FULL REPORT

COMMON THREADS

THE SEXUAL & REPRODUCTIVE HEALTH EXPERIENCES OF IMMIGRANT & REFUGEE WOMEN IN AUSTRALIA

Multicultural Centre for Women's Health
Putting Immigrant & Refugee Women's Health First

FULL REPORT

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WRITTEN BY MARIA HACH

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ACRONYMS

ABS	Australian Bureau of Statistics
AIDS	Acquired immune deficiency syndrome
AIHW	Australia Institute of Health and Welfare
BHE	Bilingual Health Educator
DoHA	Department of Health and Ageing
DIAC	Department of Immigration and Citizenship
EAG	Expert advisory group
FARREP	Family and Reproductive Rights Education Program
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
GP	General Practitioner
HIV	Human immuno-deficiency virus
ICPD	International Conference on Population and Development
IUD	Intrauterine device
MCWH	Multicultural Centre for Women's Health
NESB	Non-English speaking background
OSHC	Overseas Student Health Cover
RTI	Reproductive tract infection
SAPCRU	Southern Academic Primary Care Research Unit
SRH	Sexual and reproductive health
STD	Sexually transmitted disease
STI	Sexually transmitted infection
UNDPI	United Nations Department of Public Information
WHO	World Health Organisation
WWH	Working Women's Health

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EXECUTIVE SUMMARY

Australia is one of the world's most culturally diverse nations. The latest Census revealed that over a quarter (26 per cent) of Australia's population was born overseas and a further one fifth (20 per cent) had at least one overseas-born parent (ABS, 2012). Migration continues to be the major component of population growth in Australia, adding an additional 170, 300 persons to Australia's total population in 2010-2011 (DIAC, 2012a).

Women from non-English speaking backgrounds born overseas, or with one or both parents born overseas, comprise a significant proportion of the total Australian female population.[1] Immigrant and refugee women have poorer health outcomes and are at greater risk of developing adverse health conditions than Australian-born women. Furthermore, immigrant and refugee women are less likely than Australian-born or English-speaking women to take health related action when ill. While health services have responded to the increase in diversity by implementing culturally appropriate strategies, these strategies do not adequately address the complex and various social determinants of immigrant and refugee women's health.

Research consistently demonstrates that social determinants strongly correlate with health outcomes. In general, the lower an individual or group's social status, the lower their access to health related information and services. For immigrant and refugee women, the negotiation of their sexual and reproductive health is compounded by a number of factors including migration, gender and cultural norms, low English proficiency and other structural barriers.

The Common Threads project explores the sexual and reproductive health experiences of immigrant and refugee women in four selected populations: Chinese, Indian, Middle Eastern and Sudanese. Through the use of focus group discussions and key stakeholder consultations, seven main themes that influence immigrant and refugee women's sexual and reproductive health are identified. The key findings from these discussions are as followed.

Accessibility of information and services

Sexual and reproductive health information and services are not easily accessible for immigrant and refugee women living in Australia. This is partly due to the fact that women find the Australian health system difficult to navigate and have a lack of understanding about what services are available to them. As a result, women may have limited sexual health literacy.

Gender and cultural norms

Gender and cultural norms impact attitudes and practices towards sexual and reproductive health, as well as health outcomes. Stakeholder consultations highlight that there is a tendency for health professionals to stereotype and make particular assumptions about immigrant and refugee clients, both in the context of health and more broadly.

Pre-migration & migration experience

Immigrant and refugee women's experiences with health services in their countries of origin have an impact on the way they perceive health services in Australia. For some refugee women, past experiences of war, violence, and trauma have a profound impact on their sexual and reproductive health. Furthermore, as women are faced with competing settlement priorities, their sexual and reproductive health needs are often neglected in Australia.

Mental health

Migration and settlement is a particularly difficult and isolating experience, especially for women who have given birth shortly after migrating. Evidence suggests that immigrant and refugee women are at a greater risk of perinatal mental health issues because of certain aspects of their migration experience and the challenges associated with the resettlement process.

Violence against women

Immigrant and refugee women recognise that violence is an issue in their communities; however they have limited knowledge about available support services. Findings demonstrate a need for more culturally appropriate education and violence prevention programs for immigrant and refugee communities.

[1] The Multicultural Centre for Women's Health refers to its target group as immigrant and refugee women. This term is used often in the report, however I do acknowledge alternative terminology, such as non-English speaking background (NESB), culturally and linguistically diverse (CALD) and ethnic.

Socio-economic position

Immigrant and refugee women often have a lower socio-economic position, which limits their sexual and reproductive health choices. Women expressed the difficulties in accessing services due to the costs involved. This includes health services, but also services such as child care.

Practical issues

Accessing culturally and linguistically appropriate healthcare is an issue for immigrant and refugee women. Accessing trained interpreters with appropriate language skills is crucial, but is not common practice.

By examining the challenges that immigrant and refugee women face in accessing sexual and reproductive health services, a number of recommendations are made for the improvement of health services.

Recommendations include:

- Embedding a social determinants and gender equity framework in approaches toward national policies that impact immigrant and refugee women's health.
- Developing a best practice guide for working with immigrant and refugee women in the area of sexual and reproductive health.
- Developing and implementing gendered, cross-cultural approaches and initiatives within health services nationally.
- Making available multilingual information and resources about sexual and reproductive health in a range of media.
- Funding for women's services, in particular immigrant and refugee women's services is retained and increased.
- Creating partnership programs between mainstream services and immigrant and refugee communities as well as ethno-specific services and multicultural organisations.

The Common Threads research represents an important opportunity to understand more about the various issues that immigrant and refugee women face in accessing culturally appropriate healthcare. Inequities in health put immigrant and refugee women at further disadvantage, diminishing opportunities for wellbeing and overcoming other effects of social disadvantage. The promotion of a holistic model of care that values women's experiences, knowledge and culture should be at the core of health service provision.

A best practice guide titled *Common Threads, Common Practice: working with immigrant and refugee women in sexual and reproductive health*, has also been developed from this research. The Guide aims to provide community and health practitioners with a framework to understand and promote best practice in the delivery of services for immigrant and refugee women in Australia.

CHAPTER 1: BACKGROUND

1.1 BACKGROUND TO COMMON THREADS: WHY IS THIS RESEARCH IMPORTANT?

The Multicultural Centre for Women's Health (MCWH) is a national, community-based organisation committed to the achievement of health and wellbeing for and by immigrant and refugee women. Its mission is to promote the wellbeing of immigrant and refugee women across Australia through advocacy, social action, multilingual education, research and capacity building. All of MCWH's activities are informed by human rights, feminist, and community development principles of non-discrimination and empowerment.

In May 2000, MCWH (then known as WWH) was granted funding from the Commonwealth Department of Human Services to conduct research into the sexual and reproductive health of women from non-English speaking backgrounds (NESB). The findings from the research were published as a report called *Knowing Her Better: a Research Report about NESB Women's Sexual and Reproductive Health*. It describes the experiences of women from three different cultural groups: Turkish, Spanish and Vietnamese. The report and manual were based on consultations with immigrant and refugee women and with health professionals who work with diverse communities. The resultant resources were used to provide the framework for *Knowing Her Better,* a cross-cultural training program which was offered by the Centre. The research was pertinent in understanding the issues and concerns of immigrant and refugee women in relation to their sexual and reproductive health at that time.

Since *Knowing Her Better* was published in 2000, the demographic and circumstances of the migrant and refugee population have changed in Australia. There has been an increase in the number of refugees and humanitarian entrants, in addition to migrants entering Australia on family, skilled and international student visas. Temporary migration is also on the rise. In 2007-2008 there were more temporary visas issued than permanent visas (Oke, 2002; Collins, 2011) and in 2009, 42.1 per cent of all temporary immigrants were international students (Hugo, 2009).

Reflecting the change in migration patterns, the 2011 Census revealed that there are increasingly more Australians who were born in Asia and other parts of the world. The proportion of the overseas-born population originating from Europe has been in decline in recent years, from 52 per cent in 2001 to 40 per cent in 2011 (ABS, 2012).

Despite Australia's relative wealth, many Australian women experience poor health outcomes and a lower quality of life. With the added layer of migration, immigrant and refugee women have generally low socio-economic status and limited English, making it difficult to access sexual and reproductive health services. They may also have to negotiate various social and cultural norms (including those of their own culture and their new country) that influence their sexual and reproductive health choices.

A literature review of the sexual and reproductive health of immigrant and refugee women reveals that the themes identified more than a decade ago in *Knowing Her Better* remain significant issues for immigrant and refugee women in Australia today.

