LEFT BEHIND

Migrant and Refugee Women's Experience of COVID-19

GENVIC

GENDER EQUITY VICTORIA

MULTICULTURAL CENTRE FOR WOMEN'S HEALTH

WOMHEn

Workforce of multilingual health educators

Multicultural Centre for Women's Health (MCWH) is Victoria's state-wide migrant and refugee women's health service, in operation since 1978. MCWH provides tailored, responsive, accessible and equitable health and wellbeing programs for migrant and refugee women across Victoria. In addition, MCWH breaks down access barriers by offering in-language outreach programs delivered by trained peer educators to ensure migrant women can access information and support where it works best for them: where they work, live, study and play.

MCWH works with women who are least likely to easily access mainstream English-language services, such as migrant women workers, women who are newly arrived or parenting in the early years, women on temporary and precarious visas, those who have low or no proficiency in English and need additional information and assistance to navigate Australian health and support systems.

Victoria's Women's Health Services (WHS) provide a statewide infrastructure to promote Victorian women's wellbeing and promote good health and wellbeing to Victorian women.

Since 1988, WHS have been fundamental in the provision of preventative health projects and programs in Victoria. WHS counteract gendered health inequities by ensuring Victorian women have access to tailored, gendered, multilingual health information with which to navigate healthcare choices across the Victorian health system while also working to address the underlying systemic causes of women's ill-health.

The WHS located across metropolitan and regional regions are centres of excellence in gendered health promotion and prevention, winning awards for their innovations and achievements.

Gender Equity Victoria (GEN VIC) is the peak body for gender equity, women's health and the prevention of violence against women in Victoria.

Our vision is for equality, wellbeing and freedom from violence for every woman and girl in every community of Victoria. GEN VIC represents individual and organisational gender equity leaders across Victoria who advance gender equity and hold values aligned with feminist principles. Our current membership reaches every region and community in Victoria. We value our public, private and community sector membership.

GEN VIC recognises gender as a critical determinant of wealth, power and status in society and therefore one of the most powerful drivers of health inequities, hate and violence. Consequently, we advocate influence and collaborate to improve outcomes in gender equity, women's health and the prevention of violence against women.

Acknowledgment of Country

GEN VIC and MCWH acknowledges and pays respect to the Wurundjeri people of the Kulin nation, on whose land this report was written. Aboriginal sovereignty was never ceded.

We recognise that we live on stolen land and benefit from the colonisation of the land now called Australia. We have a shared responsibility to acknowledge and end the ongoing harm done to its First Peoples and to work towards respect and recognition. We recognise that Aboriginal and Torres Strait Islander women are leaders who have created the path for our feminist activism and who continue to sustain us as we work towards achieving equity for all women.

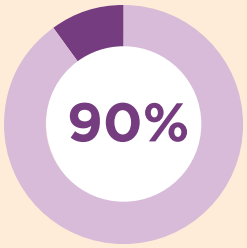
We pay our respects to Aboriginal and Torres Strait Islander peoples, their ancestors and elders, both past and present and acknowledge their continuing connection to land, sea and community. We hope our work contributes to the wider project of respect and recognition between cultures in Australia

Further Acknowledgments

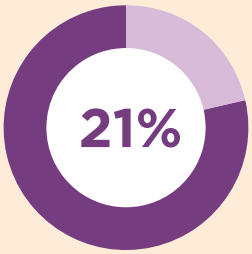
GEN VIC and MCWH also want to acknowledge and thank the migrant and refugee women who participated in this project for sharing their experiences and stories in dealing with the impacts of COVID-19 pandemic and lockdowns. We also thank the 41 health educators and outreach workers who engaged with migrant and refugee women and conducted the interviews.

GEN VIC and MCWH acknowledge the support of the Victorian Government through the Working for Victoria initiative.

We interviewed over 70 migrant and refugee women about their experiences of COVID-19



reported that COVID had a **moderate to severe impact** on them.

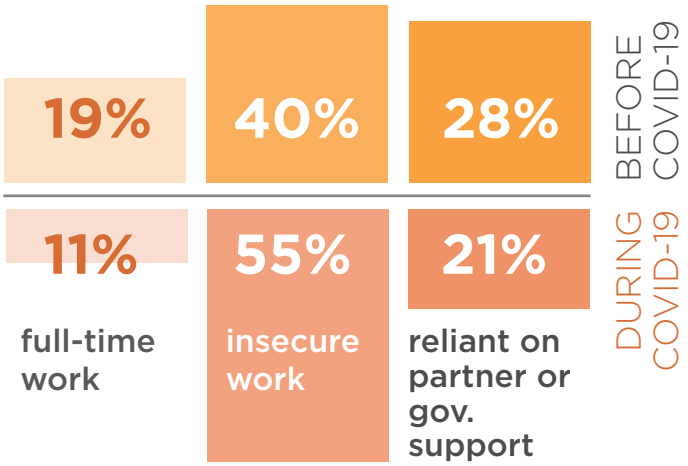


were **not aware** of government supports available during lockdown

>90%

experienced multiple hardships

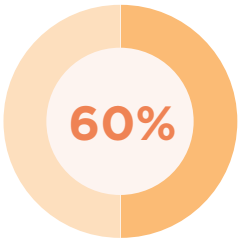
- FINANCIAL STRESS
- FAMILY SEPARATION
- COMMUNITY ISOLATION
- HOUSEHOLD INSECURITY
- DISCRIMINATION
- LOSS OF EMPLOYMENT
- REDUCED INCOME
- INCREASED UNPAID CARE WORK
- MENTAL HEALTH ISSUES
- HEALTHCARE ACCESS



The pandemic has **exacerbated** already existing **employment inequality**

40% of respondents reported either losing their jobs, having their hours cut or being unemployed.

reported an **increase in hours** of unpaid **care work**



felt **overwhelmed** and **demotivated** by this

OVER **1/4** DID NOT THINK THE GOVERNMENT'S MESSAGING DURING PANDEMIC WAS VERY GOOD

ALMOST **1/4** OF WOMEN STRUGGLED TO ACCESS GOVERNMENT SUPPORT BECAUSE OF GOVERNMENT POLICY

*"The messages from Victorian Government **should [be] translated for all**... "*

***"In the eyes of government we were not equal...** If someone is not on PR or don't have citizenship, what they can do..."*

*"I **stopped caring for myself,** just everything for children."*

*"Due to border restriction, **my family has broken down into two countries."***

Contents

Executive Summary

Across Victoria, COVID-19 infections are rising especially in regions with high numbers of migrant and refugee communities. The Delta variant has taken hold in unequal ways, outpacing contact tracers for the first time, with hundreds of people being infected and filling hospitals. Even before Victoria entered the third wave of the pandemic, it was clear that migrant and refugee communities have been disproportionately impacted.

Women from migrant and refugee backgrounds in Victoria have been particularly vulnerable to the virus and its consequences. Whether facing the most restrictive lockdown laws in the country during the Alfred Place Towers incident or suffering during the worst outbreak in an aged care facility at the St Basil's Homes for the Aged in Fawkner where residents and workers were predominantly women from migrant backgrounds. The COVID-19 pandemic has exacerbated the impact of disadvantage of migrant and refugee women.

The WOMHEn Project, a joint initiative of MCWH, GEN VIC and regional women's health services, built regional health promotion and education capacity to meet the COVID-19 women's health information needs of migrant and refugee women. Made possible by a Working for Victoria grant, targeted to addressing COVID-19 job losses in migrant and refugee women's communities, the WOMHEn project employed 50 women across 10 metropolitan and regional services, with a linguistic diversity of 20 different languages.

In over 6 months, multilingual health educators and outreach workers provided in-language education and communication about COVID-19. They also interviewed 75 migrant and refugee women from diverse cultural backgrounds and lived experiences. The data that was gathered and documented builds a picture of a deeply affected community, with shared experiences, including resilience and strength in the face of the pandemic.

The findings of this report show that the pandemic had a significant impact on migrant and refugee women across Victoria. Of the 75 women interviewed, 90% said that COVID-19 had either a moderate, major or severe impact on their lives. Over 90% of women also reported experiencing multiple hardships such as household financial stress, family separation and isolation from communities, housing insecurity, discrimination in accessing government support, loss of employment, reduced income, increased hours of unpaid care work, mental health issues, and difficulty accessing healthcare.

In particular, this report highlights how migration, settlement and visa status have an overarching impact on women's experiences of COVID-19. Almost a quarter of the women interviewed are on temporary visas and reported experiencing significant challenges including not being able to access affordable healthcare and government support such as JobKeeper and JobSeeker due to government policy that excluded them.

Gendered behaviour and expectations around family responsibilities have also impacted on migrant and refugee women's experiences of the pandemic. The majority of women interviewed are partnered with children and 60% reported carrying out increased unpaid care of children and other family members. For 83% of the women, the lockdowns had either a moderate, major or severe impact on their unpaid care work. Half of all women with unpaid caring responsibilities reported feeling overwhelmed and demotivated and many spoke about the added stress of home-schooling.

This report also shows that migrant and refugee women do not have equitable opportunities for social and economic independence and security. Before COVID-19, only 18% of the women interviewed were employed fulltime, 45% were already in insecure work and over a quarter were financially dependent and reliant on a partner's income or social security payments. During the pandemic, only 11% of women were employed fulltime and 47% stat-

ed either losing their jobs, having their work hours cut or being unemployed. While some of the women interviewed spoke about their experiences as survivors of family violence, other women told us that their economic dependency made them feel powerless and vulnerable.

Throughout Victoria's latest wave of the COVID-19 pandemic, the WOMHen workforce has pivoted towards providing advice to migrant and refugee women on the importance of vaccination. The vaccination work of health educators has become crucial to ensuring migrant and refugee women are supported with in-language advice about their vaccine choices at various stages of sexual and reproductive life, and to enable effective navigation of vaccination bookings and services.

The report highlighted that migrant and refugee women did not have access to the same level and quality of COVID-19 information in their languages and level of English proficiency. Over a quarter of women interviewed did not think the government's messaging about COVID-19 was very good because messages were not tailored to the specific needs of migrant and refugee communities and were not readily provided in languages other than English. The clear and resounding message from the women interviewed for this report is that they value in-language health education and want programs such as those delivered through the WOMHEn Project to continue.

Ensuring migrant and refugee women who want to be vaccinated are not excluded from the 80% double dose target because of structural, cultural or linguistic barriers is urgent work. Being unvaccinated should not be a consequence of disadvantage and inadequate language services. If that happens, large numbers of already marginalised people will be further stigmatised, with limitations on movement, service access and job opportunities.

The issues raised in this report provide compelling evidence for continued support of a state-wide, multilingual, information infrastructure to deliver appropriate, in-language women's health and wellbeing education and support programs to communities that have been made even more vulnerable due to the impacts of COVID-19. In the words of one woman we interviewed for this report, 'there needs to be more thought in terms of the extra issues migrant and refugee women face on top of the ones the general population face because we are getting left behind.'

All photographs were taken in accordance with public health advice

1. Key Recommendations

Health Programs and Service Delivery

- Continue to support a multilingual women-led workforce that delivers in-language health education across Victoria to communities that have been made more vulnerable due to impacts associated with the COVID-19 pandemic.
- Provide additional funding and support for peer-based and community-led, multilingual women's health education and support programs across Victoria.
- Ensure that government health messaging and COVID-19 directives are consistent, transparent and delivered in-language through bilingual health education.
- Train health professionals in gendered, cross-cultural awareness to improve migrant women's access to GP clinics and other health services.
- Ensure interpreting services are available across primary health providers in Victoria, and interpreters have specific training in women's health issues.

