, as noted by Cultural Perspectives (2000) include fear of reprisal by the perpetrator, desire to keep the family together, hoping that it will go away, and family trapped because of responsibilities for children. Some women may not be aware of the Australian laws on such offenses, while others may not know the recourse to take. Yet others may not necessarily regard it as a punishable offense, and so choose not to talk about it. Therefore, as Braaf and Gangully (2002) note, women from diverse cultural groups continue to suffer violence with little or no criminal justice intervention, health and counseling support, or social and community supports.

At a teleconference for the Points of Departure project held in October 2008, Dianna Orlando, Director of the Immigrant Women Domestic Violence Service (IWDVS), suggested a documentation of case examples of domestic violence among immigrant and refugee women. This move, or strengthening it, would ensure that there is a solid knowledge base and strong evidence for domestic violence among immigrant and refugee women. Prince (1996) notes a lack of community awareness of current domestic violence policies and legislation amongst NESB communities – another obstacle in dealing with domestic violence. Although there are several domestic violence services across Australia, many NESB women do not readily access either mainstream or ethno-specific services. Reasons for failure to access mainstream services include lack of knowledge of services, language barriers and the cultural appropriateness of services, while ethno-specific services are not preferred for confidentiality reasons:

women may have concerns over the use of interpreters who are known to them in the community (Prince 1996; Allimant and Anne 2008).

Questions

How can barriers experienced by immigrant and refugee women in accessing domestic violence services be removed?

What needs to be done to break stigma and a culture of silence around domestic violence?

How can information of domestic violence be collected and collated? How can immigrant and refugee women who are escaping domestic violence assist with this?

How can collaboration between government and service providers working with women escaping domestic violence be strengthened?

What case studies can be used to demonstrate the extent of domestic violence among immigrant and refugee women, and to assist in designing culturally appropriate strategies to address the problem?

Violence against young women

Discussions on issues affecting immigrant and refugee women often focus on middle-aged and older women, probably because of the challenges experienced by this demographic group with childbearing, parenting, literacy levels, and domestic violence: issues that are experienced mostly (but not only) in marital relationships. Focusing on these issues carries the risk of overlooking specific challenges for younger women, who, by reason of age, may not have these experiences.

Immigrant Women Support Service has worked extensively with young women, and has observed that, young women of non-English speaking background face challenges related to their cultural background and immigration experience (e.g. Gatbonton 1992; Hughes and Gatbonton 1994). The social stigma around different forms of abuse; little knowledge of reporting systems; fear of repercussions from reporting, such as blame, shame and rejection; and sometimes language barriers or inability to clearly articulate their problems, all make abuse of young women a big challenge requiring concerted efforts from service providers and other stakeholders to ameliorate the problem.

5. IMMIGRATION DETENTION

5.1 Immigration detention centres: a policy perspective

There have been significant social, political and economic changes since the launch of the National NESB Women's Health Strategy, and these have and continue to impact on the health and well being of immigrant and refugee women. The mandatory detention legislation passed in 1992 for example, is one of the major changes affecting immigrant and refugee women that has taken place since then (cf Murdolo 2002), and has received a lot of attention in recent years over the treatment of immigrant and refugee groups in immigration detention centres (IDCs). Activism on the matter, as Murdolo (2002) notes, has been marked by polarized views, with some activists against mandatory detention and others in support of it. Those against it are in different camps:- some are for the abolition of detention centres, and others have called for the improvement of conditions within it (ibid:123). Murdolo further argues that, while there are feminist groups amongst these advocates, there seem to be no clearly articulated feminist perspectives that are widely debated in public forums about this issue. The absence of a feminist perspective in immigration detention has the risk of overshadowing the many challenges faced by immigrant and refugee women in these facilities. An example of these challenges is the role played by detention centres and temporary protection visas on the rising incidence of poor mental health for Australian Asylum seekers (e.g. McLoughlin and Warrin 2007; Davidson et al 2008).