While the Australian health system has taken good steps in responding to the changes in migration by implementing cultural competency strategies, the challenges of access and engagement with diverse communities cannot be met with these strategies alone. This is because mainstream cultural competency initiatives generally take a 'one approach fits all' attitude to diversity and often focus on individual risk factors related to physical health. An approach to cultural difference should also consider the social determinants of health including migration experiences, education levels, income, and cultural and gender norms. The approach should be grounded in the principle of 'distributive justice' and human rights - that is, focusing attention on the distribution of resources and other processes that enable a particular kind of health inequality between social groups (Braveman & Gruskin, 2003).

The Australian Federal Government shares responsibility for health policy and funding with state and territory governments. The most significant national strategy addressing women's health and sexual and reproductive health is the National Women's Health Policy which was developed in 2010. The Policy outlines five goals, including prioritising 'the needs of women with the highest risk of poor health' (DoHA, 2010). Women from culturally and linguistically diverse backgrounds are explicitly stated and discussed in relation to this category. The Policy recognises that immigrant and refugee women are in need of more equitable health approaches that take into account the broad range of factors that influence women's health and wellbeing.

While there is a dearth of national level data on the issues outlined in this report, the literature that is available provides solid evidence of the challenges faced by immigrant and refugee women in accessing culturally sensitive sexual and reproductive health services. The issues discussed in this report have been raised previously: both in *Knowing Her Better* and in similar research conducted about immigrant and refugee women's health (Allotey et al, 2004; Brewer, 2009). The re-emergence of the same themes is a matter of concern and raises a critical question: what can be done differently to ensure optimum health outcomes for immigrant and refugee women in Australia?

1.2 COMMON THREADS

> "We should know that diversity makes for a rich tapestry, and we must understand that all the threads of tapestry are equal in value no matter what their colour."
> *Maya Angelou (American author & poet)*

Sexual and reproductive health is influenced by a number of complex factors. While sex is biological, ideas pertaining to sexuality and reproduction are cultural phenomena shaped by social and cultural structures such as religious values, gender roles and familial expectations (Gifford & Temple-Smith, 2005). Studies have shown that the pre-migration experience of immigrant and refugee women, their gender and cultural norms, structural inequalities and the individual difficulties they face in a new country, all contribute added layers of complexity to their negotiation of sexual and reproductive health. Moreover, often when women do access health services, their needs are not being met as services are not set up to cater for their individual circumstances.

As the quote by Maya Angelou posits, diversity is what makes a society rich and vibrant. Cultural diversity and multiculturalism are characteristic of Australian society, but often refugee and immigrant women's experiences remain untold, as they have limited opportunities to share their stories. The Common Threads project is inspired by the notion that every woman has a valuable story to tell. Her migration and subsequent health experience in Australia is an individual and personal one, however common issues and themes occur in the lives of immigrant and refugee women. Furthermore, the experiences of women can contribute to more responsive health policies and services.

Common Threads is based on a strong belief that through mutual understanding and reciprocity, equity for immigrant and refugee women in the area of sexual and reproductive health can be achieved. Inequities in health put groups of people who are already socially disadvantaged at further disadvantage with respect to their health.

Equity, as opposed to equality uses a social justice or fairness approach that is based on principles of 'distributive justice' (Braveman & Gruskin, 2003).

It implies that resources are distributed and processes are designed in ways most likely to move toward equalising the health outcomes of disadvantaged groups with the outcomes of more advantaged groups. This refers to the distribution and design of all resources, policies, and programs that play an important part in shaping immigrant and refugee women's health (Braveman & Gruskin, 2003).

Therefore, to tackle health inequities, the health system must not only improve the services available to migrant and refugee women, but must also address the social determinants that lead to particular health outcomes.

1.3 PROJECT OBJECTIVES

The purpose of Common Threads is to understand the various factors that influence immigrant and refugee women's sexual and reproductive health, and to create awareness around the types of multi-layered challenges that immigrant and refugee women face in this area. The project:

- ✓ Examines the issues, concerns, needs and experiences of immigrant and refugee women in terms of sexual and reproductive health;
- ✓ Identifies the barriers and enablers for immigrant and refugee women in accessing sexual and reproductive health services;
- ✓ Analyses how gender, power differentials and economic and cultural factors impact knowledge, attitudes and practices in regard to sexual and reproductive health for immigrant and refugee women in Australia.
- ✓ Provides recommendations for the improvement of sexual and reproductive health services for immigrant and refugee women in Australia.
- ✓ Develops a best practice guide for working with immigrant and refugee women in the area of sexual and reproductive health, based on the findings of the research.

CHAPTER 2: INTRODUCING THE ISSUES

2.1 SEXUAL AND REPRODUCTIVE HEALTH

Sexual and reproductive health (SRH) is influenced by complex biological, psychological and social factors. While for much of the last century, SRH was constructed as simply the absence of disease, the International Conference on Population and Development (ICPD) held in Cairo in 1994 marked the acceptance of a new paradigm in addressing human reproduction and health (Shalev, 1998).

Unlike previous population conferences, the Cairo conference reflected the growing awareness that population, poverty, health, education, patterns of production and consumption and the environment are all inextricably linked (Glasier et al, 2006). This shift paved the way for an emergence of an evolving discourse about the connection between health, rights, social justice and women's empowerment.

A comprehensive range of reproductive health conditions and processes were also included in the Cairo Declaration. These are summarised in the box below.

BOX 1

THE CAIRO DECLARATION'S DEFINITION OF REPRODUCTIVE HEALTH

"Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and freedom to decide, if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely the counselling and care related to reproduction and sexually transmitted diseases."

(Reference: UNDPI, 1995)

BOX 2

REPRODUCTIVE HEALTH CONDITIONS & PROCESSES IN THE CAIRO DECLARATION

- Family planning including decision making about family size (such as number, spacing and timing of children), unwanted pregnancy, and abortion (including prevention of abortion and management of adverse effects)
- Infertility
- Pregnancy including prenatal and postnatal care, safe delivery, breast feeding and care of the newborn infant
- Safe motherhood
- Responsible parenthood
- Sexually transmitted infections (STIs) - previously known as sexually transmitted diseases (STDs)
- Reproductive tract infections (RTIs)
- Human Immuno-deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)
- Cancers of the reproductive system
- Human sexuality including equitable and mutually respectful relationships between men and women, female genital mutilation, abuse and violence

(Reference: UNDPI, 1995)

2.2 SOCIAL DETERMINANTS OF SEXUAL AND REPRODUCTIVE HEALTH

The factors that shape people's health are strongly influenced by their living conditions. These conditions have come to be known as the social determinants of health (Mikkonen & Raphael, 2010). According to the World Health Organisation (WHO), "The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels" (WHO, 2012a). Key factors that impact on health and wellbeing include: gender norms, income distribution, levels of education, social exclusion, type of employment and housing. In general, the lower an individual or group's social status, the lower their access to resources and services, including health services.

Because of the inextricable links between health and social determinants, there has been an increasing recognition that a rights based approach is essential in ensuring that communities achieve optimal sexual and reproductive health (Taylor, 2011). Health services have been developed with the needs of the majority population in mind; however there is a need for health services to change to provide accessible and culturally appropriate services for immigrant and refugee women. This includes services such as health promotion, education, clinical services, preventive care and other community health services. In order to achieve positive health outcomes, social and environmental determinants must be addressed in tandem with biological and medical factors (Maslen, 2008).

The Cairo Declaration's definition of reproductive health was a turning point in the discussion about women's SRH. It was crucial in highlighting that while SRH involves biological difference between the sexes, it is also influenced by social interactions such as gender relations, power differentials and economic and cultural factors. Importantly, it concluded that SRH rights are fundamental to women's health and wellbeing.

2.2.1 CULTURE

The term 'culture' is often conceptualised as more or less equivalent to ethnicity and race, or as a variable or a characteristic in certain individuals or groups of people. However, culture encompasses more than this.

Culture can be described as "the distinctive way of life of the group, race, class, community or nation to which the individual belongs. It is the first and most important frame of reference from which one's own sense of identity evolves" (O'Hagan, 2001, p. 228). Culture can include ethnic identity, traditions, education, nationality, gender, economic position, religion, sexuality, language, and a myriad of other elements. In addition, culture is shaped by ideas, meanings and beliefs that have evolved over time, which contributes to an individual's knowledge and understanding of the world.

While ethnicity and race may influence an individual's culture, health outcomes can often be less about 'ethnicity' and more about the political and social context in which an individual lives. As such, a definition of culture must include not only ethnicity and race but also (at least) gender, age, income, education, employment and socio-economic status.

Cultural and social institutions are major influences on people's health and wellbeing. Whilst appreciating that culture is not a fixed status, in its broadest definition, culture is the most important element in shaping the way we view ourselves, and our interactions with the world around us. As well as being biological, SRH is socially constructed and ideas and values around it are very much informed by the culture and society to which one belongs or identifies with. Like other determinants of health, culture can promote or undermine SRH in various ways (Taylor, 2011).