Mental Health

- Invest in gendered, intersectional policy analysis to ensure that Victorian government policy at all levels impacts positively on migrant women's mental health.
- Provide mental health programs and support in-language to respond to migrant and refugee women's issues in culturally appropriate ways.
- Train mental health services staff and the interpreting workforce in gendered, cross-cultural awareness.
- Support innovative, tailored education and advocacy mental health interventions run by migrant women's organisations and delivered to migrant women by trained bilingual workers.
- Support the development and delivery of COVID-19 recovery mental health programs that are specifically tailored for migrant and refugee women.

Employment and training

- Provide on-going investment to prevent gender and race discrimination in workplaces and promote equity within the Victorian labour force.
- Support the post-COVID-19 recovery of Victorian industries and jobs in which migrant women are concentrated.
- Adopt a strengths-based and gendered approach when developing strategy and policy for migrants and refugees, understanding that migrant women have skills and qualifications that should be highly valued in the workforce.
- Specifically target migrant and refugee women for COVID-19 economic recovery programs, and create employment pathways to facilitate their active participation in the workforce.
- Provide training and qualifications to migrant and refugee women to deliver in-language health education for communities with limited or no English language ability and difficulty accessing critical health and wellbeing information.
- Provide English language and digital-literacy support programs that meet the needs of all migrant women, including those on temporary visas.
- Provide free or subsidised childcare for migrant and refugee women, enabling them to access the workforce and creating a more gender-equitable Australian society.

2. Project and Methodology

2.1 WOMHEn Project Background

The Workforce of Multilingual Health Educators ('WOMHEn') project is an initiative of the Multicultural Centre for Women's Health ('MCWH') and Gender Equity Victoria ('GEN VIC') in partnership with Victorian women's health services. The project aimed to build regional health promotion and education capacity to effectively meet the COVID-19 and women's health information needs of migrant and refugee women.

Funded by a Working for Victoria grant, the project employed 50 migrant and refugee women to form a rapid response health workforce. We trained a team of 41 health educators and outreach workers to provide in-language education and communication about COVID-19 in over 20 languages to migrant and refugee women.

The objectives of this project were:

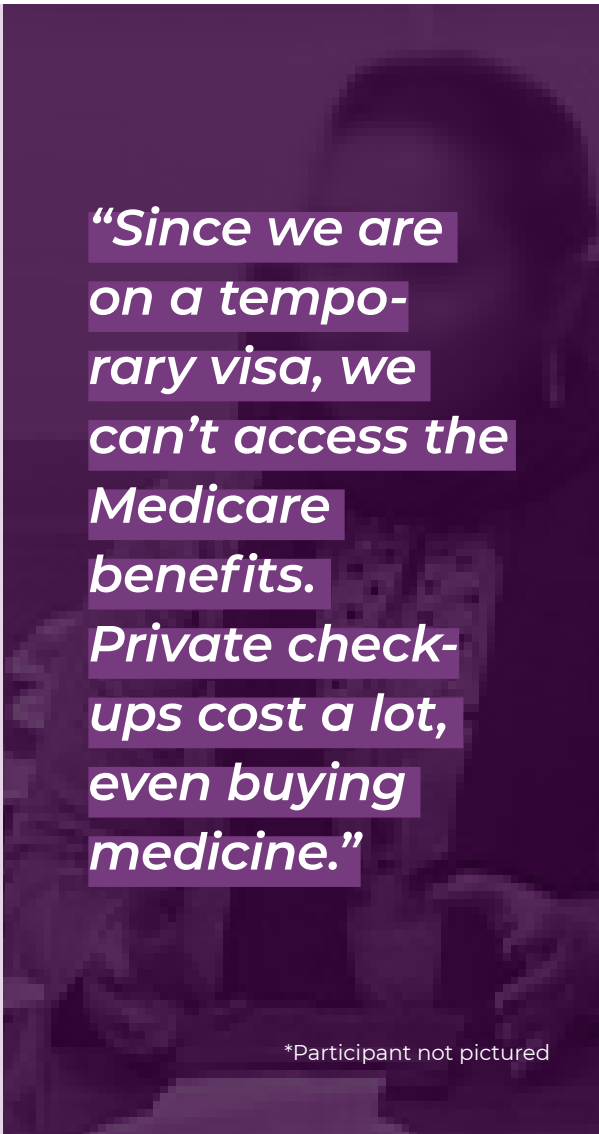
a. To provide a scaled-up, coordinated, preventative health education and promotion workforce within the regions to ensure migrant and refugee women across Victoria have access to in-language education and communication about COVID-19.
b. To prevent further outbreaks of COVID-19 in migrant and refugee communities, mainly via family and workplace transmission events, during stages of eased pandemic restriction (including vaccine rollout).
c. To ensure that migrant and refugee women's experiences of COVID-19 are understood and included in recovery initiatives and policy.
d. To build a scalable backup workforce for intensive outreach with migrant & refugee women during the disaster.

Case Study 1: Maria (38 years old) is employed part-time on a temporary visa.

Maria has lived in Australia for seven years on a temporary visa with her husband and child. When COVID-19 hit Australia, Maria was worried about how her family could continue to pay rent and buy food on their small income. She found it difficult to find information about receiving income support but eventually found out that she was not eligible for any government COVID-19 support.

"When my husband got sick for one week amid lockdown last year, it was hard for us to go to the clinic/hospital. Since we are on a temporary visa, we can't access the Medicare benefits. Private check-ups cost a lot, even buying medicine. Our health insurance did not cover it all. It is heavy for us because my husband's two weeks [off] work suffered our finances. He is only casually employed in the aged care sector," she said.

Post-pandemic, Maria wants to secure housing and find a stable job. "I want to save, invest and use our money wisely. Also to visit our family in our home country." She would like the government to look out for those who are on a temporary visa. "I believe we are still important in the economic growth in Australia since we are paying our taxes."



2.2 Methodology

Data Collection Design

In order to ensure that migrant and refugee women's experiences of COVID-19 were understood, the WOMHEn health educators and outreach workers were trained to conduct interviews with women from migrant and refugee communities.

MCWH and GENVIC drafted the interview questions (with input from the WOMHEn health educators and outreach workers) to capture the impacts of COVID-19 on women and their resilience in managing the impacts. The themes covered in the interview questions included:

a. The severity of COVID-19 impacts on daily life, including access to health care and the impact of government public health messaging.
b. The impact of COVID-19 on employment, income and navigating access to support.
c. The impact of COVID-19 on unpaid care work, including care support and home-schooling.
d. Future hope and visions based on participants' experiences.

Interview workshop

MCWH delivered an interview workshop to the WOMHen Project health educators and outreach workers. Workers were guided through the interview process and provided with interview techniques, including ensuring confidentiality and managing possible disclosures of family violence during an interview. It was also an opportunity to ask questions about any other aspect of the interview process. Following the workshop, participants were provided with the project brief and consent form for interview participants, interview questions, interviewing guide, and information about managing any disclosures.

Challenges and limitations

All interviews were conducted by phone or video-conferencing software due to COVID-19 restrictions and lockdowns. As a result, the opportunity for the interviewers and participants to build rapport may have been inhibited by the lack of face-to-face contact. For some participants interviewed in their own homes, privacy may have been difficult to negotiate, and thus they may not have felt comfortable sharing personal information. In addition, some interviews were conducted in a language other than English to help facilitate communication between the interviewers and participants for whom English is not the first language. The interviewers then translated the outcomes into English for the purpose of data analysis and writing this report. While the translation process may lose some precision in meaning, this approach nevertheless allowed women to voice their concerns in a way which would not have otherwise been possible. Their stories and experiences have provided valuable insights into the actions needed to ensure migrant and refugee women are included in COVID-19 recovery efforts.

Data Collection and analysis

Upon completion of the interviews, health educators/interviewers entered the data into the 'Survey Monkey' platform. The data was then collated and distributed to the project team for analysis.

Report Writing

MCWH and GEN VIC jointly wrote this report. The data collected have been de-identified and pseudonyms have been used throughout this report to protect the privacy and identity of the respondents.

Pictured: Health educators employed as part of the WOMHEn

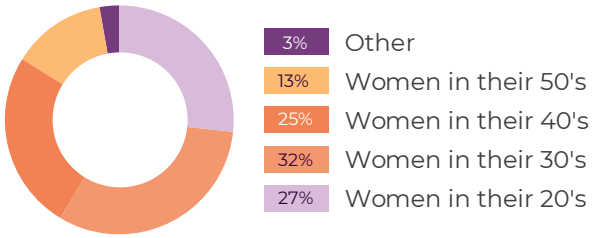
3. Demographic Data

Seventy-five migrant and refugee women were interviewed about their experiences of the COVID-19 pandemic. COVID-19 has disproportionately impacted migrant and refugee women due to the embedded gendered inequality, multiple burdens, and caring responsibilities that women endure. Below is the summary of the demographic data of migrant and refugee women that participated in this project.

3.1. Age Group

The majority, or 84%, of women who took part in the interviews were in the 20 – 40 years age range. Women aged in their 50s and over made up the remaining 16% of interview participants.

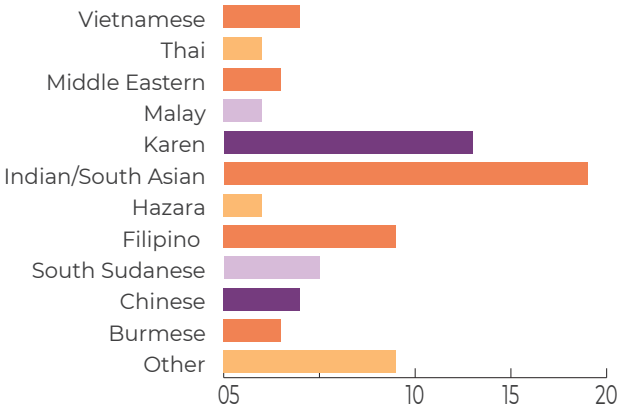
Chart 1: Age



3.2. Country of Birth and Ethnicity

The data across highlights the cultural and ethnic diversity of the participants we interviewed. The majority of participants were born in India (23%) followed by Myanmar with 17% . The majority of women interviewed identified as Indian/South Asian (25%), followed by Karen women at 17%.