Detention Centres and Human Rights

Kathleen Maltzahn (2008), in *Trafficked*, writes about violence against women in the sex industry. She details the experiences of especially Filipino women who are trafficked to Australia for prostitution, the violence they suffer at the hands of traffickers, the ill-treatment they have received in detention centres, and the apparent lack of political will to acknowledge the problem of trafficking, which in turn impedes any efforts in ending the crime. Through the activism of Maltzahn and others on this issue, federal government now acknowledges the problem of trafficking. Efforts of activists also resulted in some significant shift in public policy to the benefit of trafficked women. The federal government's Action Plan unveiled at a Conference on Trafficking in 2003 had significant changes, as follows:

- rolling back of the mandatory detention scheme to allow women suspected of being trafficked to be released and live in the community on bridging visas
- introduction of a victim support scheme
- ratification of the United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children,
- and development of a community awareness campaign to raise awareness among Australians.

The pressing issue of a visa arrangement that would allow trafficked women to make reports to police, followed by prosecutions (if women wanted to), and granting of residency permits with work and education rights, was not addressed (Maltzahn 2008). However, it is important to acknowledge the efforts and political will of government in addressing challenges faced by immigrant and refugee women, while lobbying efforts on other pertinent issues continues.

Detention as a cause for poor mental health

The process of reviewing and determining immigration status in Australia can take anything between 2 – 7 years, and during this time asylum seekers and their families are held in detention. Detention centres are located in isolated areas of Australia – in semi-arid and desert regions, and on small Pacific Islands, such as Christmas Island (McLoughlin and Warrin 2008). The asylum seeker policies of Australia remains unparalleled compared to those of other industrialized countries. Evidence points to this approach as being directly responsible for the increasing incidence of mental illness and self-harm among asylum seekers, most particularly contributing to post-traumatic stress disorders, depression and associated disability. At a conference held in Sydney in October 2008, advocates and academics met to deliver a report card on the Rudd Government's performance.⁶ In commenting on immigration policies, many human rights activists noted some of the shortcomings of the Howard government in dealing with immigration issues, and hoped that Kevin Rudd's election marked an end to a Government that pursued a harsh immigration policy and had very little tolerance for multicultural issues.

⁶ www.abc.net.au/news/stories/2008/10/03/1492.htm

Current literature that examines the incidence and experience of mental health in IDCs takes a biomedical approach to studying health and illness. This approach does not adequately address the issue of space/setting and its impact on mental health. The effect of immigration detention centres is therefore seen as eroding personal and social resources for coping, and exacerbating vulnerabilities and post-traumatic stress (McLoughlin and Warrin 2008; Davidson et al 2008). Health cannot be separated from place/space. Where you live and how you live is an important predictor of mental health.

5.2 Immigration detention centres: recent developments

As noted above, immigration detention has received a lot of attention in recent times, and there have been breakthroughs in reviewing Australia's immigration detention. The Parliament of the Commonwealth of Australia published a report of an inquiry into immigration detention in Australia conducted by the Joint Standing Committee on Migration in December 2008 (The Parliament of the Commonwealth of Australia 2008). The inquiry, which was prompted by the injustices of immigration detention, involved inspecting detention centres, examining the criteria for release from detention, considering community alternatives to detention, and how international experience can be tapped into. During the course of the inquiry, the Australian Government announced some changes to the immigration policy, and only specific groups of people would be subject to mandatory detention namely:

- unauthorized arrivals for the purpose of health, identity and security checks
- those who pose an unacceptable risk to the community
- those who have been repeatedly non-compliant with visa conditions or immigration processes

Outside these criteria, people awaiting the outcomes of their immigration status are allowed to live in the community (ibid:viii).

Further to this, the Australian Human Rights Commission, following visits to immigration detention facilities between June and September 2008 (Australian Human Rights Commission 2008), made several recommendations for the improvement of conditions in immigration detention centres. Specific areas around which recommendations include monitoring of standards in immigration detention, length and uncertainty of detention, attending to health care needs of immigrants, and children in immigration. If

recommendations made by the Commission could be translated into policy, this will see a significant change in the health and general well-being of immigrant and refugee women, who, as noted in different places in this paper, suffer stress and trauma due to the harsh conditions in detention, and to the uncertainty of the outcome their immigration status. There is need to keep track of future developments regarding new legislature on detention.

Questions

What are the specific needs of immigrant and refugee women in detention?

Given the cultural diversity of detainees, how do gender roles play out in relation to use of space and resources such as cooking areas, recreation facilities, and access to reading materials?

What part can NGOs and service providers play in influencing a shift in detention policies?