2.2.2 SOCIO-ECONOMIC STATUS

Socio-economic disadvantage, at the macro and micro levels, is both a cause and outcome of poor SRH (WHO, 2010).

At a macro level the amount of government funding allocated to health, education, housing, transport, childcare and income support impacts upon the level of socio-economic disadvantage in the community, and exacerbates the underlying causes that compromise SRH (WHO, 2012). At the micro level, factors such as employment status, income, educational level, and occupation can influence an individual's ability to make informed decisions or seek treatment for sexual and reproductive related conditions. Socio-economically disadvantaged people are more likely to have shorter lives, are at higher risk of disease risk factors and lower use of preventive health services than those with a higher standard of living (AIHW, 2008).

2.2.3 GENDER

Gender norms refer to the social and cultural meanings associated with masculinity and femininity and are often deeply embedded attitudes in society. Just as the distribution of labour, resources, and opportunities within society follows gendered lines, health too is gendered (Maslen, 2008). Gender based discrimination is a major cause of sexual and reproductive ill health. Among other things, it is expressed through the division of labour and resources; experiences of violence; levels of social inclusion; unequal access to health information and health care; and the roles women perform within their communities.

Analysing SRH through the combined lenses of social determinants and gender justice allows for the recognition of structural factors that impact women's health and wellbeing. Viewing women's SRH within a wider and more holistic/social framework enables us to appreciate the diverse needs of women based on their individual life circumstances. Gendered structures of power and inequality profoundly influence health status because hierarchies of all kinds determine life chances and opportunities (Hofrichter, 2003, p. 9). The lack of opportunity in both social and economic spheres can result in poorer health outcomes and a lower quality of life for many women.

2.2.4 SEXUAL VIOLENCE

Sexual violence has enduring psychological and physical health consequences. It is multi-dimensional and can occur in the home, in the general community, workplace, educational institutions, and at the hands of the state (Poljski, 2011a). It is estimated that as many as one in five women living in Australia experience sexual violence and one in three Australian women experience physical violence at some point in their lives. In Victoria, male intimate partner violence is found to be the leading contributor to death, disability and illness for women aged 15 to 44 years (VicHealth, 2004). Sexual violence takes many forms, including sexual assault, intimate partner rape, gang rape, forced prostitution, human trafficking for sexual exploitation and sexual harassment and intimidation in the workplace and other social settings (Taylor, 2011).

The consequences of violence against women are far-reaching. Women who experience intimate partner violence are more likely to have adverse pregnancy outcomes than women who do not experience violence, including unwanted pregnancy, miscarriage, low birth weight, preterm births or foetal death. Violence can also lead to gynaecological disorders, sexually transmitted infections and HIV (WHO, 2002). Research shows that some male perpetrators of intimate partner violence maintain control over their female partners through threats, physical violence or birth control sabotage (Taylor, 2011).

Traditionally, efforts to prevent violence against women have been secondary and tertiary in nature. While it is essential that women experiencing violence are supported, a strong body of evidence suggests that primary prevention initiatives are crucial not only in improving SRH, but also in changing the culture that allows violence against women to occur in the first place.

2.3 IMMIGRANT AND REFUGEE WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH

While current evidence indicates that immigrants arrive with good, if not better, health than the Australian born population, the health advantage seen on arrival is known to become smaller with increasing length of residence in Australia (AIHW, 2002). Studies show that immigrant and refugee women have poorer health outcomes and are at greater risk of developing adverse health conditions than Australian-born women. Furthermore, immigrant and refugee women appear less likely than Australian-born or English-speaking women to take health related action when ill. The reasons for this are multifaceted and are further complicated by experiences of displacement and migration (Allotey et al, 2004). Some factors include language barriers; challenges associated with accessing health services; a lack of culturally appropriate support; and previous experiences with the health system in their country of origin.

The social determinants of immigrant and refugee women's health are often deeply ingrained in the social and cultural structures in women's lives. Broadly speaking, a model of care that recognises women's unique lived experiences, socio-political situation and cultural beliefs should form the basis of culturally appropriate practice. Only an approach that demonstrates the complexity of the interactions between health, its determinants and its outcomes can adequately provide immigrant and refugee women with the care they need.

An analysis of the social determinants of immigrant and refugee women's SRH is provided in the discussion of findings in Chapter 4.

The challenges that women face in accessing health related information and services can manifest in various ways. For example, research has found that immigrant and refugee women:

- are at greater risk of suffering poorer maternal and child health outcomes;
- are less likely than Australian-born women to have adequate information and familiarity with modern contraceptive methods. This is more likely to be the case with newly-arrived immigrant and refugee women. A recent study of current contraceptive management in Australian general practice found that women who spoke a language other than English at home had a rate of management of general contraception that was half that of women from English speaking households (Mazza et al, 2012);
- are at greater risk of contracting a sexually transmitted infection (STI), such as HIV and hepatitis B, especially migrant women who are from countries where the condition has a high prevalence (this may be due to the fact that when partners return to their countries of origin, they may engage in unsafe sex practices outside of their relationships).
- are less likely to use health and social/ support services;
- are less likely to have access to evidence-based and culturally relevant information which will enable them to make decisions about their health;
- are well placed to improve sexual and reproductive health through preventive health education.

(Reference: MCWH, 2010)

CHAPTER 3: PROJECT DESIGN AND APPROACH

3.1 INTRODUCTION

Immigrant and refugee women's experiences of SRH services in Australia have not been widely documented. There is a need for more research in this area if services are to move towards a rights based and social model of health that values women's experiences and knowledge. In order to achieve this, an understanding about the various dimensions of SRH of immigrant and refugee women in Australia is required. Common Threads was conceived out of this need. In line with MCWH's best practice principles, this research has been conducted using a community development, feminist and human rights approach. This approach values and creates opportunities to draw on women's knowledge and wisdom and promotes participation and meaningful discussion.

The primary research on which this report is based involves two targeted groups: women from immigrant and refugee backgrounds and health professionals who work with them. Four groups were chosen for further exploration of the issues at a micro level: Sudanese, Indian, Middle Eastern and Chinese communities. One focus group was also conducted with 8 immigrant and refugee women from multicultural backgrounds. Stakeholder consultations and focus group discussions aimed to identify the experiences and concerns of the different groups of women and the health professionals who participated in the research.

3.2 APPROACH

Community development principles of participation, non-discrimination and empowerment are the backbone of Common Threads. Women's accounts of their own health and wellbeing experiences provide the foundation for a health framework based on social determinants and were obtained through MCWH's bilingual health education (BHE) team.

An Expert Advisory Group (EAG) was established during the initial stages of project planning. The group ensured that the project was well planned, monitored and coordinated and ensured that mechanisms were in place for good practice throughout the project. Members' knowledge of the issues around immigrant and refugee women's SRH were used to develop and explore potential themes for the focus group discussions and key stakeholder interviews. EAG members (see Appendix 1) included academics, researchers and health professionals who engage with women in the clinical setting.

3.3 LITERATURE REVIEW

A review of literature consolidating existing knowledge about immigrant and refugee women's SRH in Australia was conducted. Literature was sourced from journals, websites of key organisations, government departments and women's health agencies.

3.4 KEY STAKEHOLDER CONSULTATIONS

Individual interviews were conducted with stakeholders to identify what they perceived to be the key sexual and reproductive issues affecting immigrant and refugee women, inhibiters and enablers to women accessing information and services and challenges they face when working with immigrant and refugee women. Successful SRH promotion activities carried out with women from diverse backgrounds were also discussed. Consultations were conducted either face-to-face or by telephone. Although data collection was carried out in Victoria, responses also came from service providers and agencies in New South Wales, South Australia and the Northern Territory.

Overall, 14 interviews were conducted with 17 health professionals who had knowledge of or expertise in immigrant and refugee women's health. Appendix 1 lists the agencies involved in the consultation process. Nursing, medicine, social work, and health promotion were the main disciplines represented in the consultation. Appendix 2 contains the questions discussed during the consultation.

3.5 FOCUS GROUP DISCUSSIONS

The factors that influence access to SRH services for immigrant and refugee women are both structural and personal. In order to understand the individualised nature of their experiences, immigrant and refugee women themselves were consulted.

MCWH's Bilingual Health Educator (BHE) team played a central role in working with women as peers in the collection of data, and not as 'researchers doing research about them.' Prior to running the focus groups, the Project Officer and two of her colleagues conducted a focus group facilitation training session with the eight BHEs involved with Common Threads. It was an opportunity for BHEs to learn about the project, the purpose of focus groups and their role as facilitators.