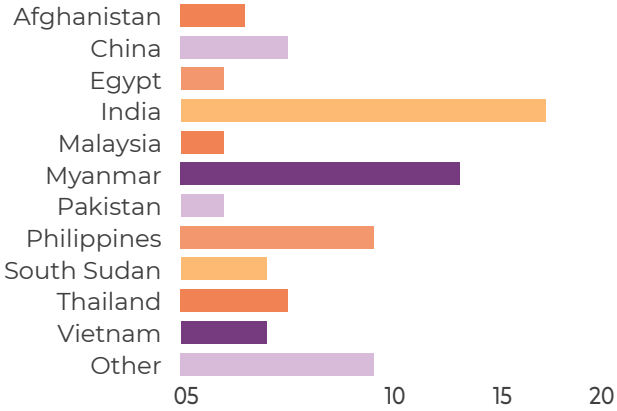
Chart 2: Ethnicity



3.3 Length of Stay in Australia/Citizenship Status

The majority of women interviewed have lived for a more extended period in Australia and had permanent status. Around 40% had lived in Australia for between 5-10 years, and 36% for more than ten years. Seventy-three percent had either Australian Citizenship or permanent residency status. Almost a quarter (22%) of those interviewed were on a partner, student and/or bridging visa. This report highlights how migrant and refugee women on temporary visas have experienced significant challenges during the COVID-19 pandemic. People on temporary visas were unable to access government support such as JobKeeper and JobSeeker payments due to government policy that excluded them. (see Chart 8 and 9)

Chart 3: Country of BIrth



3.4 Relationship and Parental Status

The majority (66%) of participants interviewed are partnered compared to around 21% who are single. Over 71% of women have children. Of those with children, 81% have either two or more children

Chart 4: Parental Status

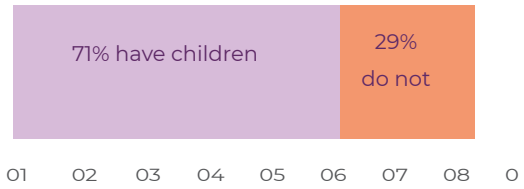


Chart 5: Relationship Status

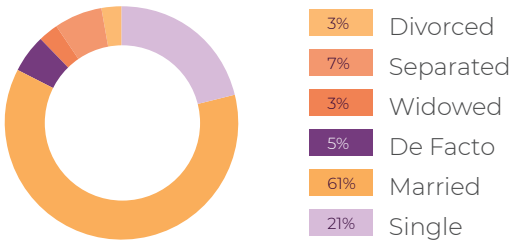
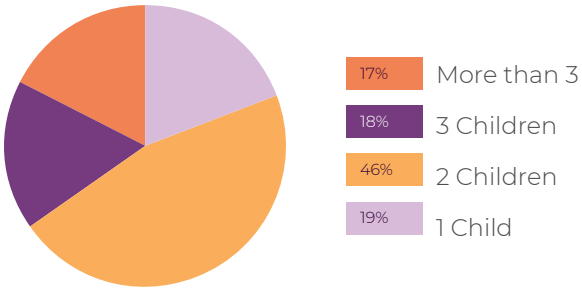


Chart 6: Number of Children



3.5 Education Level

Over 66% of participants had completed a tertiary education compared with only 8% who had not completed any formal education. Nevertheless, we found that for many migrant and refugee women, a tertiary education does not guarantee secure employment.

Chart 7: Education Level

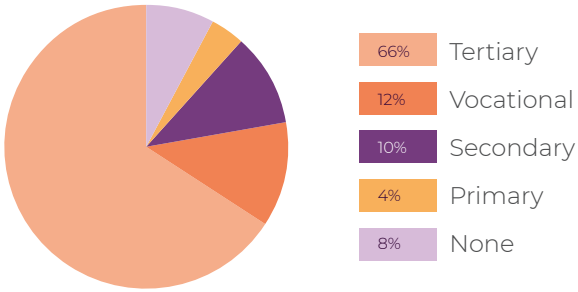
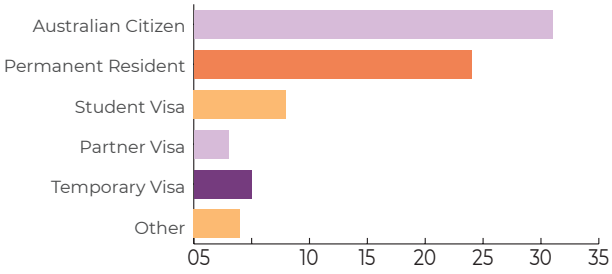


Chart 8: Citizenship / Residency Status



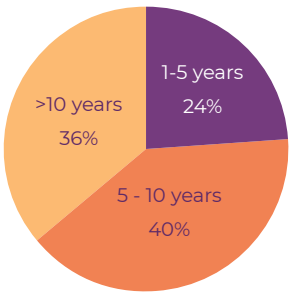


Chart 9: Length of Stay in Australia

4. Key Findings

4.1 COVID-19 Impacts on families, health and access to healthcare

The overwhelming majority or 90% of participants reported that the pandemic had impacted their families. Close to half (43%) stated that COVID-19 had a moderate impact and 37% of participants stated that the pandemic had a significant impact. An equal percentage (10%) of women reported that COVID-19 had either a severe or minor impact.

When participants were asked as to why the pandemic impacted their family in this way, many described a multiplicity of challenges that women face as migrants when settling into a new country. These challenges include separation from family, social isolation, low English proficiency, and barriers to employment and healthcare due to visa status:

Household finance, family support and mental health

"Financial aspect is the most important one being on student guardian visa I do not have any work rights, and my husband who is [overseas] supports me and my children financially. He runs a business there but due to COVID his business has been significantly impacted and has resulted in financial hardship for my family and me. Along with this, being apart from each other has caused significant friction in our relationship. This long-distance relationship is getting hard and tense, which impacts me psychologically a lot. I feel like I am under stress most of the time. It is impacting my physical health a lot now adays, I see breakout on my skin and headaches a lot. Due to financial hardship I am [postponing treatment of my] health issues. I am also worrying a lot for my family overseas and I've lost the emotional support I use to get from them as they are also going through hard times due to COVID."

Household finance and employment

"Both my husband and I have low income. My working hours were cut. I got no JobKeeper payment because of my bridging visa status. I was stressed whenever any bill came to my home. I felt the Ministry of Home Affairs process my visa slowly. My children had to learn online and I could not help them with their study. They were depressed and did not listen to me."

Unpaid care

"I am single mum and three children. I don't understand English, I can't read and speak English. The remote learning for myself and my children has made me sick. I don't have a skill of using technology. I don't know how to use computer. I couldn't help my children with the schoolwork. I couldn't do the Centrelink report, I received a letter from the hospital, its written in English, I don't understand what the letter is, and I can't go to my friend for help due to the lockdown. I don't know how to use telehealth. I feel hopeless and I am not a useful mum for my children. It impacts on my mental health and wellbeing."

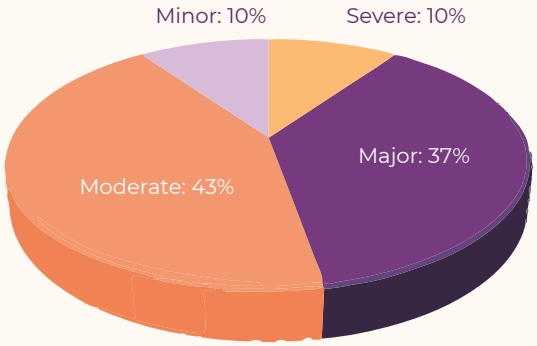


Chart 10: Impact of COVID-19

Health access

"When my husband got sick for one week in the midst of lockdown last year, it is hard for us to go to the clinic/hospital. Since we are on temporary visa, we can't access Medicare. Private check-ups cost a lot even buying medicine. Our health insurance did not cover it all. It is heavy for us because two week that my husband can't go to work suffered our finances, since he is only a casual worker in Aged Care."

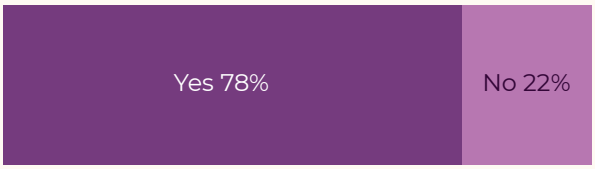
Pre-existing conditions

Over a quarter of the participants interviewed (36%) reported a pre-existing health condition.

"I have pre-existing health conditions that I need to have regular blood tests [for], then book an appointment with my doctor and depending on my blood results, my doctor advises about the dosage of my medication. During the pandemic, I was psychologically scared to go out anywhere because I thought that if I get the infection, it will be difficult for me to recover. The other issue was that my doctor had tele-appointments with me. The results of my blood tests were emailed to me, and the doctor and the consultation took place over the phone. I was not very comfortable or confident with those phone appointments."

Chart 11: Pre-existing health conditions

Chart 12: Accessed Health Care Services During Lockdown



Access to health care during lockdowns

The majority of the women (76%) reported that they needed access to healthcare during the lockdowns. Almost all (93%) visited a GP clinic, with hospitals (28%), specialists (28%) and dentists (13%) being cited as other services that were accessed. Only 9% of women reported visiting a community health centre.

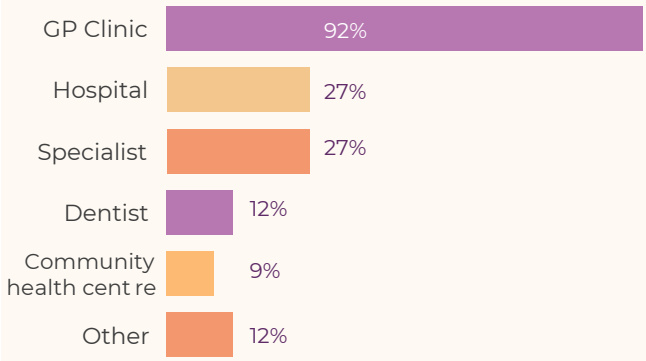
For those participants who reported challenges in accessing healthcare services during lockdown, many cited lack of access to appropriate services, lack of safe transport options, and lack of interpreters:

"Since I don't have Medicare it was really hard for me to book in, this barrier existed prior to COVID but was worse during the pandemic. Really struggled with access to mental health services during lockdowns, I had to wait months to see a psychologist."

"I can't drive so I have to go by bus. I was scared for the safety of my baby too. There was only a phone interpreter and I have to wait for so long for the availability of the interpreter on the phone."

"It's difficult for me because during lock down when I have appointments to attend, there was no interpreters, as interpreters were not allowed to come so for me it was a problem."

Chart 13: Health Care Services Accessed



Accessing information about COVID-19

Participants were asked to identify how they accessed public health information about COVID-19. A total of 68 participants responded to this question. Based on the data received, some women said that they accessed more than one source of information about COVID-19. The internet was cited as the primary source (84%), followed by television (57%). Almost half (45%) of the women stated they received public health information from family and friends, and others (13%) also reported receiving information from a community member. In other words, a total of 58% of women accessed information via community-based channels.

"I used to get information from community members and some community channels on Internet. Most of the information was in English which I was struggling to understand at that time. So, I used to get second hand information from community members, which you can not be sure how correct it is. I used to listen community language updates on internet to validate."

"I use to get most information from community members as this way you get translated information easily. In my community this is how we get information verbally. Also, I use to get updates on radio as it was easy to access with my busy schedule."

"Social media is the easiest way to access COVID info, since most of the time I am using my FB but I only choose the right organisation that will give the updated info."
"I do not have access to TV, so I was using my phone and internet to get the updates. Also for some of the information about COVID-19 restriction I use to get from my friends and community as well. In the second lockdown, I started getting some updates from different community organisations such as BRMC and BCH. Although for restrictions I use to check updates regularly, to ensure that I do not do anything against law."

Government Messaging about COVID-19

Although 46% of women reported that the government had communicated messages about COVID-19 'well', only 23% of women thought that the government was doing it 'very well'. On the contrary, well over a quarter (31%) of women thought that public health messaging was either 'poor' (9%), *'very poor' (1%), or felt it was 'neutral' (21%).*

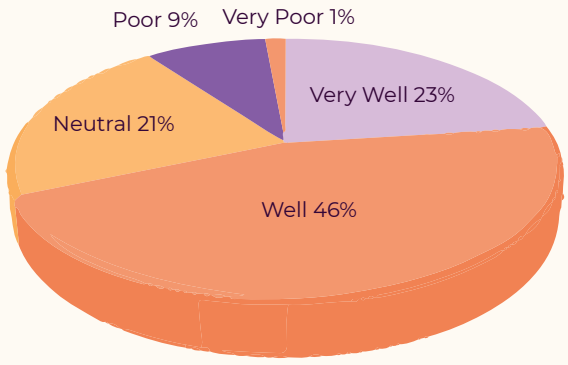


Chart 14: Access to Information about COVID-19

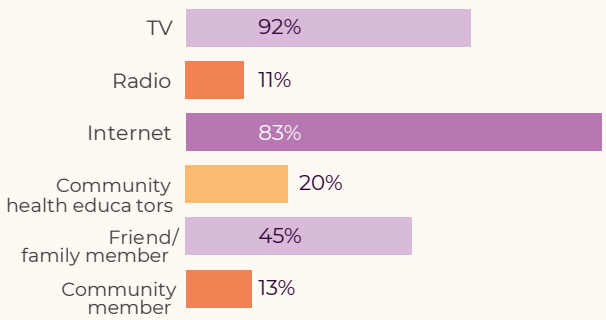


Chart 15: Source of access to Information about COVID-19

"The information was provided in a fairly reasonable way. Although the information was not very easy to understand if they do not have good hold on English. The different language resources were made available very late."