What are the case studies to be drawn on in making a case for a review of detention policies?

6. WOMEN'S RIGHTS AND REPRESENTATION

6.1 The Bill of Rights

As I was writing this discussion paper, I followed with much interest the debate on the proposed Bill of Rights for Australia. I was astounded to learn that Australia is the only democracy in the West without a constitutional Bill of Rights, and that regardless of this Victoria and the Australian Capital Territory were the only two States that have Bill of Rights. In a news report on an Australian TV channel (SBS) on 2 January 2009, the implications of a Bill of Rights on immigrant and refugee populations were explained. The absence of a Bill has implications on the way cases are handled, for instance, it has been impossible for Judges to intervene in cases fast enough; its enforcement would ensure that asylum-seekers are not kept in detention for lengthy periods; and having a Bill in place would also raise some controversial questions. An example given was that of the recent Abortion Bill: if a Bill of Rights was in operation, should such an issue (as the Abortions Bill) be determined by the Judge or by Politicians – or in the case of the proposed closure of Guantanamo Bay, if prisoners are released, would they be accepted

in Australia as detainees or immigrants. The Bill of Rights, its proposition and all the debate around it, has profound and far-reaching implications on the human rights of immigrant and refugee women, and therefore there is need to raise their awareness on these issues and how they impact on them, and more so, devising ways of engaging them in such policy debates, as I elaborate below.

Questions

How can immigrant and refugee women be assisted to participate in the Bill of Rights debate, and other national debates?

What examples of previously successful strategies to engage immigrant and refugee women can be drawn on?

6.2 The Citizenship test

At the time of developing this discussion paper, the citizenship test introduced by the Howard government in 2007 was still in force. When the test was first introduced, there was great concern over the implications of this on people from non-English speaking background (NESB), whose main challenge has not only been the difficulty in comprehending questions, but language barrier as well. For immigrant and refugee women, failure to acquire citizenship interferes with all social inclusion efforts.

The Government has made some positive strides in addressing the concerns around the citizenship test. For instance, a committee that was set up to review the test, (the Australian Citizenship Test Review Committee), has found the current test can be improved (Commonwealth of Australia 2008). To this end, a new Citizenship Test process will be ready by August 2009. Further to this, the standard of English will be lowered for disadvantaged applicants such as refugees, and other women from non-English speaking backgrounds, who will be made to sit a special course. Following the work of the review committee, funding has been made available for citizenship education. The need to inform immigrant and refugee women about this service, and to encourage them to access these services, remains a task for all relevant stakeholders.

While there have been these positive developments on this subject, it should be noted that from a historical perspective, the introduction of the test has had negative

psychological effects on immigrant and refugee women. The likelihood of deportation and uncertainty of their future in Australia as a result of failing the test instilled fear in most women, contributing to poor mental health outcomes. It also likely that women who previously failed may face problems rewriting the test, for fear of repeated failure. Appropriate counseling and advice should be given to those affected.

6.3 Representation

Although this may not be perceived as a problem area by immigrant and refugee women, there is need to review current policy on women's health, and the extent to which immigrant and refugee women are represented in policy debates on issues affecting their health. For instance the National Women's Health Policy, built on the National NESB Women's Health strategy, has been applauded for adopting a social model of health, where women were consulted on their prioritized health needs and considers the gendered nature of women's everyday lives and the disadvantages women can accrue. The policy was also concerned with increasing women's participation in organization and management of health services and research (Commonwealth Department of Community Services and Health 1989). Nonetheless, the same report notes that women's voices continue to be suppressed in critical consultations, a view shared by other authors. For instance, Small (1999), in commenting on the consultation processes on women's views of maternity care in Victoria, notes that women of non-English speaking background were consistently under-represented.

In some communities, women's roles are seen to be devalued and they (the women) are given little support by community members (Commonwealth Office of the Status for Women 2001). In many cases, culture determines how women are treated. Male dominance is pronounced in certain cultures, and this restricts women's movements to positions of leadership within their communities and other social circles. In regards to access to information, among immigrant and refugee communities, men tend to have better access to information. This is facilitated by different factors. For instance, higher employment levels among men means that they can access information more easily in their workplaces, which women cannot. Attendance at leisure facilities is higher for men than it is for women, yet these are the places where information is shared. Men who fear

that their wives or partners will do better than them may hide this information. Withholding of information may also occur in abusive relationships, as a strategy to keep the woman under the man's control.