Working with BHEs is an effective way of conducting qualitative research with immigrant and refugee women. Rather than acting as interpreters, they are women with in-depth knowledge of the issues who have likely shared experiences similar to the participants.

While it is inaccurate to assume that BHEs who come from and/or share similar characteristics with the community with whom they work will automatically possess inbuilt or 'natural' knowledge about the best ways of engaging with their community (Moses & Quiazon 2010), the focus group training provided BHEs with the additional skills needed to facilitate, analyse and interpret the focus group participants' stories.

All focus group discussions were facilitated by MCWH's BHEs in the participating women's preferred language. Focus group meetings took place in contexts that were familiar and accessible to the participants, and in venues that the women frequented often, such as local community centres and secondary schools.

In total, 72 women participated in 6 focus group discussions. The women were from four different population groups: Sudanese, Middle Eastern, Chinese and Indian. One focus group was also conducted with 8 immigrant and refugee women from multicultural backgrounds. The ages of the women ranged from 25-60 years with a period of residency ranging from 6 months to 10 years. Participants were recruited through community organisations that work directly with immigrant and refugee women from these communities. Due to variables such as time constraints and the education and literacy levels of some participants, the Project Officer was unable to conduct a broader demographic review. If more time and resources had been available, verbal information could have been conveyed via BHEs at an individual level.

BOX 3

DEMOGRAPHIC OF FOCUS GROUP PARTICIPANTS

Session language	Cultural background of participants	Number of participants	Age range of participants
Middle Eastern Arabic	Iraqi Egyptian Lebanese Syrian Jordanian Palestinian Chaldean Kurdish	18	30-60
Sudanese Arabic	Sudanese	19	30-50
English	Sudanese Chinese Indian Lebanese	8	25-56
Mandarin	Chinese	18	25-45
English	Indian	9	21-30
Total		72	

The focus groups covered themes that related to the personal meanings and beliefs surrounding women's general health, SRH, and their experiences in accessing health related information and services in Australia (see Appendix 3 for the themes covered during the discussion).

3.6 ETHICAL CONSIDERATIONS

Examining the SRH experiences of immigrant and refugee women raised some ethical considerations when conducting the research. All participants were provided with a brief about the project, and the nature of the discussion prior to their involvement. As the research was based on a holistic approach to health and wellbeing, it was anticipated that conversation would cover a range of topics such as mental health, spousal and family relationships, cultural practices such as female genital cutting (FGC), and other health issues.

Participation in the focus group discussions was entirely voluntary. Informed consent was sought from participants in writing and they were aware that at any stage they were welcome to leave or disengage from the discussion (see Appendix 4 for participation consent form). Participants were asked to provide verbal consent to be audio-recorded. All focus groups were conducted in a safe space, and facilitated by MCWH's BHE in the women's preferred language. All the BHEs who facilitated focus groups were experienced in the delivery of SRH education in a culturally appropriate way. Participants were made aware of the Project Officer's role in conducting the research and met with her prior to the meeting; however she was not present during the discussion in order to ensure greater comfort for the women involved. Sessions were recorded and later transcribed by the facilitator. Only the BHE and Project Officer had access to the recordings.

Privacy of participants was respected throughout the process. Confidentiality was assured for all participants and their names have thus been withheld in this publication. Individual health problems were not highlighted or discussed unless the individual(s) concerned wanted to.

3.7 DATA ANALYSIS

The qualitative data generated by the key stakeholder consultations and focus groups was analysed by the Project Officer. Stakeholder interviews were recorded and transcribed by the Project Officer and focus group discussions were recorded and transcribed by the BHE, and handed over to the Project Officer.

All transcripts and field notes were coded, interpreted, and reviewed by the Project Officer. As English is the second language for all of the women who participated in the focus groups, quotes were edited for clarity, rather than expressed verbatim. In all instances where women were quoted, the Project Officer did her best to preserve the authenticity of their voices.

3.8 PARTICIPATING COMMUNITIES

Australia is one of the world's most culturally diverse societies. As a nation, its inhabitants speak more than 300 languages, practice more than 100 religions and originate from over 230 different countries (DIAC, 2008). The latest Census revealed that over a quarter (26 per cent) of Australia's population was born overseas and a further one fifth (20 per cent) had at least one overseas-born parent (ABS, 2012).

There are several challenges to gathering information about immigrant and refugee women in Australia. Specific data about particular cultural groups is generally not collected and is difficult to obtain. Furthermore, it is impossible to calculate the exact number of newly arrived women in Australia due to the different government agencies involved in the collection of data, the various methods used to collect data, and the significant overlap in women moving across visa types (Poljski, 2011a).

Women from culturally and linguistically diverse backgrounds enter Australia under various circumstances, including as migrants, refugees, international students and unaccompanied minors. They have different levels of education and literacy as well as diverse cultural practices, socio-economic backgrounds, rural and urban backgrounds, religious beliefs, family structures, race and ethnicity (Allimant & Ostapiej-Piatkowski, 2011).

They may be from well-established communities or from countries with a recent migration history in Australia.

Following a demographic review, four cultural groups were chosen to further explore the SRH experiences of immigrant and refugee women in Australia: Chinese, Indian, Middle Eastern Arabic speaking and Sudanese. The groups chosen represent a large number of recent immigrants and refugees to Australia. The Middle East region was chosen rather than a distinct country from the area, as there has been a significant increase in women from this region arriving in Australia under the Humanitarian Program.

In recent years, there has been a major increase in the number of refugees arriving from African and Middle Eastern countries affected by war and political and civil unrest. Over 73 per cent (or around 14,000) of Australian residents born in Sudan arrived in 2001 or later and similarly, a high proportion of the population born in Iraq (34 per cent or 11,000) arrived in 2001 or later (ABS, 2007). Between 1998 and 2008, humanitarian entrant migrant women predominately came from Sudan, Iraq, former Yugoslavia and Afghanistan (ECCV, 2009). Whilst people from China and India have arrived in Australia since the 1850s to the present, growth in migration from these countries has been most substantial since 1996, with most arriving in Australia as skilled immigrants or international students (Victorian Multicultural Commission, 2008a and 2008b).

3.8.1 CHINA

The China-born population is one of the largest country-of-birth groups in Australia and is concentrated in large cities, such as Sydney, Melbourne and Brisbane. The 2011 Census recorded 319, 000 China-born people in Australia, making it the third highest country of birth for the overseas-born population in Australia (ABS, 2012). Of the China-born in Australia, there were 93, 280 males (45.2 per cent) and 113, 310 females (54.8 per cent). The sex ratio was 82.3 males per 100 females (DIAC, 2012b). The total number of China-born temporary entrants present in Australia in June 2011 was 123, 811 (DIAC, 2011b).

3.8.2 INDIA

The latest Census recorded 295, 400 India-born people in Australia with up to 200, 000 India-born people arriving between 2001 and 2011 (ABS, 2012). Of the India-born in Australia, there were 81, 190 males (55.2 per cent) and 65, 910 females (44.8 per cent). The sex ratio was 123.2 males per 100 females (DIAC, 2012c). The total number of India-born temporary entrants present in Australia in June 2011 was 129, 578 (DIAC, 2011a).

3.8.3 THE MIDDLE EAST REGION

Many recent arrivals from the Middle East have entered Australia under the Humanitarian Programme. Available Census data shows that there were 193, 333 people born in the Middle East who were residents in Australia in 2006 (ABS, 2008). This accounted for 4.4 per cent of the overseas-born population. Almost 40 per cent of those from the Middle East were born in Lebanon, 16.8 per cent were born in Iraq, 15.7 per cent in Turkey, 11.6 per cent in Iran, 4.0 per cent in Israel and 3.6 per cent in Syria. 46, 363 females from the Middle East region settled in Australia between 2000 and 2012 (DIAC 2012e).

3.8.4 SUDAN

The Sudan-born poplulation is one of the fastest growing groups in Australia. Before 2001 this group included a number of skilled migrants, but due to war and conflict, more than 98 per cent have arrived under the Humanitarian Program. The 2006 Census recorded 19, 050 Sudan-born people in Australia, an increase of 287.7 per cent from the 2001 Census. Between 2006 and 2012, DIAC recorded 6, 439 new Sudanese arrivals in Australia (DIAC, 2012d). Of the Sudan-born in Australia, there were 10, 320 males (54.2 per cent) and 8, 730 females (45.8 per cent). The sex ratio was 118.2 males per 100 females (DIAC 2012d).