"I am not clear the messages. Mostly the information that I got from the internet, social media. Support income just applied for Australian citizens and people who [are] permanent residents. My visa, temporary visa, doesn't have any support. The messages from Victorian Government should [be] translated for all... so [it can be] easier to approach the information because my English is not good enough (just basic)."

"It was not clear at all, lots of people were telling different stories and the messages on social media also was not in plain English. In the eyes of government we were not equal... If someone is not on PR or don't have citizenship, what they can do... No equal opportunities for everyone. Messages circulating was only for PR [permanent residency] holders and Citizens."

"It has not been clear until some of my friends explain to me. I hope the messages in my language could be mailed to my home."

Even if information was considered to be clear and in-language, it was pointed out the information still needs to be consistent:

"Vaccination information has been clear however there has been a lot of inconsistency which has made me more reluctant to take the vaccine."

4.2. COVID-19 Impacts on Employment, Income and Hardship Support

Impacts of COVID-19 on Employment and Income

Participants were asked about their employment and household income before March 2020 when the COVID-19 pandemic hit Australia and the ways in which the pandemic and Australia's response impacted on their employment and income and how they sought support. Women were also asked about their employment status at the time of the interviews (July – August 2021).

Although the majority of participants had a tertiary education (66%), only 18% of participants reported having full-time employment before COVID-19 hit Australia.

A total of 45% of women were employed in insecure (and possibly underemployed) work arrangements, in which 17% of participants worked part-time, and 28% were casually employed. Concerningly, more than a quarter (27%) of participants were unemployed in different contexts – either receiving no income at all, relying on their husband/partner's income, or relying on Centrelink payments. The findings indicate that many migrant and refugee women were already economically disadvantaged before the COVID-19 pandemic. Evidence has shown that financial insecurity and dependency are predictors of women staying in abusive relationships and create significant barriers for migrant women seeking to leave situations of family violence.

Seventy per cent of women stated that COVID-19 and lockdowns had impacted their employment and income. This finding highlights the structural disadvantages experienced by migrant and refugee women

Case Study 2: Zahra (32 years old) is unemployed and on a bridging visa.

Zahra migrated to Australia seven years ago and is on a bridging visa. Since migrating, Zahra has not been able to see her parents, siblings and extended family members who are overseas. Zahra is unemployed and her husband is only employed casually. Because of her visa status, Zahra does not receive any financial support from the government, including Medicare. "[There is only] one breadwinner of the family [my husband], and a lot of struggle to keep up with my husband current casual job," she said.

Zahra's financial problems often led to arguments with her husband. In early 2021, Zahra underwent surgery that left her with a $15,000 medical bill. "I would prefer to die than going up to the hospitals for any [more] treatment."

Even after her husband lost some of his work hours due to COVID-19 restrictions, Zahra continued to take full responsibility for the care of her three children, including home-schooling. "It was tough for me to get any me-time or to call my family overseas.' The increased burden made her feel overwhelmed and constantly tired.

Being financially dependent on her husband has left her feeling unfulfilled and directionless. Zahra fears being homeless and being unable to provide for her children. Returning permanently to her home country is not an option. Zahra says she feels like a puppet with no choices or life of her own. Zahra would like to earn income but needs to develop her professional skills and assistance with navigating employment pathways. She also needs help with childcare and is unable to access any form of support because of her visa status. Zahra would like a dedicated helpline number for migrant and refugee women on a temporary visa to call and talk about their concerns. Zahra also suggested compulsory in-person settlement information sessions for migrant women as soon as they arrive in Australia.

*Participant not pictured

Employment/Income Status	Before COVID-19	Impact of COVID-19	Current
Full-time	18%	-	11%
Part-time	17%	-	37%
Casual	28%	-	17%
Unemployed	27%	-	20%
	Centrelink 12 % Rely on partner 11% No income 4%		Centrelink 11% Rely on partner 5% No income 4%
Self-employed	4%		4%
Other	2%	21%	7%
Work hours were reduced by at least 50%	-	21%	-
Lost Employment	-	15%	-
Unemployed and found it hard to find a job	-	11%	-

Table 1: Employment and Income status before and during the COVID-19 pandemic

in Australia, which have been exacerbated as a result of COVID-19. Among those whose employment and income were affected by COVID-19, 21% had their work hours reduced, 15% lost their jobs, and 11% were unemployed and found it harder to find a job.

Participants also shared their experiences concerning the impacts of COVID-19 and lockdowns on their employment and income. Their experiences included working extra hours as an essential worker, having reduced income but no reduction in workload, experiencing financial abuse, resigning from work to perform caring work and having their partner lose their job.

During the pandemic and at the time of the interviews (between July – August 2021), only 11% of participants reported that they had full-time jobs. Also, when compared to the pre-COVID-19 status, less women reported being unemployed (20%) and in casual employment (17%). More women (37%) reported being in part-time employment.

While it would appear that there has been an improvement in migrant women's employment status, further research and analyses of a larger data set is required. Nevertheless, it's important to note that Australia's employment, underemployment and part-time participation rates are 4.5%, 9.3% and 31% respectively (ABS August 2021). The findings of this section suggests that migrant women make up a high proportion of the unemployed, underemployed and part-time employed in Australia.

Migrant and refugee women also expressed other impacts of COVID-19 on employment and income:

"I had to work all five days in the centre to cater to children in the centre as we were essential workers, and it was our business."

"I experience family violence in the form of financial abuse."

"My work hours and income were reduced with no reduction in workload".

"I resigned from work and need to look after my children."

"(I'm) running my Asian grocer. The demand was very high but so difficult to get supplies due to restrictions."

"My husband lost his job, and it was very stressful. I was also unable to find a job."

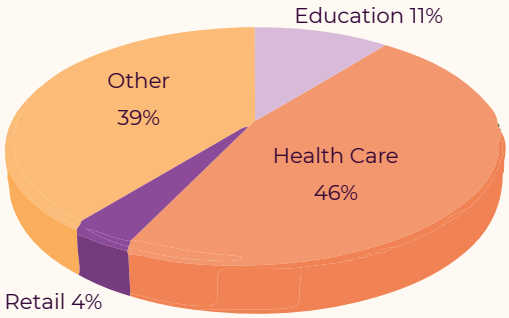
"I was working casually because of the newborn, but my husband lost his job."

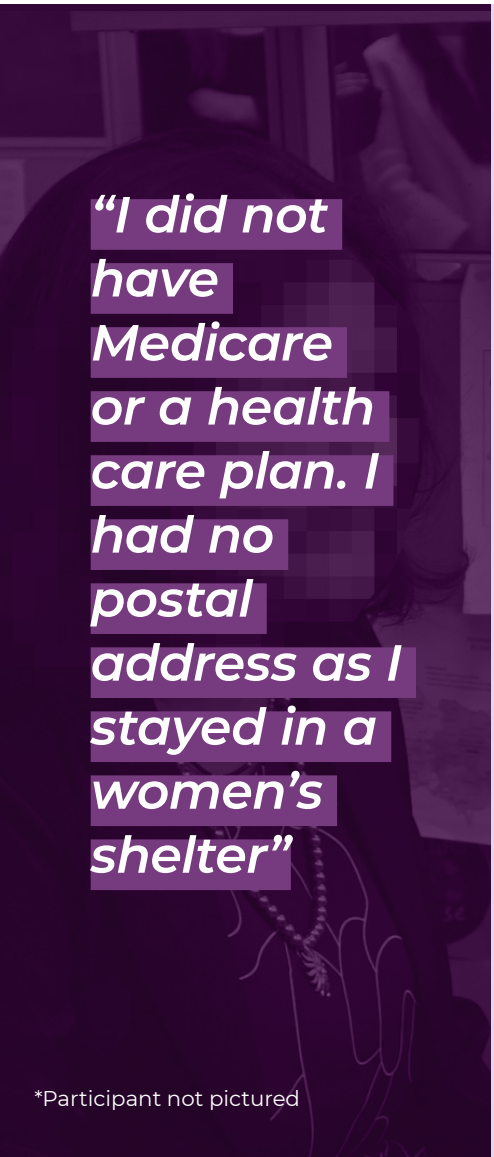
Employment in essential sector

Almost half or 41% of the women in jobs were employed as essential workers during the COVID-19 pandemic. The majority of women, at 46%, were employed as essential workers in the health care sector. Eleven per cent reported working in education and 4% reported working in retail. It should be noted that while 39% of women specified working in 'other' essential sectors, the sectors specified included childcare, agriculture, community/social work, residential aged-care, food delivery and warehouse. The finding confirms the concentration of migrant and refugee women in the essential services sector in jobs which are vital but often low-paid and precarious. Many migrant workers have been at the frontline of the COVID-19 and have helped to keep the economy running especially during the far-reaching lockdown measures. However, as the next section outlines, migrant and refugee women's contributions as workers and tax-payers did not translate into equitable support when they needed to access government support as a result of the pandemic.

Chart 16: Employed as an Essential Worker

Chart 17: Essential Sector Employment Category





*Participant not pictured

Case Study 3: Mey (47 years old) is on a partner visa and unemployed.

Mey moved to Australia 11 months ago on a partner visa. As soon as COVID-19 hit Australia, Mey separated from her partner as a result of his violent behaviour and financial abuse towards her. She was unemployed before the pandemic and had relied on her partner's income. Now she relies on Centrelink payments to support herself.

During lockdown, Mey needed to access a GP Clinic, hospital and specialist. As a survivor of domestic violence, her experience was positive. Mey said, "The staff were very friendly and helpful. They were very understanding at that time because of family domestic violence. Unfortunately, I did not have Medicare or a health care plan. I also had no postal address as I stayed in a women's shelter,"

Mey felt thankful she could access the JobSeeker payment but she was aware it was only a temporary solution. The payment barely covered Mey's basic living costs so she also looked for employment and sent her resume to 20 organisations each month.

Mey's traumatic experience has made her think carefully about her future goals: attain job security, complete an Australian education, secure permanent housing, to recover from her experience of domestic violence, and to be able to afford out-of-pocket health expenses. For May, support to achieve these goals is the most critical aspect of her road to recovery. 'I would like to stay in Australia. But, if that is not possible, I would like to know it as early as possible, to make arrangements to go back to my original country.'

Hardship Experiences and Accessing Support

Participants were asked questions to understand their experiences navigating the impact of COVID-19 and their experiences accessing support.

Over 90% stated that they experienced hardship due to the COVID-19 pandemic. Most of the participants reported that they experienced more than one type of hardship. The most common difficulty experienced by migrant and refugee women is financial and mental health issues. A total of 28% of participants had financial problems and 28% of participants experienced mental health issues This finding is not surprising since many women interviewed were unemployed or financially reliant on a partner's income or Centrelink payments.

One woman told us that financial hardship led to escalated arguments with her husband:

"I had a lot of argument with husband which escalated further at times because of the frustration with lack of job hours and low income."