The preceding shows that women are silenced on many levels, and there is a need to ensure that this culture of silence is broken. The Association of non-English Speaking Background Women of Australia (ANESBWA), the peak national organization for women of NESB committed to ensuring that the voices of immigrant and refugee women are heard, was de-funded in 1998 after eleven years of existence. This development certainly resulted in a gap in understanding the needs of immigrant and refugee women. The complexity of the needs and challenges faced by immigrant and refugee women makes mainstreaming unrealistic. In addition, immigrant and refugee women should be empowered with the mandate to set the social inclusion agenda, based on their lived experiences and deeper insight into issues at stake. The need for a national body with a similar mandate as ANESBWA, one that is driven by immigrant and refugee women themselves, is imperative if any meaningful and sustainable strategies in addressing the challenges faced by immigrant and refugee women are to be designed.

Questions

What are the most effective ways of ensuring self-determination and self representation of immigrant and refugee women?

How can service providers, through their work, build the capacities of immigrant and refugee women in making their voice heard in policy debates?

In what ways can men be involved to ensure cultural forces do not impede the representation of women?

What case studies on self representation and self determination can be drawn on?

7. CONCLUSION

In this Discussion Paper I have attempted to map out some key issues affecting immigrant and refugee women, based on available literature, and evidence provided by service providers in their work. While there is a dearth of national level data on these issues, the amount of literature available from scholarly journals and reports from organizations working with CALD/NESB/immigrant and refugee women provide sufficient evidence on the challenges faced by this group. The amount of media coverage also testifies to the efforts of lobby groups to bring these issues the fore, and media is a major force that advocates can continue to rely on. The list of issues discussed in this paper is by no means exhaustive: however, it would appear that issues raised here are the most pertinent. Indeed, some of the issues raised are not new, which 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? and what can be done differently? The diversity of the population of interest (i.e. immigrant and refugee women), and the complex challenges they face require combined efforts from all stakeholders, who, as part of the process of mapping out these issues, are invited to comment on this paper and to provide deeper insights from their experiences with the daily realities of immigrant and refugee women.

Appendix 1: Details of Expert Advisory Committee

Name	Organization	State	Tel
Adele Murdolo	Multicultural Centre for Women's Health adele@mcwh.com.au	VIC	(03) 9418 0923
Juliana Nkruma	African Women's Advocacy Unit ampofowaa2000@yahoo.com.au	NSW	(02) 8835 7934
Luara Ferraccioli	National Immigrant and Refugee Women's Association nirwa@ycwa.org.au	NSW	(02) 6262 5091
Helen Sara	Federation of Ethnic Communities Council Australia hsara@stjosephs.woll.catholic.edu.au	NSW	(02) 4271 1983
Jane Corpuz-Brock	Immigrant Women's Speakout executive_officer@speakout.org.au	NSW	(02) 9635 8022
Zeliha Iscel	National Ethic Disability Allowance zel@neda.org.au	WA	(08) 9356 6470
Beata Ostpiej-Piatkowski/ Stephanie Anne	Immigrant Women Support Service beata@iwss.org.au Stephanie@iwss.org.au	QLD	(07) 3846 3490
Diana Orlando	Immigrant Women Domestic Violence Service iweof@infoxchange.net.au	VIC	(03) 9418 0923
Nuzhati Lotia	Islamic Women's Welfare Council of Victoria silc@islamicwomenswelfare.org.au	VIC	(03) 9481 3000
Mary Dankert	Centre for Multicultural Youth mdanckert@cmy.net.au	VIC	(03) 9418 0923
Veronica Wensing	Canberra Rape Crisis Centre eo@rapecrisis.org.au	ACT	(02) 6247 8071
Manja Visschedijk	Multicultural Women's Advocacy Inc. manja.visschedijk@ywca-canberra.org.au	ACT	(02) 6239 6878
Frederica Gaskell	Multicultural Council of the NT families@mcnt.org.au	NT	(08) 8945 9122
Deborah Van Velzen	Tasmania Dept of Health and Human Service Deborah.vanvelzen@dhhs.tas.ov.au	TAS	(03) 6222 7656
Shobhana Chakrabati	'Ishar' Multicultural Women's Health Centre shochakra@yahoo.com	SA	(08) 9479 6202
Kaleeda Rasheed	Migrant Women's Lobby Group shay_kelly@bigpond.com	SA	
Maria Johns	Multicultural Age Care Inc mariaj@mac.org.au	SA	(08) 8241 9900
Jan Williams	Migrant Health Service Jan.Williams@health.sa.gov.au	SA	(08) 8237 3912