CHAPTER 4: DISCUSSION OF FINDINGS

4.1 FACTORS INFLUENCING IMMIGRANT AND REFUGEE WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH: THE COMMON THREADS

The results of the consultation process largely reflect the information gathered in the literature review. SRH outcomes in immigrant and refugee communities can be attributed to a number of socio-cultural factors including access to health related information and services, the dynamics of the migration experience and gender and cultural norms that exist in various communities. As an individual's culture is influenced by many factors such as gender, religion, ethnicity, socio-economic status, sexual orientation and family configuration, it is vital that SRH is conceptualised within a broader social and political framework.

The identification of seven main themes influencing immigrant and refugee women's SRH is the outcome of a literature review and data analysis of interviews with stakeholders and focus group discussions. The main themes that will be discussed in this chapter are:

- Accessibility of information and services
- Gender and cultural norms
- Pre-migration and migration experience
- Mental health
- Violence against women
- Socio-economic position
- Practical issues

These issues are not necessarily discussed in order of priority, but are rather organised thematically. It is also important to note that these themes interrelate with one another to provide a picture of the factors that influence immigrant and refugee women's SRH.

While it is clear that there are many strengths in Australia's current health system, including a strong record of safety and quality, and a highly committed and professional workforce (DoHA, 2009), on-going evidence demonstrates there is a need to adopt an alternative approach, grounded in principles of equity and human rights, to ensure that women's health programs and services are accessible and responsive to the diverse needs of immigrant and refugee women across Australia.

4.1.1 ACCESSIBILITY OF INFORMATION AND SERVICES

The women interviewed indicated that 'health' was mainly a physical phenomenon. They claimed that if they don't have a major disease or chronic physical pain, then they consider themselves to be 'healthy.' Many women viewed their own sense of wellbeing in terms of their ability to perform domestic duties and whether or not they could care for their families. The notion that women's health is, in a sense, a family issue was highlighted across all focus group discussions.

> *'If I can take care of my child, and my husband without difficulty then I consider myself healthy.' (Indian focus group participant)*

While the women indicated that physical wellbeing was the defining factor in terms of feeling healthy, immigrant and refugee women also connect notions of 'wellbeing' and 'healthiness' to good mental health and emotional stability. For many of the women interviewed, emotional wellbeing is possible because of the support they receive from women in similar circumstances.

> *'This women's group is my life. Without the group I could not survive.' (Middle Eastern focus group participant)*

It is vital that SRH is conceptualised within a broader social and political framework.

Some women in the focus group claimed that they had never visited a GP before, and would find it difficult to know what to do or where to go for their general health needs, let alone if they had a specific SRH concern.

Unfamiliarity and lack of information regarding available services was frequently raised in the focus groups. When faced with ill-health, women generally claimed that they would see a pharmacist first, and if the pharmacist could not provide them with medicine to treat their condition, then they would visit a general practitioner (GP). According to the ABS, in 2009, 23 per cent of the overseas born population had not seen a GP within the last 12 months (ABS, 2009b). Reflecting this trend, some women in the focus groups claimed that they had never visited a GP before, and would find it difficult to know what to do or where to go for their general health needs, let alone if they had a specific SRH concern.

SRH remains taboo in many cultures. While immigrant and refugee women are very receptive and have a strong desire to receive information, they have a limited understanding about what SRH encompasses. They find it difficult to define SRH outside of pregnancy related issues, and generally do not see it in broader or holistic terms. The level of knowledge women possess also depends on determinants such as level of education and literacy, length of time spent in Australia and ability to access information. If women are not well linked into the health system, they are less likely to have information about modern contraceptive methods; to commence timely antenatal care; or to access prevention services.

The results of the focus groups and key stakeholder consultations suggest that navigating Australia's health system, even for those who can speak English, can be difficult. The Australian health system is complex, and often vastly different to health systems in other countries. When seeking healthcare or health information, women are confronted by a multifaceted set of health and community services (MCWH, 2011). For many immigrant and refugee women, primary care and health promotion may be difficult concepts to understand because of their experiences with the health system in their country of origin. Further complicating navigation is residency and visa status as each visa category carries different entitlements, which can change. This means that it is difficult both for immigrant and refugee women to link into the system and for service providers to make referrals (MCWH, 2011).

Immigrant and refugees either come from countries with a specialised health system, where there is less emphasis on primary care, and more focus on treatment than prevention, or countries with poor or limited sexual and reproductive health services. Women who have lived for an extended period of time in refugee camps are less likely to be aware of the types of services that are available. Subsequently, immigrants and refugees are over-represented in acute and emergency care, and often their first point of contact with Australia's health system is the emergency room. For example, a recent report by the Southern Academic Primary Care Research Unit revealed that residents from refugee source countries in the south-eastern metropolitan region of Melbourne have a 23 per cent higher rate of public hospital emergency department presentation than non-refugees (SAPCRU, 2011, p. 24).

This was reflected in the focus group discussions, as participants claimed that they had often accessed the local public hospital for medical assistance, particularly if their children were unwell. Participants identified family members and friends as the primary source of health-related information and, only in their absence, a GP or community health nurse. However, when women did access these services, cultural and language barriers were commonly experienced. These constraints act as a disincentive to utilise services.

> *'Sometimes information isn't suited to our needs and isn't culturally appropriate. It is better if an Indian person tells us things. Information should be clear, because sometimes people don't understand. I want someone to explain these things to me in my language. If I don't understand, the information isn't useful and I won't go back.'*
> *(Indian focus group participant)*

Younger female participants claimed that the internet was their 'go to' for information related to their SRH. This may be indicative of a larger issue pertaining to fear of family members or friends discovering that (for a single woman) she is engaging in sexual activity before marriage, or is concerned and/or interested in sexual health at all (Poljski, 2011b). The internet therefore is perceived as a 'safe' and 'confidential' way to access sexual health information.

Women claimed that meaningful engagement with health professionals is the key, although low English proficiency and inflexibility of health services makes this difficult.

While this is convenient, it is not preferable, as women cannot acquire specific and tailored information. It also means that women cannot interact and engage in a conversation about their sexual health or be completely confident that they are receiving accurate information.

Women claimed that meaningful engagement with health professionals is the key, although low English proficiency and inflexibility of health services makes this difficult. For example, a health service that only operates between business hours, that offers no outreach services and that underutilises interpreters, is not providing accessible and adequate health care to immigrant and refugee communities. Failure on the woman's part to attend health consultations may be considered by such services as a reflection of the client's lack of interest or need, rather than an inability to overcome barriers. This then has an adverse impact on continuity of care.

A gendered approach is essential in health promotion initiatives for immigrant and refugee women. Flexible and responsive, culturally appropriate service models, such as using bicultural and bilingual workers, are essential in ensuring that services reach women who are unable to overcome barriers imposed by rigid, mainstream services.

> *'Community workers are the best because they speak our language. They have the knowledge of both the medical and cultural expectations and experiences. If they feel we need more, they can refer us to other services.'*
> *(Chinese focus group participant)*

Gender-specific SRH education, delivered by female health educators from a similar cultural background, enable women to engage with information in a non-threatening, culturally safe way (McMichael, 2008; Shepherd et al, 2000).

4.1.2 GENDER AND CULTURAL NORMS

The outcome of certain gender norms on sexual and reproductive health is that some women may be less knowledgeable than others about things such as contraception and the negotiation of their sexual rights. Gender and cultural norms influences ideas about what it means to be feminine and masculine in every community.

> *'In my culture, people don't talk about contraception and sex. You get married, wait a couple of years and then have children.'*
> *(Indian focus group participant)*

Some women in the focus groups explained that they do not speak about their sexual health unless there is a specific issue that causes them physical discomfort, and definitely not with immediate family members. Some women are also more likely to confide in close female friends, rather than talk to their partners or husbands about their sexual health concerns.

Despite wanting to learn about contraception options, women claimed that often they are unable to discuss this issue with their husbands or male partners as they feel the pressure from their families to comply with gender and cultural expectations to have children.

> *'They (our families) only think about having a baby and they don't give us any information, like you have to think about this and this. They just want the baby.'*
> *(Indian focus group participant)*

In terms of their spousal relationships, the women interviewed recognised that power imbalances exist in their communities. Some women explained that while they are becoming more aware of SRH issues because of the information and support they receive from various women's organisations, the men in their communities are being left behind, which can make it difficult for the women to negotiate their reproductive rights. They felt that there needed to be more education programs targeted at men in the area of sexual and reproductive health, in particular, programs that were couched in the context of cultural myths and cultural norms.

In order to do this, multiple strategies need to be used. These strategies should be dependent on the communities' needs. While education should be targeted at both men and women, in some instances these discussions should be kept separate.

Cultural stereotyping and cultural assumptions often result in the tendency to treat immigrant and refugee women as a homogenous group, rather than as individual women, with individual beliefs and desires.