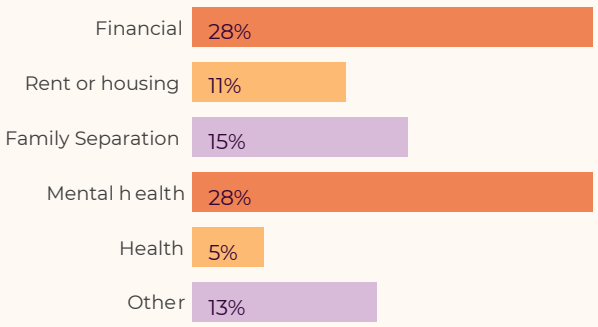
Hardship relating to mental health issues was not always linked to financial stress but to concerns about family wellbeing, family separation and lack of social support, and the overall impacts of COVID-19:

"I experience mental-health related-stress, especially because I was pregnant and afraid that I would get COVID-19 and it would affect my baby."

"I don't have any family to support me, and no one was allowed to come. Kids were home-schooling, so we were not sure what would happen. Few of the family members died back home. Everything was too much, and because of all the pain and anxiety, my mental health went really bad."

Not surprisingly, 15% of participants experienced family separation as a result of COVID-19. The Australian government closed international borders by 20th March 2020, exposing many people to separation from families and loved ones, including from partners and children. Although the impact of closed borders is not unique to migrant and refugee women, the situation is nevertheless more likely to profoundly impact their mental health and wellbeing given their visa and residential status.

Chart 18: Hardships as the Result of COVID-19



"I experience separation from my children and my parents in Thailand."

"Due to border restriction, my family has broken down into two countries. My husband and I cannot be together until the border is open again"

In addition, 15% of migrant and refugee women experienced rental or housing hardship, 5% experienced a health-related issue, and 13% experienced other types of hardship such as carer stress, isolation or being away from close relatives.

"I am worried about instability as I want to work, but I also need to look after my children."

During the 2020 lockdowns, various supports were available to Australian residents who experienced hardship due to COVID-19. We asked migrant and refugee women about their experience about accessing these different supports.

The majority of participants at 79% accessed supports and government policies for addressing COVID-19-related hardship. A total of 16 women reported that they accessed the 'Early Access to Superannuation' initiative. The policy was a temporary measure of the Australian government to enable people who experienced financial hardship to access their superannuation fund. Only 6 women accessed JobKeeper payment, 11 women accessed JobSeeker payment, 2 women accessed mortgage holidays, 2 women accessed rent relief grants, and 19 women indicated they accessed other types of supports such as university COVID-19 supports.

Participants were then asked about their experience accessing those supports. Several women reported that accessing their superannuation was beneficial:

"Accessing super funds was very easy; however, accessing other financial hardship services was very difficult."

"It was positive for me because I lost 50% of my job during the lockdown, so when I get to accessing with that support, it helps me a lot."

"I did lose my work hours at the start of the pandemic, so getting support from the early superannuation helped me a lot."

However, several women reported frustration when they tried to access support as they were deemed ineligible or had difficulty navigating the process:

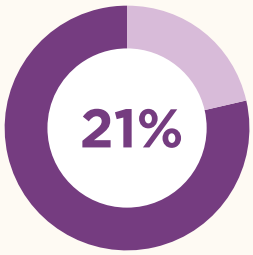
"[My job] was not eligible for any Jobkeeper or Jobseeker payment or early superannuation. Although I was sick and couldn't work the normal working hours, I wasn't eligible to access any support. I just got $450 support payment COVID testing."

"It was a very difficult process. There were so much paperwork and really confusing application forms. It caused a lot of mental stress for me."

"I need to answer a lot of questions from the Centrelink website. I think it is hard for people who are not good in English."

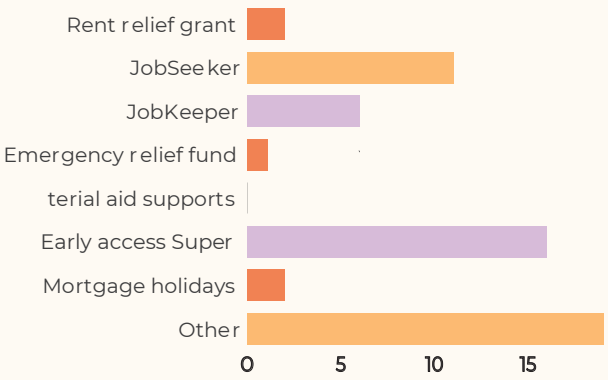
"It was challenging as we had to submit so many different documents that Centrelink already has. It was very frustrating".

Chart 20: Knowledge of Social Supports



were **not aware** of government supports available during lockdown

Chart 19: Supports Accessed During COVID-19



"The government said having to undergo COVID testing will entitle anyone of the $450 after experiencing symptoms. But after applying online, it said I was not qualified. I have to miss three days of work until I receive the result."

Several women on temporary and student visas reported difficulties because they were ineligible due to exclusions on the basis of visa status and subsequently denied access: "I did not apply for Centrelink support because it's tough to figure out the process, and it's hard to get, especially for people like me holding the temporary visa."

"It was hard to find it initially, I didn't know it existed as it wasn't advertised. I wasn't eligible for any other support, which was a real challenge."

"I did not get any supports as was ineligible."

"I tried twice to access emergency relief fund. Although I wasn't working, I was told not eligible."

"I have got some support from the university for food and groceries. But most of the government initiatives I was not eligible for as I am an international student. I did apply for one grant for international students, but it was very complex to access and was only available if you do not have any money in your bank."
Nevertheless, some women who benefitted from government support spoke of their positive experiences:

"The supports available to us were positive as it helped us with financial struggles and provided mental health services when the community were going through stress and anxiety during the lockdown."

"The mortgage holidays were really helpful. I was on Jobkeeper when the pandemic hit last year, and the money that I was receiving was more than my regular salary, which was a positive experience for my family."

"(I) did not find it difficult. I rang Australia services. Everyone was supportive. Centrelink was very helpful and supportive."

"At the start of 2020, before pandemic/ lockdowns, I was unemployed and had no income. The financial support I got was really helpful in helping me pay bills and afford living expenses."

"I received more money from Jobseeker payment. It covers my rent, food, utility bills, internet bill and medication supply"
"It really helps a lot financially with an extra payment from the government, just thankful and appreciates it."

"We have to provide evidence that we have a financial issue and are very happy with the university. They also shared contacts for Mental support Also, free childcare during lockdown was a relief for me as I had no family support when my baby was born and to help with my kids."

Other supports needed

Many women interviewed stated that supports should be available to women on temporary visas (some government grants such as JobSeeker and JobKeeper payments were only available to Australian citizens and permanent residents who had worked at their employer for at least 12 months).
"It should be no discrimination in terms of accessing jobseeker and job keeper payment based on residency status. It should have been the same for all taxpayers."

"Financial support will be helpful from the government for temporary visa holders, especially during COVID. However, it is unfair my husband used up his accrued leave while his colleagues got Job keeper payment."

"I have received no financial support in terms of grants from the government, which made it very hard to keep pace with bills and expenses during the lockdown, and my husband reduced work hours. Furthermore, whenever I tried to apply for a government grant, I was not eligible and that the grants were available only for residents/citizens."

For women with caring responsibilities, child support and child education-related supports were identified as critical to minimise the impacts of COVID-19 on their children's learning and parents' mental health.

"It was stressful for single parents. Working and online learning were very challenging, and there was not much mental support for parents."

"I think the main thing was support for my kids. COVID-19 had interrupted their learning a lot, especially because we don't speak English at home. I just want my kids to be at the same level as the other kids at school. Right now, I think they are below an average."

"I need support to help my children with the schoolwork. It was, fortunately, easy to get those support due to the lockdown."

"I need home school support such as academic and emotional support from the school to students."

"The most important thing is knowing how to look after my family and supporting my children with school work."

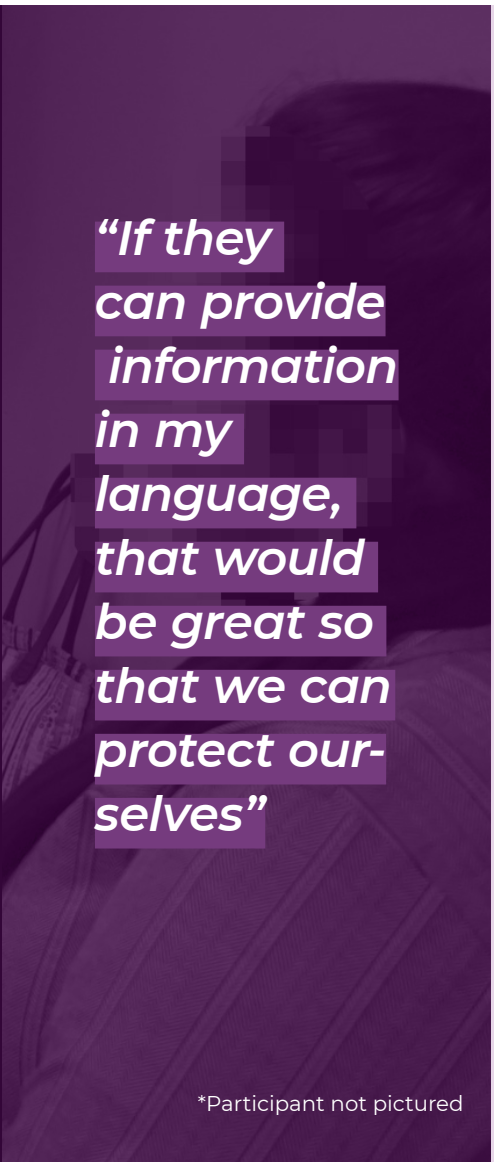
4.3 COVID-19 Impacts on Unpaid Care Work

Interview participants were asked a range of questions concerning their caring responsibilities to understand how COVID-19 impacted on women's unpaid care work. 69% of women reported that they provided unpaid care, including to children, family members and relatives during the pandemic. Most participants indicated that they provide care to more than one person.

Our findings show that 69% of participants provided unpaid care to children and half provided care to husbands or partners. Less than a quarter (23%) provided care to elderly parents and 4% provided care to family member/s with a disability. In addition, 20% of participants indicated that they perform care work to others, including friends, grandparents, friend's children and emotional support for women in the community.

With over 69% of participants providing unpaid care work during the pandemic, it is essential to understand how lockdowns have affected their caring responsibilities. We found that over 60% of participants reported doing extra hours to perform care work, and 50% home-schooled children. In addition, 50% of all responses reported that they felt overwhelmed and demotivated to perform care work. Only two respondents reported that unpaid care work helped them mentally. Given that unpaid care work is predominantly provided to family members, we sought to understand how the lockdowns affected unpaid care work in relation to both housework and schooling. Eighty-three percent of women had experienced moderate to severe impacts in relation to care work due to the COVID-19 lockdowns. In comparison, 17% indicated that there was little impact on their caring role/s.

Women were also asked to elaborate on the impact of lockdowns on caring responsibilities. The key themes cited include juggling multiple caring roles and mental health impacts.



"If they can provide information in my language, that would be great so that we can protect ourselves"

*Participant not pictured

Case Study 4: Myint (57 years old), caring for three children and a husband with a disability

Myint has been living in Australia for two years and is a permanent resident. Being a newly arrived migrant, Myint has difficulty communicating in English. "We face many challenges. Even when we go to the hospital, we can't speak the language, so we have many problems," she said.

Myint has a pre-existing health condition that requires her to see a medical professional regularly. She is unemployed and receives Centrelink payments. During the lockdown, she visited a GP Clinic, a hospital, a specialist and a community health centre for treatment. Interpreters were not always available when she attended these health services. When she tried to find public health information online, Myint couldn't understand anything that was provided. Instead, she prefers to call her friend who speaks her language for health information and advice. "If they can provide information in my language, that would be great so that we can protect ourselves", she added.