REFERENCES

- ABC News
2008 Govt's Human Rights Record Under Spotlight.
www.abc.net.au/news/stories/2008/10/03/2381492.htm. Accessed
November 24, 2008
- Australian Bureau of Statistics
2008 *Australian Social Trends, 2008*.
www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Chapter42022008.
Accessed 20 January 2009.
- Alcorso, C. and Schofield, T.
1991 *The National Non-English Speaking Background Women's Health Strategy*.
Canberra: Australian Government Publishing Service for the Office of the Status
of Women, Department of the Prime Minister and Cabinet.
- Allimant, A. and Anne, S.
2008 *"No Room...Homelessness and the Experiences of Women of NON-
English Speaking Backgrounds"*. 5th National Homelessness Conference in
Adelaide, Australia.
- Australian Bureau of Statistics
2008 *Australian Social Trends, 2008*.
www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Chapter42022008.
Accessed 20 January 2009.
- Australian Government Productivity Commission
2009 *Report on Government Services 2009*.
- Australian Institute of Health and Welfare
2002 "Australian Health Inequities." Bulletin, Issue 2
- Australian Human Rights Commission
2008 *Immigration Detention Report: Summary of observations following visits to
Australia's immigration detention facilities*.
- Braaf, R. and G. Gangully
2002 *Cultural Challenges for Violence Prevention: Working Towards an Ethical
Practice of Sustainable Interventions*. Sydney: University of Sydney.
- Bertone, S. and B. Leuner
2007 *Immigrant Women in the Service Industries: Towards a new strategic plan
for MCWH and beyond*. Melbourne: Multicultural Centre for Women's Health.
- Chang, S.
2000 *Seamstress: A Report on the Health Issues of Women Workers in the
Textile Clothing and Footwear Industries*. Melbourne: Working Women's Health

- Choudry, U. K.
1997 "Traditional Practices of Women from India: Pregnancy, Childbirth, and Newborn Care." Journal of Obstetric, Gynecologic and Neonatal Nursing **26**(5): 533-539.
- Commonwealth of Australia
2008 *Moving Forward... Improving Pathways to Citizenship: A report by the Australian Citizenship Test Review Committee*. Barton: Commonwealth of Australia.
- Commonwealth Department of Community Services and Health
1998 *National Women's Health Policy Advancing Women's Health in Australia. Summary of the report presented to Australian Health Ministers in Burnie, 21 March 1989*. Canberra: Australian Government Publishing Service.
- Commonwealth Office of the Status of Women
2001 *State and Territory Consultations with Migrant and Refugee Women. Australian Women Speak*. Barton: Commonwealth of Australia.
- Cultural Perspectives
2000 *Attitudes to Domestic and Family Violence in the Diverse Australian Community*. Sydney: Commonwealth Office for the Status of Women.
- Davidson, G., K. Murray, et al.
2008 "Review of Mental Health and Wellbeing: Australian Perspectives." Australian Psychologist **43**(3): 160-174.
- Department of Immigration and Citizenship
2008 *The People of Australia: Statistics from the 2006 Census*. Commonwealth of Australia, 2006.
- Department of Immigration and Citizenship
2007 *New Migrant Outcomes: Results from the third longitudinal survey of immigrants to Australia*. Commonwealth of Australia, August 2007.
- Dolman, J., G. Shackleton, et al.
1996 "A Survey of Health Agencies' Responses to non-English-speaking Women's Health Needs in South Australia." Aust N Z J Public Health **20**(2): 155-60.
- Dunn, K., N. Klocker et al.
2007 "Contemporary Racism and Islamophobia in Australia: Racializing Religion". Ethnicities **7**(4): 564-589
- Ethnic Communities' Council of Victoria (ECCV)
2008 *Availability, Affordability, Accessibility: Housing Victoria's New Migrant and Refugee Communities*. Statewide Resource Centre, Victoria. ECCV Policy Discussion Paper No 4. 2008.