Often immigrant and refugee women feel that they cannot participate as actively and freely if men are present. Ideally, information should be tailored to suit specific groups. For example, one stakeholder said:

> *'We met with some men from Ghana to run a health education session on sexual and reproductive health. They said that they didn't want to be separated from their partners and that it was inappropriate for them to receive this kind of information. We realised that maybe the men and women should be in the same location, just in different rooms, and they could come together after the sessions. We had different sessions. Men and women were separated or together, depending on the topic.'*
> *(Key stakeholder - Health Promotions Manager)*

Findings suggest that there is a tendency to assume that because of 'culture', women from immigrant and refugee communities will refuse certain interventions, for example, contraception. Representations of immigrant and refugee women are often limited in their diversity. The stereotype is that women are essentially married, heterosexual and will always put their husband's or children's needs ahead of their own. While there may be an element of truth in this for some women, descriptions of immigrant and refugee women tend to focus on 'disadvantage' and 'problems' and construct women as passive victims who are subject to the control of their husbands, their cultures and their religions. 'Culture' is sometimes seen as the cause of all of women's problems and something that cannot change or be reasoned with.

Cultural stereotyping and cultural assumptions often result in the tendency to treat immigrant and refugee women as a homogenous group, rather than as individual women, with individual beliefs and desires. This perception limits the options that immigrant and refugee women are given in the clinical setting. While some women may refuse certain contraceptive options based on cultural beliefs, others will consider their individual circumstance and decide accordingly.

> *'I thought because of their religious background and culture, they wouldn't be as eager to use contraception, but I'm finding that probably once they settle here and are little bit overwhelmed by their situation (I don't know whether or not they're thinking, 'I don't want children anymore') that they have no problem asking for contraception.'*
> *(Key stakeholder - Refugee Health nurse)*

While some topics are difficult to broach, it should not be assumed that women do not want to learn more about particular aspects of SRH. If education is facilitated in a culturally sensitive and meaningful way, women are able to make informed decisions about their health and often with the support of their husbands. An example of this is the role that FARREP workers (Family and Reproductive Rights Education Program) play in communities where female genital cutting/mutilation (FGC/M) is practiced.

> *'FARREP workers espouse their traditions, customs and religion and think it's really important, which it is, but they also advocate for no more circumcision for the next generation of girls within this framework.'*
> *(Key stakeholder - Community development worker)*

> *'One of the things that should be framed differently, in terms of sexual and reproductive health, is that it's not always about culture. Place and setting has a big impact on how women perceive things, and the access they have is not really culturally based.'*
> *(Key stakeholder - Community health worker)*

While culture (in its narrowest definition) plays a significant role in the lives of all women, immigrant and refugee women have the added complexity of navigating cultural attitudes and beliefs within the context of migration. Even if women do come from similar cultural backgrounds, their individual experiences mean that they will have different attitudes and beliefs about their SRH. For example, a woman who has been displaced for many years may have very limited sexual health literacy compared to a woman from a similar cultural background who has spent little, or no time in a refugee camp.

The promotion of SRH in multicultural societies must take into account the diversity of beliefs and practices, the different ways in which social and cultural norms are created and strengthened.

As such, health outcomes amongst immigrant and refugee populations are not necessarily caused by 'cultural' factors. Social class and/or gender may be more significant. Therefore, a full understanding of migrant health requires an examination of class, gender and age as well as ethnicity (Julian, 2004).

Health professionals recognise culture as a contributing factor to attitudes pertaining to SRH but struggle to conceptualise it as something broader than race, religion and language. In fact, existing measures seem to conceptualise culture as more or less equivalent to ethnicity and race (Kumas-Tan et al, 2007). Dominant groups are seen as not having a culture, and therefore the rhetoric around cultural competency subsequently acquires an 'us' and 'them' dichotomy. In critically examining the measures of cultural competence most commonly used in the health professions, Kumas-Tan et al. claim that current measures of cultural competency imply that the challenge of culture can be overcome by repeated exposure and contact with clients from diverse backgrounds, or what is referred to as the 'Other.' Cultural competence is then achieved when practitioners acquire sufficient awareness and knowledge of the Other.

> "*The assumption that cultural incompetence is a matter of individual attitudes or discomfort denies the larger structural and systematic realities of racism, ethnocentrism, and other forms of social inequality. Practitioners who have tolerant, non-discriminatory attitudes will not necessarily be culturally competent if they are not also trained to recognise when actions and inactions that support the status quo and business as usual unintentionally, but systematically, privilege some and marginalise others.*"
> *(Kumas-Tan et al, 2007, p. 554)*

Existing measures seem to conceptualise culture as more or less equivalent to ethnicity and race.

An understanding of the social, cultural and economic factors that shape a woman's response to her SRH needs to be incorporated into mainstream notions of cultural competency. Caution must be exercised when making generalisations about culture, gender, and sexuality. Accordingly, the promotion of SRH in multicultural societies must take into account the diversity of beliefs and practices, the different ways in which social and cultural norms are created and strengthened, and the ways in which these differences are played out in the arena of education, prevention, and treatment (Gifford & Temple-Smith, 2005).

For example, the issue of FGC within immigrant and refugee communities is one case where an understanding of the cultural factors that shape a women's attitude to her sexuality and health is crucial.

FGC was discussed, albeit very briefly in one Sudanese focus group session. The terms FGC and FGM are frequently used interchangeably in public discourse, but the expression 'FGM' is often considered offensive by women from affected communities (Manderson, 2004).

By law, FGC is illegal in Australia. FGC comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (WHO, 2012b). It is a practice that is culturally complex, practiced as a ritualised activity and is often viewed by family and community members as an important cultural tradition and social necessity (NiMhorda, 2007). FGC is often considered a rite of passage from childhood to adulthood and deeply embedded in the society and culture of those who practice it (Ogunsiji et al, 2007).

Women in this group had a sound understanding of the legislation and agreed that there are negative ramifications on health, as some of the women experienced the impacts of the practice first-hand.

While the women in the focus group accept the legislation, they voiced their frustration at what they view as a double standard and contradiction within hospital policy, and inequity before the law. Some women spoke of their unhappiness toward health professionals when their wishes to be re-infibulated after childbirth were prohibited.

Many women indicated that they often felt uncomfortable to talk to health professionals in their countries of origins about their bodies, reproductive anatomy and sexual rights.

The women questioned why then Australian women are able to undergo gynaecological surgeries for cosmetic and other reasons. While medical legislation does not impinge on these procedures, and at least some of the surgeries are undertaken for psychological (and social) rather than physiological reasons, in contrast, women who are de-infibulated after birth are not entitled to be re-infibulated (Manderson, 2004).

While agreeing that the practice is a violation of the human rights of girls and women and reflects a deep rooted inequality against the sexes (WHO, 2012)[2] the focus group discussion highlights that a more nuanced understanding around the issues of FGC and re-infibulation are needed within Australia's health community. The women in the focus group expressed their lack of trust in Australia's health system because they felt discriminated against by a law that suggests that their needs and values are inferior to that of Australian women.

4.1.3 PRE-MIGRATION AND MIGRATION EXPERIENCE

The migration experience can influence immigrant and refugee women's SRH in both positive and negative ways. While the migration experience was challenging, participants indicated that living in Australia has provided them with opportunities to make better informed decisions about their reproductive health, which would otherwise be absent or more problematic in their countries of origin.

Many women felt that it was difficult for them to seek advice about SRH in their home countries because many of the issues associated with sexual health aren't openly discussed. Many women indicated that they often felt uncomfortable to talk to health professionals in their countries of origin about their bodies, reproductive anatomy and sexual rights. They claimed that where they come from, there is not a culture of asking questions, and generally the health practitioner will not enquire about anything other than the presenting issue. However, the women explained that in Australia, health professionals ask questions that sometimes seems unrelated to their health concern.

The level and quality of sexual health education provided where immigrant and refugee women come from is variable. In some countries, sexual health education in schools is rarely gender specific, with male teachers providing information in a rigid manner to female and male students collectively (Poljski, 2011b). As a result, girls feel uncomfortable and intimidated to ask questions in front of their male peers. This pattern may then continue if the woman's male partner or husband is present in a medical consultation, or if the medical practitioner is male.

While it may still be uncomfortable to discuss sexual health issues with health professionals in Australia, the women explained that if the health professional is open, friendly and appears unrestrained by time, then the women feel more comfortable to talk about their concerns. Also, the perception that Australian society is more liberal than their countries of origin also allows women to be more open about SRH.