As the primary carer in her family, Myint felt the increased burden of looking after her family and often felt overwhelmed and demotivated. "I'm looking after my three younger children with disabilities, and my husband also has a disability. It is a lot of work." She often couldn't leave her younger children and husband by themselves to run errands as they could not take care of themselves without support. Her eldest son would sometimes help her out but Myint often had to rely on support from friends for errands and transport because none of her family members has a driver's licence.

Juggling multiple caring roles

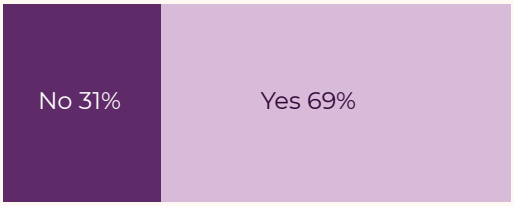
Women reported that they had a challenging and complex time trying to balance multiple and varied caring roles.

"It is hard to support your child with this home-schooling while you have another child to look after as well, not to mention the household chores too."

"I had to do the household chores like cleaning, cooking, washing etc., as usual. But, in addition to that work, I had to help my son with home-schooling. I was occupied from 7 am to 9 pm. I had to be with my son throughout the day while he was attending his school online. It took away a major chunk of my day, and my schedule was very disturbed, and I was busy all day. The online schooling made it very difficult for me."

"More cooking, more cleaning and the general increase in care for my family members. I consider looking after the women in my community who consider me their leader as a part of my caring responsibilities. I had to keep the lines of communication open, I would listen to their fears and concerns and provide moral and emotional support daily. I was working non-stop during the lockdown."

Chart 21: Provide Unpaid Care



"I had three seniors above the age of 70 with co-morbidities and two children 6 and 2 years respectively. I had to manage to home-school and take care of toddlers and medicines and other support required for seniors. My husband being the only one earning it was difficult to manage everything at home."

"I had to borrow the device from school and then learning the technology and learning system to support her education. This was more work than I had to do on top of my regular work. Also, to ensure that no one gets sick at home, I have to extra deep cleaning. Finally, keeping children busy at home and avoiding boredom, I had to spend more time with them to provide activities. I felt the COVID time was very demanding physically and mentally."

Chart 22: Persons Supported by Participants

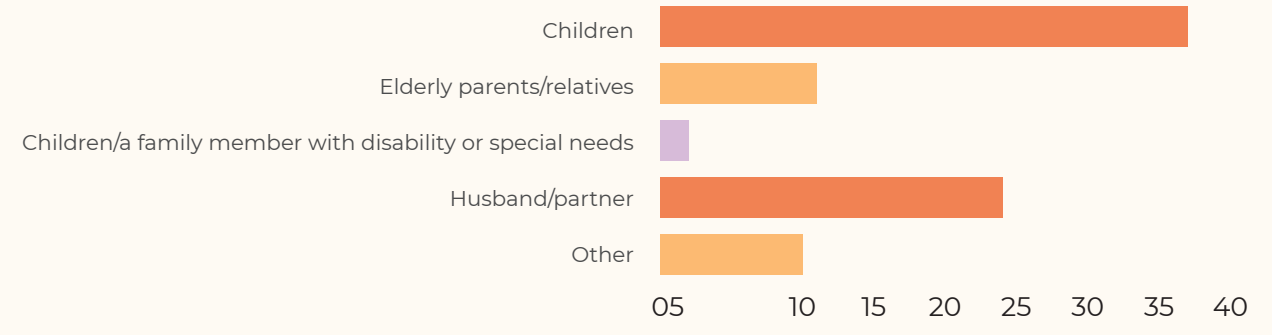
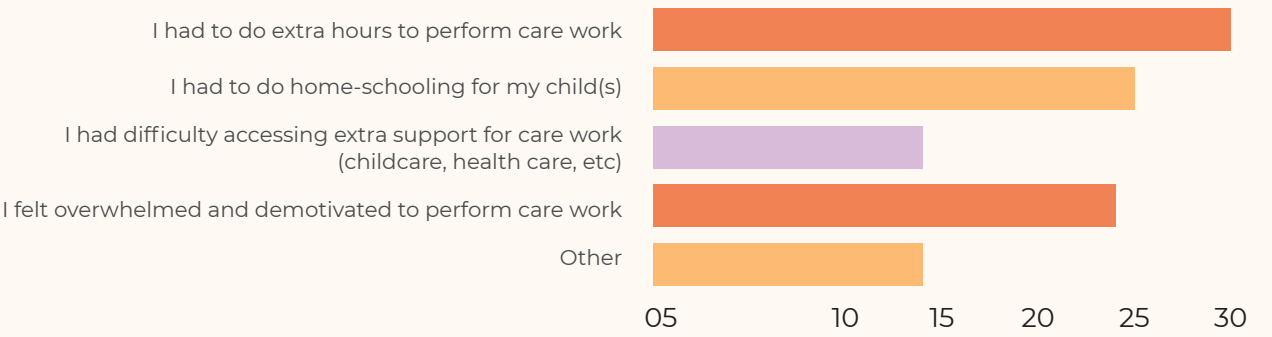


Chart 23: Effect of COVID-19 on caring responsibility



Mental health, COVID-19 and lockdown

Negative mental health impacts of COVID-19 and lockdown came through strongly in the qualitative data, with respondents reporting:

"I was physically, emotionally and psychologically tired."

"Baby becomes irritable as he can't go out, visit anybody, and I am stressed because of workload and all, so it was tough to look after everything on your own and thus mental health was extremely affected."

"We had to cancel special events, and we were isolated from friends and community, which was emotionally stressful and impacted my caring responsibilities."

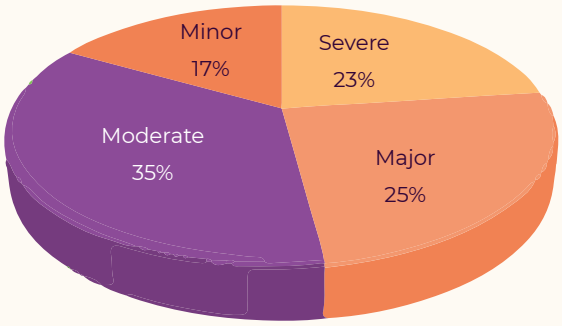
There was a strong connection between home-schooling and mental health impacts for some participants:

"Home-schooling, I really want to do great and perfect, but it [has] affected my mental health. I stopped caring for myself, just everything for children."

"Apart from working from home, I had to take care of all the people in my household, including myself. I never had this experience of being a teacher from Monday to Friday. I was becoming a teacher at home for my children and a nurse for my husband. I felt overwhelmed."

"I would say I am so overwhelmed with home-schooling and shifts and all that. It has totally broken my mental status. I am a writer and could not give any time to my own social activities and my writing or anything I was just so busy looking after my kids catching up on their homework looking after their mental health."

Chart 24: Perception on Overall Impacts of COVID-19 on Caring Responsibilities



Case Study 5: Aneela (29 years old) is on a student visa.

Aneela migrated to Australia with her two young children (10 and 3 years old) 18 months ago on a student guardian visa. Aneela's husband lives overseas and sends money to the family to pay for their living expenses "The financial aspect is the most important one being on student guardian visa. I do not have any work rights. My husband, who lives and works overseas, supports my children and me financially. Due to COVID-19, his business has been significantly impacted, which resulted in financial hardship for my family and me."

In addition to her financial worries, maintaining a relationship while living apart caused stress and anxiety for Aneela. She feels socially isolated and is reluctant to contact her friends and relatives back home for emotional support as they are also having a difficult time dealing with the impacts of COVID-19.

Aneela found home-schooling her children while completing her own education in a new country, physically and mentally demanding: "Being a sole carer in this country, everything is on me. During the period when people were bulk buying, I struggled a lot to get my essentials. I had a child who was adapting to home-schooling and not having a car relying on public transport or walk have to make several rounds for shopping to get what I needed. We were just learning and adapting to the education system and then the home-schooling for the children and me. I had to borrow the device from school and then learning the technology and learning system to support her education."

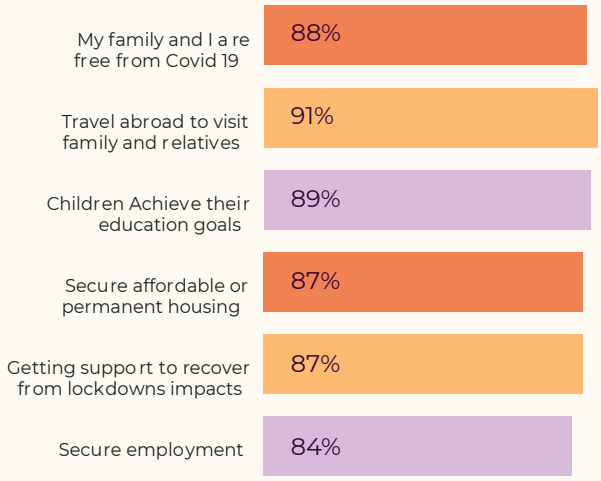
*Participant not pictured

4.4 Future Hope and Vision

Short, medium and long term goals

Participants were asked about their goals, supports needed to achieve their goals and their priorities as part of COVID-19 recovery.

Chart 25: Future Hope and Vision



The majority (91%) of women interviewed hoped to travel abroad to visit family and relatives, which shows that family reunification is essential for migrant and refugee women as many were separated from close relatives due to the COVID-19 international border closure. Many women (89%) also hoped for their children to achieve their education goals.

The third goal was for themselves and their family to be free from COVID-19. Fourth at an equivalent number, women wanted to secure affordable or permanent housing and get support to recover from the impact of lockdowns. In addition, 84% of women nominated secure employment.

Interview participants were then asked about their short-term, medium and long-term goals.

In the short term, women stated they wanted to achieve better health and wellbeing outcomes. These include regaining physical fitness, spiritual and mental health, being safe from contracting COVID-19 and free of the challenges relating to separation from friends and family during a pandemic. For two women, attaining safety and recovering emotionally from family violence was an immediate priority.

Ten women stated that receiving a COVID-19 vaccination was a high priority, one stating it is 'paramount that we are all healthy and vaccinated.' Some participants saw vaccination as associated with freedoms such as eased or abandoned lockdown restrictions, the ability to travel to visit family, and more job opportunities. Many women expressed a desire to be reunited with family overseas or interstate or to have their family come to Australia to visit or live. One participant described the importance of going back to their home country to visit, saying it would be 'a big emotional release'.

In the medium term, many women wanted to either finish their studies or for their children to finish theirs. They felt that obtaining an Australian qualification to secure employment was an essential factor in developing a sense of agency to plan one's future and career.

Clarity about visa status was on the wish-list for the many women living on a temporary visa. For these women, visa restrictions not only impacted their ability to access government supports, it also hindered their capacity to make long term plans and created a barrier for leaving an abusive relationship.

One women on a temporary visa and who is financially dependent on her husband, expressed feeling like 'a puppet with no choice or life of her own'. She has been separated from her parents, siblings, and extended family members who live overseas for seven years.

Half of the women interviewed stated finding a stable job as a long-term goal. Many also wanted to buy a house and reside in Australia more securely, free of the stresses and restrictions of being on a temporary visa. Many saw their exclusion from the rights and supports afforded to Australian citizens and permanent residents as discriminatory. As one woman stated, 'my husband has been paying taxes all his life but has never got care or support from the government.'

Women stated other goals such as improving English language skills and digital literacy skills, learning how to drive, saving and investing money, and growing their business. Many women saw these goals as a means to settling successfully in Australia.

Supports needed to achieve goals

We asked the participants what would assist them to achieve their goals to obtain better health and wellbeing, to find a secure job and reside in Australia with more ease. Short-term, participants stated that living in a society free of COVID-19 through COVID-safe practices and getting vaccinated would provide many benefits. For example, eased restrictions or no lockdowns were seen as a gateway to many positive impacts such as more access to jobs, improved mental health, and overseas and interstate travel to visit family.