ECCV

2009 *Restricted Access: Humanitarian Migrant Women and Employment in Victoria*. Statewide Resource Centre, Victoria. ECCV Policy Discussion Paper 2009.

ECCV

2008 *Real Jobs: Employment for Migrants and Refugees in Australia*. Statewide Resource Centre, Victoria. ECCV Policy Discussion Paper No 3. 2008.

Gatbonton, T.

1992 *"I Sometimes Want to Move Out..." Abuse of Young Women of Non-English Speaking Background*. Brisbane: Migrant Women's Emergency Support Service..

Haj-Yahia, M.M.

1998 "Beliefs about Wife Beating among Palestinian Women." Violence Against Women **4**(5): 533-558

Hughes, D. and T. Gatbonton

1994 *Working with Diversity: A Study of Access to Services by Young People of non-English Speaking Backgrounds*. Brisbane: Immigrant Women's Support Services..

Human Rights and Equal Opportunity Commission

2004 "Isma - Listen: National Consultations on Eliminating Prejudice Against Arab and Muslim Australians." Sydney: Human Rights and Equal Opportunity Commission.

Inglis, C

2003 Mothers, Wives, and Workers: Australia's Migrant women. Migration Information Source. [URL:www.migrationinformation.org/Feature](http://www.migrationinformation.org/Feature)

Islamic Women's Welfare Council of Victoria Inc.

2008 "Race, Faith and Gender: Converging Discriminations Against Muslim Women in Victoria. The Ongoing Impact of September 11, 2001." A summary report on racism against Muslim women. Melbourne: Islamic Women's Welfare Council of Victoria Inc.

Kennedy, S. and J. T. McDonald

2006 "Immigrant Mental Health and Unemployment." The Economic Record **82**(259): 379 - 504.

Liamputtong, P.

2000 "Motherhood and the Challenge of Immigrant Mothers: A Personal Reflection." Families in Society **82**(2): 195-201.

Liamputtong, P. and C. Naksook

2003 "Life as a Mother in a New Land: The Experience of Motherhood among Thai women in Australia." Health Care for Women International **24**: 650-668.

- Liamputtong, P. and C. Naksook
2003 "Perceptions and Experiences of Motherhood, Health and the Husband's Role among Thai Women in Australia." Midwifery **19**(1): 27-36.
- Maltzahn, K.
2008 Trafficked. Sydney: University of New South Wales Press Ltd.
- Manderson, L. and P. Allotey
2003 "Storytelling, Marginality, and Community in Australia: How Immigrants Position Their Difference in Health Care Settings." Medical Anthropology Quarterly **22**(1): 1-21.
- Manderson, L. and S. Rapala
2005 "Making Sense of Disruptions: Strategies of Re-grounding of Ailing Polish Immigrants in Melbourne, Australia." Human Organization **64**(4): 350 - 359.
- Manderson, L. and M. Matthews
1981 Vietnamese Attitudes Towards Maternal and Infant Health. The Medical Journal of Australia **1**(2): 69-72.
- Markovic, M. and L. Manderson
2000 "Nowhere is as at Home: Adjustment Strategies of Recent Immigrant Women from the Former Yugoslav Republics in southeast Queensland." Journal of Sociology **36**(3): 315-328.
- McLoughlin, P. and M. Warin
2008 "Corrosive Places, Inhuman Spaces: Mental Health in Australian Immigration Detention." Health and Place **14**: 254-264.
- 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.
- Meyer, M. C., S. Torres, et al.
2003 "Immigrant Women Implementing Participatory Research in Health Promotion." Western Journal of Nursing Research **25**(7): 815-834.
- Miller, A. M., O. Sorokin, et al.
2004 "Demographic Characteristics, Menopausal Status, and Depression in Midlife Immigrant Women." Women's Health Issues **14**(6): 227 - 234.
- Multicultural Children's and Young People's Domestic and Sexual Violence Network
2001 *Exploring the Future of non-Violence: Innovative Practice Models for Responding to Immigrant and Refugee Children and Young People Living with Domestic and Sexual Violence*. Brisbane: Immigrant Women's Support Service.
- Murdolo, A.
2002 Keeping Our Women Safe: Containing Australian Fear and Danger Through Immigration Detention. Hecate. C. Ferrier. Brisbane, Hecate Press. **28**: 123-131.