> *'I'd never been to a doctor before, but a few weeks back I had pain in my lower stomach and I went to see a doctor. She was very nice and taught me and explained things about my body. I found that information to be very useful. She asked me how long I'd been married and if I had thought about contraception or family planning. I could ask her anything I wanted.'*
> *(Indian focus group participant)*

It is possible that women may have withheld information in the focus groups because they did not wish to talk about their negative experiences in front of others or because they did not want to be critical of their new country. Consultations with health professionals suggest that while services in Australia are of a high quality, women's individual pre-migration experience has a big influence on their perceptions of the Australian health system, and sometimes the perception is not always a positive. Often services in Australia do not meet women's expectations because of their past experiences.

> *'In China, the facilities are not as good, but you have more medical attention, such as more doctors and nurses caring for you.'*
> *(Chinese focus group participant)*

[2] *See MCWH's fact sheet, The elimination of FGM: what works, for more information about FGC and effective approaches to eradicating the procedure.*

'If anything happens to me, I always think, who am I going to tell? Who can I talk to?'
(Indian focus group participant)

Of the refugees who have arrived in Australia in the past 50 years, 48 per cent have been female. For these women, the barriers they face in accessing SRH care are compounded by their migration experience. Common experiences prior to arrival include disrupted schooling, long periods of time living in refugee camps, limited or no access to primary health care, experiences or threats of sexual violence and family life, all of which impact on sexual health and sexual health literacy (McMichael & Gifford, 2009). Rape and sexual abuse are the most common forms of systematised torture used against women, and can lead to numerous resulting physical and mental health issues.

Health outcomes are inextricably linked to the refugee and migration experience. Some of these experiences can result in negative outcomes. Refugees are more likely than non-refugees to be discharged from regional public hospitals with diagnosis related to: mental health (psychosis anxiety/ somatisation and depression), obstetric complications (female genital mutilation or circumcision, foetal death in utero and still births) and infectious diseases (tuberculosis) (SAPCRU, 2011).

When refugees leave their country it is often due to war or conflict and, as a result, they are forced to flee quickly with little time to prepare for exodus. On arrival in Australia, immigrants and refugees are faced with a number of competing priorities such as gaining employment, securing housing, and learning English. Consequently, their health needs, in particular their SRH needs, are neglected and often not addressed until there is a chronic physical issue. Immigrant and refugee women often have limited access to preventive SRH activities such as cervical screening and breast cancer screening (SAPCRU, 2011). Moreover, in new arrivals, asymptomatic disease may have a lower priority than more immediate concerns (Walker, 2006). According to key stakeholders, immigrant and refugee women are also more likely to present later for maternal services than Australian-born women.

'If they've come from a traumatic situation, their health will be the last thing they deal with or if they're pregnant we probably won't see them until they're going to give birth, because they won't present until late.'
(Key stakeholder - Nurse)

However, the fact that women from immigrant and refugee backgrounds often present late to maternity services may not just be an issue of priority. Past experiences are also significant. The approach to antenatal care in many countries is vastly different to that of Australia. Many women come from countries where they may attend antenatal care at the end of the first trimester instead of immediately after pregnancy confirmation, as is the case in Australia. For example, while the WHO recommends at least four antenatal visits for women from developing countries, in Australia, the traditional antenatal care schedule requires 14 visits (Team et al, 2009). It is important to recognise these differences in order to understand why immigrant and refugee women may have certain expectations and different ways of approaching treatment and care than Australian-born women.

4.1.4 MENTAL HEALTH

The stresses associated with relocating to a new country places an obvious burden on the mental health of immigrant and refugee women. Some of the women interviewed felt the pressure of needing to immediately learn the language and find employment and this caused them an immense amount of anxiety, and often depression. Some women spoke of family support, while others claimed that they have limited resources in terms of support.

'If anything happens to me, I always think, who am I going to tell? Who can I talk to?'
(Indian focus group participant)

According to key stakeholders, immigrant and refugee women are also more likely to present later for maternal services than Australian born women.

‘I think women keep things to themselves, and if there is a problem she will not share with her husband so that’s why she has depression, because she doesn’t want to discuss it with anyone.’

(Indian focus group participant)

Immigrant and refugee women feel the added weight of having to settle into Australian society. Becoming a part of the wider community can be difficult for women who have very low English language skills, or who are physically and emotionally isolated.

Loneliness and social isolation as a result of migration can also impact immigrant and refugee women, particularly women who have given birth shortly after migrating. It is well established that the year after giving birth is one of heightened vulnerability for women in terms of social and emotional adjustment and mental illness (Evans et al, 2001). While there has been adequate research on the experiences of new mothers and their transition to new roles and responsibilities, research on the experiences of immigrant and refugee women in their new homeland has been limited and there is little data that sheds light on the impact that cultural differences in beliefs and practices have on immigrant and refugee women’s experiences of care and on their birth outcomes (Wong, 2012).

Women who are particularly at risk of perinatal mental health disorders are those with a history of mental illness, limited emotional and social support, stressful life events or losses, change in role and identity, and those women with compromised socio-economic status (State Perinatal Reference Group, 2008). Research into postnatal depression shows that the experience of stressful life events either prior to or during pregnancies emerged as a common risk factor among immigrant and refugee women. Some evidence suggests that certain aspects of women’s migration history may increase their experience of stress and anxiety and therefore the risk of postnatal depression (Collins, Zimmerman & Howard, 2011).

For immigrant and refugee women who are pregnant or who have just given birth, the support mechanisms they customarily receive back home are diminished or non-existent when they migrate to Australia. Extended family plays a large role in the care of both the mother and the newborn, and often women find it difficult to articulate their concerns due to cultural beliefs that influence traditional and rigid roles within the family structure.

A recent study, Bbkayi (Baby Plus 2), conducted by MCWH about the experiences of first-time Chinese mothers living in the Whitehorse Community of Melbourne, Australia, found that many grandparents visit from their countries of origin and live with new parents as primary child carers for the length their visa will allow. However, not all families can afford to do that, and as fathers generally return to work or study shortly after birth, mothers spend long days alone with the baby with little or no family and service support (Wong, 2012).

Limited language skills also increase the risk of perinatal mental health disorders due to difficulties in verbalising depressive symptoms and expressing emotion. Shame and culturally driven reluctance to confide in others because of stigma further compound problems (State Perinatal Reference Group, 2008). Some participants recognised that after the birth of their baby they felt depressed and did not understand why, and subsequently did not know where to go for help.

> *‘I think women keep things to themselves, and if there is a problem she will not share with her husband, so that’s why she has depression, because she doesn’t want to discuss it with anyone. She can’t tell her parents, because they will worry about her, and she can’t tell her husband because she doesn’t want to fight with him, and she can’t tell her in-laws because they will tell her husband, so who can she tell? She keeps it to herself.’*
> *(Indian focus group participant)*

For immigrant and refugee women who are pregnant or have just given birth, the support mechanisms they customarily receive back home are diminished or non-existent when they migrate to Australia.

Women from immigrant and refugee backgrounds rarely have established networks and, as a result, can have difficulty in accessing resources.

There is limited data available about perinatal depression among immigrant and refugee women. However an increasing body of research demonstrates that incidences of perinatal depression cross all cultural boundaries, and therefore cannot be considered a culturally bound phenomenon (State Perinatal Reference Group, 2008). Immigrant and refugee women are arguably at a greater risk of perinatal mental health issues because of the challenges associated with the resettlement process. Moreover, their capacity for management is made more difficult because of those same settlement challenges.

4.1.5 VIOLENCE AGAINST WOMEN

In Australia, violence occurs among all cultural, religious and socio-economic groups, but women marginalised by age, culture, ethnicity, sexual identity and visa status are more vulnerable to violence and are less likely to report it (Poljski, 2011a).

While women in the focus groups recognised that violence against women may be an issue in their communities, many admitted that they would not know where to seek help if they were to personally experience it. This is reflected in the trend that domestic violence cases tend not to be reported by immigrant and refugee women. Some factors behind this include the limited availability of interpreter services, cultural or religious shame around domestic violence, religious beliefs about divorce and the fear of being deported (Bartel, 2010). Women from immigrant and refugee backgrounds rarely have established networks and, as a result, can have difficulty in accessing resources from formal institutions (Brewer, 2009).

As a result, there is a lack of data pertaining to violence against women within immigrant and refugee populations. This is perhaps partly due to the tendency to stereotype domestic violence as an intrinsic part of a particular culture. However, such views are inaccurate and perpetuate non-response to domestic violence among immigrant and refugee communities (Brewer, 2009).

Violence against women does not occur more in immigrant and refugee communities, but women's vulnerability to violence is compounded by a number of factors including visa type[3], language barriers, lack of access to dignified employment, financial insecurities, and separation from family. Social isolation can also be a precursor to domestic conflict and to the breakdown of marriages.