In-language information and education

Many participants expressed the need for more accessible government information about the pandemic and the vaccine rollout.

Women felt that more could have done in relation to targeted, in-language communication in advertising and the media, especially in relation to supporting mental health: 'people have been depressed, committing suicide...government should put information in a different language or create positions for supporting people to access these services in their language.'

One woman reflected the view of several others suggesting that 'in-language information and support services [will] enhance service accessibility along with vaccination process to increase vaccination rate and trust on it.' And according to another, 'government need to build more trust, which can be only achieved by enhancing engagement with migrant and refugee community and making them feel like an important part of the nation and its economy.'

Most interview participants made clear that the provision of in-language health was not only one of the best ways to engender trust in the health system, it also encourages the active participation of women in the community:

"Women's participation at all levels is very important for diversity and change in the outlook of our future generations, who will give more importance to skills, knowledge than the gender-specific stereotypes."
"More projects like WoMHEn which help support migrant and refugee women support themselves and their communities."
'Appreciate inclusion of refugee women in the COVID-19 recovery plan and providing people who can deliver health information in my language. I hope that the government continues to provide us with more health educators as well as include us migrant people in all services, not just during the COVID-19 recovery plan.'

Equity in employment and support services

Many women stated that financial and social support to study and upskill would assist them and their communities to pursue better job opportunities. In addition, tailored programs and inclusive employment processes were also suggested so that migrant and refugee women can equitably participate in employment.

One woman stated,
'I want to have more support for mental health, also if that could happen without having further repercussion on my visa. COVID time has much more impact on people who have a temporary visa. I feel government need to acknowledge that and treat people on temporary visa fairly. Also, provide a little flexibility to be eligible for support".
Her comments speak to the desperate need for accessible mental health support that meets the specific needs of migrant and refugee women. As another woman suggested, 'in-language and culturally appropriate mental health support programs will help migrant and refugees background women recovery from COVID-19 impact.'

Women also shared their experiences of interpersonal and systemic racism and discrimination. For example, one woman stated that 'policy from the Australian Government to eliminate discrimination based on visa condition/migration status' would assist in more equitable outcomes for migrant and refugee communities. In the words of another woman who had difficulty finding a job,

'I want the average Australian to look past any accent, or the lack of 'Aussie' accent and actually tap on our experiences. More jobs that migrant women can take up are not just a tick in the box to say that something has been done for us. We want to contribute long term and not just be part of an unsustainable project. To be properly integrated into the society, we need to be part of the workforce.'

The women interviewed also expressed that learning English, free or subsidised childcare, sponsorship by an Australian business, and in some cases, escaping family violence were substantial factors in achieving their goals. For one woman, the aim was to 'leave our home and move to a safe and comfortable dwelling for myself and my children.'

Overall, migrant and refugee women wanted to be granted equal rights and opportunities in Australia as they saw this as the first step in being able to achieve their goals. As one woman put it, 'if we get equal opportunity, we can achieve what we want.'

What governments need to know

We asked the participants what they thought government needed to know to ensure migrant and refugee women's needs were met during the COVID-19 recovery stage. In offering their recommendations, many stated that migrant and refugee women need more support and should have the right to access all Australian services. They expressed some of the unique challenges they face, such as their pre-arrival experiences and histories of trauma, living in a foreign country, juggling family responsibilities with little support, and accessing services with limited or low English language proficiency. Around one-third of the women expressed wanting to be treated fairly and respectfully in Australian society. One woman stated, 'the government must also look up to those on a temporary visa. I believe we are still important in Australia's economic growth since we are paying our taxes'.

Migrant and refugee women also said they want to be informed about COVID-19 and receive the best resources to help protect themselves, their families, and their communities. However, there are barriers to accessing this information. For example, little or no digital literacy skills, or limited access to digital technology, have affected how some women access information about the pandemic. Many women identified the need for more access to interpreters and information in their language, written, visual, audio and video, showing that information distribution in the English language is not sufficient for conveying crucial public health messages. Some women suggested the need for more in-language workers and delivery of health education sessions because as one woman stated 'they are helping a lot especially those migrants who are struggling to communicate due to language barrier'.

Furthermore, women urged that the messaging must be consistent in order to instil a sense of trust in the government's management of the pandemic. Women highlighted the importance of governments listening to migrant and refugee voices through direct engagement with communities to facilitate trust and build connections.

Government consultation and co-design with communities to learn about migrant and refugee women's needs were also suggested as a helpful starting point for addressing the needs of communities. As one participant stressed, the needs of migrant and refugee communities cannot be met using a 'one-size-fits-all approach' as 'everyone has a different experience' and that governments need to understand the complexity within and across different communities before designing and implementing a program. This need for tailored, culturally responsive services and support was clearly articulated by a woman who shared her experience of escaping a violent relationship:

"The police weren't empathetic with what I was going through...people do forget the struggle and journey that migrant and refugee women go through. Have a better understanding the cultural awareness, how to communicate and messages with women from that background.'

Many of the participants also stated that migrant and refugee women need financial assistance, support for their small businesses, job and educational opportunities that do not require costly and extensive training, better access to mental health services, and greater acknowledgment of the transferable skills and cultural value that migrant and refugee people add to the broader Australian community. As one woman commented, 'there needs to be more thought in terms of the extra issues migrant and refugee women face on top of the ones the general population face because we are getting left behind.'

Pictured: Health educators employed as part of the WOMHEn project

5. One Step Ahead: WOMHEn Project and Vaccination Health Education

During the delivery of WOMHEn Project, health educators and services identified a lack of in-language vaccination information was creating barriers to migrant and refugee women taking up opportunities to protect themselves against COVID-19. Mainstream English-language messages about the right vaccination to take while on fertility treatment, pregnant, while breastfeeding, experiencing menopause and other stages of sexual and reproductive life for women were confusing and were further complicated by a lack of translated information in languages other than English.

Vaccination uptake amongst migrant and refugee communities is a practical demonstration of the impact of intersectional gender inequity – multiple attributes of sex, gender, race, cultural and religious identity and socio-economic disadvantage – combining and compounding to entrench disadvantages.

Background

Vaccine hesitancy amongst women is not new. Vaccine hesitancy amongst some cohorts of women in Australia was a concern prior to the pandemic with childhood immunisations impacted by the choices made by maternal parents leading to No Jab No Play policies and other health strategies to build compliance and confidence with infant immunisation . Women from low socio-economic communities with limited access to services, childcare and public transport have been identified as one group at risk of vaccine hesitancy as well as women with high usage of alternative medicine and wellness industries who conscientiously object. The lack of tailored health information and messaging has identified higher vaccine hesitancy amongst Australian women compared to men. If women from English speaking backgrounds are expressing concern about the interaction of the vaccine with their reproductive health, including pregnancy, fertility and breastfeeding, there is no doubt that this hesitancy is magnified within migrant and refugee communities. There is a need for a mechanism for migrant women to access up to date information in their languages on these topics.

Addressing vaccine literacy and health service navigation amongst migrant and refugee women.

Reaching migrant and refugee women and women in low socio-economic areas through the provision of online resources or digital resources alone will not address vaccine hesitancy. Instead, face to face, place-based in-language support where Migrant and refugee women live and work and play in their own communities.

Community development within intimate settings is critical to reach migrant and refugee women. Service providers have stated their concern that people who have lower proficiency in English are accessing vaccination at significantly lower rates than the rest of the population. Supporting women to book in appointments, balance childcare responsibilities and other caring responsibilities is essential to a COVID-19 recovery. Community vital health information in language is essential.

It is recognised by the World Health Organisation that access to healthcare services including vaccination is more difficult for migrants. Many immigrant communities experience lower immunisation rates and a higher burden of vaccine-preventable diseases than host populations. Xenophobia (real or perceived) in the host nation may render some migrants both reluctant to vaccinate. Among many immigrant parents and families, vaccine hesitancy is largely associated with fears and misinformation about vaccine harms, limited knowledge of both preventable diseases and vaccines, distrust of host countries' health systems and their attendant intentions, language barriers, and perceived incompatibility between vaccine uptake and migrants' religion.

International research has shown that there is a need to build up public trust and con-

fidence among women in particular, and that this role cannot be left to health service providers and government officials alone as it will not be effective.

"For those who do not follow COVID-19 news through any media and have high vaccine reluctance, alternative communication methods are needed. Lessons learned from previous new vaccine roll-out including human papillomavirus (HPV) vaccine roll-out and Ebola vaccine trial field experiences have all underscored the importance of community work with sensitivity toward country, local and subgroup specific culture contexts."

WOMHEn educators are addressing vaccine hesitancy

The WOMHEn workforce is addressing vaccine hesitancy amongst migrant and refugee communities. The following intimate case studies across Victoria explain how:

Loddon Mallee

In recent vaccine health education sessions provided to women members of the Karen community in the State's Far North west, WOMHEn educators embedded in Women's Health Loddon Mallee succeeded in engaging 90 per cent of women training participants to book vaccinations online, supporting women connect across families to provide support to care for children and attend vaccination hubs together after the training session.

Women's Health Loddon Mallee Bendigo team also partnered with Bendigo Community Health to staff a dedicated health information hotline in Karen language. The "Karen Hotline" enabled members of the Karen community to book a dedicated vaccination day at the health service. WOMHEn bilingual educators assisted interpreting services on the mass vaccination day. 120 members of the Bendigo Karen – women and men – were vaccinated on the day.

In the central west

Women's Health Grampians (WHG) conducted community consultations with approximately 650 migrant and refugee people, who cited the distance to the closest vaccination centre as a as a significant barrier to vaccine uptake. WHG, Department of Health and the Ballarat Regional Multicultural Council partnered to organise 3 conveniently located pop-up vaccination centres in the region. To date, 55 people from the Karen speaking community and 13 people from other communities have been vaccinated at the Nhill vaccination hub. Across the pop-up vaccination centres, approximately 100 people have been fully vaccinated, 80 people have received their first vaccination, almost 50 people booked in for first vaccination.

In the inner west

Women's Health West organised pop-up clinic vaccination for a particularly isolated group of women from Pakistan utilising a private WhatsApp group as the women could not use video-conferencing facilities. On 20th September, 80 women from this community will be getting vaccinated by Western Health at their place of worship in Ravenhall. In addition, WHW has helped 140 men from this community secure vaccine appointments at the Melton Hub on 20th and 21st September.

In the south east

Women's Health in the South East WOMHEn educators have delivered 14 sessions to 127 women from Southern Melbourne Area in Tamil, Dari, Hindi, Punjabi and English. These sessions have reduced vaccine hesitancy informed and provided information to women on how to book in for a vaccine. The sessions have also provide opportunities for specific cultural concerns to be addressed including the ingredients in vaccines (eg. Are they halal friendly? Do they contain animal products?) and what impact vaccines would have on pre and post pregnancy including breast feeding. There is a growing concern in the women that WHISE are engaging with about the impact of vaccine on unborn children and what the risks are to young children who the government is keen to get vaccinated.

Evaluation results indicate a marked increase in vaccine confidence in the women that attend as a direct result of our targeted community-based information sessions.

- 80% of participants more likely to book in a vaccination as a result of the session
- 93% of women felt more informed as a result of the sessions
- 70% of women rated themselves extremely confident to get the vaccine, and 30% rated themselves as very confident to get the vaccine as a result of our sessions

The women from our community have told WHISE that they found the group discussions helpful as it provided the opportunity to have some of the "myths" of vaccine addressed. The relaxed in language approach beneficial to understanding the vaccine and be more comfortable with the process to book for a vaccine.