- Meehan, E. and K. Hanson
1999 *Three-D: A Preliminary Report on Sexual and Occupational Health of NESB Women with Disabilities*. Women in Industry and Community Health Inc. Melbourne, 1999
- Nahas, V. L., S. Hillege, et al.
1999 "Postpartum Depression: The Lived Experiences of Middle Eastern Migrant Women in Australia." Journal of Nurse-Midwifery **44**(1): 65-74.
- Naksook, Charin
2000 *Knowing Her Better: A Research Report about NESB's Women's Sexual and Reproductive Health*. Melbourne: Working Women's Health.
- Njovana, E. and C. Watts (1996). "Gender Violence in Zimbabwe: A Need for Collaborative Action." Reproductive Health Matters **4**(7):46-55
- O'kane, M.
2003 "Refugee and Asylum Seeker Issues in Australia." Northern Press,
- Parliament of Australia
2008 Bills Digest 102 1995-96: Social Security Legislation Amendment (Newly Arrived Resident's Waiting Periods and Other Measures) Bill 1996.
- Points of Departure (POD) Teleconference. 27 January 2009.
- Poljski, C. and A. Murdolo
2009 *To Every Woman: Money, Power, Freedom - Credit and debt experiences of immigrant and refugee women. (Full Report of the Healthy Credit Project)*. Melbourne: Multicultural Centre for Women's Health.
- Prince, Grace
1996 Brisbane City Council Domestic Violence Initiative Research Project: *Domestic Violence in Non-English Speaking Background Communities in Brisbane*. Brisbane: Immigrant Women's Support Service.
- Report of the Evaluation of the Commonwealth Disability Strategy, September 2006
[http://www.facsia.gov.au/internet/facsinternet.nsf/via/disabhome/\\$file/CDS_Evaluation2006.txt](http://www.facsia.gov.au/internet/facsinternet.nsf/via/disabhome/$file/CDS_Evaluation2006.txt)
- Rossiter, J. C.
1998 "Promoting Breast Feeding: The Perceptions of Vietnamese Mothers in Sydney, Australia." Journal of Advanced Nursing **28**(3): 598 - 605.
- Sakall, N.
2001 "Beliefs about Wife Beating Among Turkish College Students: The Effects of Patriarchy, Sexism, and Sex Differences." Sex Roles **44**(9-10): 599-610.

- Small, R., P. Liamputtong 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.
- Small, R., J. Lumley, et al.
2003 "Cross-cultural Experiences of Maternal Depression: Associations and Contributing Factors for Vietnamese, Turkish and Filipino Immigrant Women in Victoria , Australia." Ethnicity and Health **8**(3): 189-206.
- Small, R., J. Yelland, et al.
2002 "Immigrant Women's Views About Care During Labor and Birth: An Australian Study of Vietnamese, Turkish, and Filipino Women." Birth **29**, **Number**(4): 266-277(12).
- Stephens, J and S. Bertone
1995 *Manufacturing Uncertainty: Non-English-speaking-background women and training*. Canberra:AGPS.
- Strong, V.
2001 *Women's Health at Work Program: Reaching Women from Culturally and Linguistically Diverse Backgrounds in the Workplace*. Strategic and Business Plan 2001-2003. Sydney: Multicultural Health Unit.
- Strong, V.
2001 *Chinese Speaking Women Working in Market Gardens Across the Sydney Basin. Early Project Development*. Sydney: Working Women's Health.
- Sword, W.S., Watt, et al.
2006 "Postpartum Health, Service Needs, and Access to Care Experiences of Immigrant and Canadian-Born Women." Clinical Research **35**(6): 717-727.
- The Parliament of the Commonwealth of Australia
2008. *Immigration Detention in Australia: A New Beginning. Criteria for release from immigration detention*. First report of the inquiry into immigration detention in Australia. Canberra: Joint Standing Committee on Migration..
- URCOT
2005 *Safe at Work? Women's Experience of Violence in the Workplace: Summary Report of Research*. Office for Women's Policy. Department of Victorian Communities.
- Workplace Health and Safety. Australia – Occupational Health and Safety Legislation www.workplacehealthandsafety.com.au/servlet. Accessed February 27, 2009.