“It was nice to be with other women and know that I wasn’t the only one with these concerns... I felt better after attending the session and will share these learnings with my family” - Gayatri

Of all the sessions that the WHISE team has run, the session held with a group of migrant women from Afghanistan who had significant low level of English literacy demonstrated most powerfully the need for bicultural women workforce of health educators. Because the session was run in language (Dari) was women only and a safe space, it empowered these women, new to Australia with minimal understanding of our health systems and services, the ability to access COVID-19 vaccine and information.

Migrant and Refugee women reached through the WOMHEn Project

The workforce of bi and multi-lingual health educators span across Victoria, with key cultural and linguistic cohorts targeted in each region.

South East Victoria (Women’s Health in the South East)
- Punjabi
- Hindi
- Urdu
- Northern India
- Pakistan
- Tamil
- Sikh

Eastern Metropolitan Victoria – (Women’s Health east)
- Mandarin
- Hakha Chin (a Burmese language)

Northern Metropolitan Victoria (Women’s Health in the North)
- Indian (general)
- Punjabi
- Pakistani
- Tamil (Indian and Sri Lankan)
- Arabic (Middle Eastern)

Western Metropolitan Victoria (Women’s Health West)
- Indian
- Nepali

Loddon Mallee Region (Women’s Health Loddon Mallee)
- Karen Community
- Filipino

Grampians Region (Women’s Health Grampians)
- Islamic
- Punjabi
- Vietnam
- Filipino
- African and South-Sudanese
- Karen

Gippsland Region (Women’s Health Gippsland)
- Filipino
- Muslim women
- Indian

Statewide – MCWH
- Chinese
- Filipino
- Vietnamese
- Arabic
- Dinka
- Hindi
- Tamil
- Punjabi
- Dari

The WOMHEn Project Team

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Women's Health Services
Gippsland Women's Health
Multicultural Centre for Women's Health
Women's Health and Wellbeing, Barwon South West
Women's Health in the East
Women's Health Grampians
Women's Health Loddon Mallee
Women's Health in the North
Women's Health in the South East
Women's Health Victoria
Women's Health West

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Madhuri Sameera
Malavika Kadwadkar
Mary Edward
Megha Gupta
Mura Htoo
Nabila Yusof
Naomi King Bol
Neha Gogia
Nilaufer Singh
Paw Paw Nway Moo
Quynh Trahn
Rachel Kar Yee Chung
Rebecca Bol
Resayna Tu
Salma Hasan Subhani
Shazia Syed
Shu La Ma
Shweta Kawatra
Sohaila Safdari
Sui Cin Zah
Sui Ram Lawt
Sumira Chhabra Gambhir
Tam We Paw Noe
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Trishula Nagarajan
Wendy Liu
Xiaohua Jia (Jane Brierty)

WOMHEn

Workforce of multilingual health educators

Appendix

Appendix I – Interview Questions

Interview Questions

Interviewer Script (for filling in the demographic data):

In this section we ask for information about your background – your family, cultural background, visa status and about your education and current work.

This information will be kept strictly confidential. You can decide what you feel comfortable telling us. You do not have to answer all questions.

The questions aim to build a picture about you, your family and background. It will help us better understand what types of support are needed for migrant women during a COVID-19 response and recovery. For example, we may link some of what you tell us about yourself to the interview questions that follow, to better understand your specific experience.

Do you have any questions before we begin?

A. Participant's Demographic Data

1. Participant pseudonym:
2. Age (in years):
3. Country of birth:
4. Gender identity:
5. Preferred ethnic/cultural identity:
6. Language spoken at home:
7. Presence of disability:
8. Religious preference:
9. Length of time in Australia:
10. Citizenship: ☐ Australian Citizen ☐ New Zealand Citizen ☐ None of the above
11. Residency status: ☐ Permanent Resident
☐ Temporary Resident / Visa Holder - Type of Visa (Please specify)
12. Relationship status: ☐ Single ☐ Married ☐ De Facto Partnership ☐ Widowed ☐ Separated ☐ Divorced
13. Do you have children? ☐ Yes – continue to question No. 14
☐ No – Continue to question No. 16
14. How many children do you have? ☐ 1 ☐ 2 ☐ 3 ☐ More than 3
15. How old are your children? (Please specify) ……
16. Do any relatives live with you?: ☐ No ☐ Yes – (Please specify) ……..
17. Education Level completed: ☐ None ☐ Primary ☐ Secondary ☐ Vocational ☐ University Degree (Please specify) ……

B. Health and Well-being

In this section we would like to understand what impact the COVID-19 pandemic and lockdowns have had on the health and well-being of migrant and refugee women and their families. For example, the participant may have pre-existing health conditions and needed to access healthcare during the pandemic, however it was difficult due to lack of information and/or language barriers. The participant may have been confused about the various COVID-19 government directives and perhaps they have suggestions for how government messaging could be improved.

*(**Prompts if needed:** the impacts of COVID-19, existing health conditions, knowledge about and access to healthcare services and COVID-19 information, Victorian Government communication, suggestions to government to help to improve your health and well-being).*

Questions:

18. What impact has COVID-19 had on your family?
    ☐ Severe ☐ Major ☐ Moderate ☐ Minor

19. Could you please tell us why it had this impact?

20. Do you have a pre-existing health condition?
    ☐ Yes – (Please describe) ……..

    ☐ No

21. Did you need to access health care during the lockdowns?
    ☐ Yes – Continue to question No. 22
    ☐ No – Continue to question No. 24
22. Which health care services did you access? *(Tick applicable boxes)*
    ☐ GP Clinic ☐ Hospital ☐ Community Health Centre

    ☐ Specialist ☐ Dentist ☐ Others Describe ……..

23. How was your experience in accessing health care services during the COVID-19 pandemic?

24. How did you access the public health information about COVID-19? *(Tick applicable boxes)*
☐ TV ☐ Radio ☐ Internet ☐ Newspaper ☐ Community health educators

☐ Friend/family member ☐ Community member

☐ Other – (Please specify) ……

25. Could you please tell us more about why you accessed health information about COVID-19 that way?

26. How well do you think the Victorian Government has communicated messages about COVID-19?
☐ Very Well ☐ Well ☐ Neutral ☐ Poorly ☐ Very Poorly

27. Have messages about income support, lockdown measures, social distancing, vaccination etc. been clear to you? If not, why? How do you think the messaging can be improved?

C. Economic Situation

In this section we are interested to understand more about how migrant and refugee women's economic situation has been impacted by the COVID-19 pandemic.

For example, perhaps the participant lost work during the lockdowns which caused both financial and emotional stress. Perhaps the participant did not know how to access supports because they did not know about them.

*(**Prompts if needed:** knowledge of support services available, financial responsibilities, updating skills and training, financial stress, relationship/family dynamics).*

Questions:

28. What was your employment/income status **before** the COVID-19 pandemic?
    ☐ Full-time employed ☐ Part-time employed ☐ Casually employed
    ☐ Self-employed ☐ Reliant on partner's income
    ☐ Unemployed – no income ☐ Unemployed – Centrelink payments
    ☐ Other – (Please specify) ……..

29. What impact did the COVID-19 pandemic and lockdowns have on your employment? *(Tick applicable boxes)*
    ☐ None
    ☐ My work hours were reduced and I had up to 50% less work
    ☐ My work hours were reduced more than 50%
    ☐ I lost my job
    ☐ I was unemployed and it was harder to find a job
    ☐ Other – Please specify ……

30. What is your employment/income status **now**?
    ☐ Full-time employed ☐ Part-time employed ☐ Casually employed
    ☐ Unemployed – no income ☐ Unemployed – Centrelink payments
    ☐ Other – Please specify ……

31. Were you employed as an essential service worker during lockdowns?
    ☐ Yes, continue to the next question

    ☐ No, continue to the question no. 33.

32. In what sector were you employed
    ☐ Health care ☐ Education ☐ Food & beverages ☐ Retail ☐ Other – Please specify ……

33. What hardship(s) did you experience as a result of lockdowns and the COVID-19 pandemic? *(Tick applicable boxes)*
    ☐ Physical health related ☐ Mental health related ☐ Financial ☐ Rent or housing

    ☐ Family separation

    ☐ Others – Please specify…….

34. Were you aware of any Government initiatives or supports that were available to you during the COVID-19 lockdowns?
    ☐ Yes – *Please continue to the next question*

    ☐ No – *Please continue to question No. 37*

35. Have you benefited from any of the below COVID-19 supports offered by Government or other organisations? *(Tick applicable boxes)*
    ☐ Rent relief grant ☐ JobSeeker ☐ JobKeeper

    ☐ Emergency relief fund ☐ Material aid supports

    ☐ Early access of superannuation ☐ Mortgage holidays

    ☐ Other – Please describe ……

36. Please describe your experience in accessing those supports? *(e.g positive experience, challenges or hurdles, etc.)*

37. What kind of other support did you need during the COVID-19 pandemic and lockdowns?

D. Unpaid Care Work

In this section we would like to understand how the lockdowns affected migrant/refugee women's caring and household responsibilities. We would like to get an insight into how migrant and refugee women could be better supported in their unpaid work/domestic labour

*(**Prompts if needed:** childcare issues, homeschooling, housework and household duties, family members with special needs, emotional support, knowledge of support services).*

Questions:

38. Did you provide any (unpaid) care support (including housework) to children/family members/relatives during the lockdowns?
    - ☐ Yes – *please continue to the next question.*
    - ☐ No – *please continue to section E*.

39. To whom did you provide your care work (including housework)?
    - ☐ Children
    - ☐ Partner
    - ☐ Elderly parents/relatives
    - ☐ Children or Family member with disability/special needs
    - ☐ Other, please describe ……

40. In what way have the lockdowns and COVID-19 affected your caring responsibility? *(Tick applicable boxes)*

☐ I had to do extra hours to perform care work

☐ I had to do home-schooling for my child/children

☐ I had difficulty accessing extra support for care work (child care, health care, etc.)

☐ I felt overwhelmed and demotivated to perform care work

☐ Other – please describe

……..

41. Overall, what impact have the lockdowns had in relation to your caring work (housework, home-schooling)?

☐ Severe ☐ Major ☐ Moderate ☐ Minor

42. Could you please tell us why the lockdowns had this impact?

E. Future Vision

In this section we look to the future. We are interested to know what goals migrant and refugee families hope to achieve in the COVID-19 recovery stages, what would help them to achieve these goals, what their priorities are. We encourage the participant to share any opinions about what they think the government needs to know with regard to improving the health and well-being of migrant and refugee women during and post pandemic.

Questions:

43. What goals would you like to achieve for yourself and your family in the near future?

44. What would help you to achieve these goals?

45. Which are the most important things for you in relation to your future hopes and visions?
(Please rank each item from 1-6, 1 being the most important to 6, the least important)
    a. My family and I are free from COVID-19
    b. Travel abroad to visit family and relatives
    c. Secure employment
    d. Children achieve their education goals
    e. Secure affordable or permanent housing
    f. Getting support to recover from lockdowns impacts
    g. Other – describe ……

46. What do you think the Government needs to know to make sure migrant and refugee women's needs are met during the COVID-19 recovery?

47. Are there any other comments that you would like to add?

Concluding the Interview:

- *Thank them for sharing their experiences, and for their ideas for any improvements that could be made as we will use this information to advocate for migrant and refugee women's employment, health and well-being at this time.*
- *Ask if they would like a follow up phone call to see how they are after the interview – record on demographic form.*
- *Ask if they have any questions or other things that they would like to add or share.*
- *Let them know you will be in touch to check the information captured is accurate and includes everything they wish to tell us.*
- *Check if they would like to review the final report before it is finalised and record on consent form.*
- *Finalise details for distributing the gift voucher.*