There is also a culture of silence around violence in some communities, particularly when it concerns intimate partner violence. Some immigrant and refugee women do not see sexual violence within marriage as a 'real' crime, or they may feel a sense of obligation to stay in the relationship due to religious beliefs or traditional attitudes. Women may be completely dependent on their abusers for money, and issues of finance become paramount in planning to leave the relationship (Allimant & Ostapiej-Piatkowski, 2011).

> *'It's financial control. I have a friend whose husband does not allow her access to money. He does not allow her to go shopping as well. If she goes, she needs to show him evidence like receipts of what she bought. But what can she do?'*
> *(Middle Eastern focus group participant)*

Findings from the focus groups demonstrate that more research and sensitive discussion are needed with women from immigrant and refugee communities with regard to sexual and domestic violence. In particular, there needs to be culturally appropriate education and provision of culturally relevant information about the support mechanisms that are in place, as well as the services that are available to them, should women require it.

4.1.6 SOCIO-ECONOMIC POSITION

Socio-economic circumstances are particularly important when examining health outcomes in immigrant and refugee communities. The realities of settlement for immigrant and refugee women often mean that they will have a lower socio-economic position and this will heavily impact the choices they can make in terms of their SRH.

[3] *See MCWH's publication, On Her Way: primary prevention of violence against immigrant and refugee women in Australia, Carolyn Poljski, September, 2011 for a comprehensive break down of women's vulnerability to violence according to visa type.*

‘Bills are the biggest pressure on women and mothers in this country. Women choose not to work to look after their children, but they have to work.’

(Middle Eastern focus group participant)

Unemployment is common among newly arrived refugees, and those who do attain employment are often employed in low paying jobs or casual employment (Murray & Skull, 2005). Immigrant and refugee women are more likely to accept employment in hazardous occupations and also less inclined to take time off work to access health care for fear of income loss or threat of dismissal (Bhagat et al, 2002).

The women interviewed saw their sense of wellbeing inextricably linked to having financial independence and control. They felt the pressure of having to provide for their families, and many spoke of the difficulties of going back to work after maternity leave.

> *‘Bills are the biggest pressure on women and mothers in this country. Women choose not to work to look after their children, but they have to work.’*
> *(Middle Eastern focus group participant)*

Women claimed that while they would prefer to stay at home to look after their children, they are forced to start working almost immediately after childbirth because of financial pressures. Some women said that they do not have the support network or extended family to care for their child, and must use childcare services. However, this can also be problematic as immigrant and refugee women may feel that childcare is not culturally appropriate. The Bbkayi (Baby Plus 2) study found that working Chinese parents prefer not to send their baby to childcare because it is too expensive. In addition to the cost, they are concerned about the quality of care and the language barrier. The conflicting cultural practices of childrearing also act as a deterrent from utilising childcare services because families may fear that their culture and language will be lost (Wong, 2012). This attitude might explain the low percentage of migrant users of children’s services in spite of the fact that studies indicate that this population group are in need of support outside the home. As a result, immigrant and refugee women may engage in shift work so they can work around their child care needs, or decide to stay at home until the child is of school age, resulting in economic hardship for the family.

Bbkayi (Baby Plus 2) also reveals that when both parents are busy with full-time work, study, or dealing with financial pressures, and grandparents are unable to receive extended visas in Australia, grandchildren are often sent to live in their parents’ country of origin for a few years with their grandparents. While this is an issue of concern as some children experience cultural shock, language barriers and emotional detachment from their grandparents when they return to Australia, this is a reality for many immigrant and refugee communities who are unable to afford childcare costs and do not have the social support networks in Australia (Wong, 2012).

For the women interviewed, financial concerns appear to be one of the major underlying reasons behind their reluctance to access health services.

> *‘I had been in Japan for five years. They had a similar system to Medicare in Australia but it covered specialist. I could go see a specialist straight away and did not worry about cost. But here it costs me so much to see a specialists, I usually wait until I go back to Malaysia to see my dentist.’*
> *(Chinese focus group participant)*

Whether actual or perceived, the costs associated with seeing a health professional (transport, child care, medicine) are a significant barrier for immigrant and refugee women. This is compounded for most by a lack of knowledge about the right to access bulk-billing or other ‘no cost’ services (Murray & Skull, 2005). Often women will seek out the services, but have a poor record of following up with their physicians if they think that there will be additional costs involved.

The conflicting cultural practices of childrearing also act as a deterrent from utilising childcare services because families may fear that their culture and language will be lost.

'For a lot of them, they're what you call 'non-eligible' so they don't have Medicare Access, so they're quite concerned about the cost of healthcare. For example they go home before the 48 hour tests are due, because they have to pay extra for that.'
(Key stakeholder - Midwife)

The realities of socio-economic disadvantage (low income, financial pressure, low education levels) mean that women are not prioritising their health and are less likely to use preventive and curative sexual and reproductive health services than women from wealthier households (Taylor, 2011).

The research also reveals that accessibility and entitlements to SRH services is complicated by residency or visa categories. International students[4] make up a large group of temporary migrants; with particularly high numbers from China and India (two of the cultural groups interviewed in Common Threads).

Female international students in particular face numerous challenges when it comes to accessing SRH services in Australia. High rates of unplanned pregnancy and abortion are characteristic in the female student population, a widely acknowledged fact by researchers and within the international education industry in Australia. These health outcomes are symptomatic of limited sexual health literacy, poor access to health services in Australia, and the dynamics of the immigration experience (Poljski, 2011b).

A recent change to the Overseas Student Health Cover (OSHC) Deed (a legal document the Federal Department of Health and registered health insurance fund that provides the mandatory cover) has detrimental implications for the sexual and reproductive health of female international students. The Deed now precludes the need for OSHC providers to pay benefits to overseas students or their dependents for the treatment of maternity related conditions in the first 12 months after arrival in Australia, except when emergency treatment is required (MCWH, 2012).

[4] *See MCWH's publication, On your own: sexual and reproductive health of female international students, Carolyn Poljski, 2011 for more information about issues facing international students.*

'I wanted to have an IUD and requested a female doctor. They provided me with a male doctor and I refused to have it. It was two years ago and until now I do not have one.'

(Middle Eastern focus group participant)

Since the Deed was implemented, various cases have been reported in the media, highlighting the difficulties international students have in accessing maternity related services. As an already vulnerable and often marginalised group, the change in the Deed serves to disadvantage and discriminate against international students' right to access health services.

4.1.7 PRACTICAL ISSUES

Practical issues such as the logistics of transport and childcare were discussed during focus group sessions. While women acknowledged that it was often difficult for them to maintain appointments due to lack of childcare or transport options, they claimed that if they felt it was important and beneficial for them to see a health professional, they would make it happen. More important concerns for immigrant and refugee women include lack of time for consultations, hospital waiting lists for procedures, and challenges associated with the language barrier.

The women interviewed said that it was not essential to see a health professional from the same cultural background. While it is convenient if the practitioner can speak their language, women accepted that this is not always possible. The gender of the health practitioner is crucial however. Most of the women said that they prefer to see a female physician because of the confidential and sensitive nature of sexual and reproductive health issues. Women claimed that if they couldn't see a woman GP or health professional, it is likely that they would not return to the clinic.

'I wanted to have an IUD and requested a female doctor. They provided me with a male doctor and I refused to have it. It was two years ago and until now I do not have one.'
(Middle Eastern focus group participant)

Most of the women interviewed admitted to having never used a professional interpreter in the clinical setting before.

'Often it's part of their culture to not have male health carers, that's an issue because we have a lot of male health carers, so that's not culturally appropriate for them, and they can request to not have a male doctor, but we can't always provide that.'
(Key stakeholder - Midwife)

Accessing culturally and linguistically appropriate healthcare is an issue for women from immigrant and refugee backgrounds. Most of the women interviewed admitted to having never used a professional interpreter in the clinical setting before. They claimed that when they visit a GP, they are not given the option of using an interpreter. Some women said that they would not feel comfortable asking for an interpreter, and did not feel like it was their responsibility to request one. Participants spoke of their frustration at feeling rushed in a GP consultation and suggested that perhaps they weren't being offered an interpreter because it would add further pressure to this perceived lack of time.

Women in this study voiced their concern about the gender and ethnicity of interpreters, availability of interpreters and quality of services. Women from smaller communities felt uneasy about using a professional interpreter for fear of being judged, or other members in their community finding out. Accessing trained interpreters with appropriate language skills is crucial, although this is not always adequately funded, particularly for recently arrived communities (Murray & Skull, 2005).

'Whenever we request an Arabic interpreter, we always get Lebanese or Egyptian speaker which makes things more complicated for us and the doctors.'
(Sudanese focus group participant)

If an interpreter is required, the women claimed that the health professional would generally use a family member or friend. One woman recalled a situation where the GP used her eight year old son as an interpreter. While she knew that it was inappropriate, she had no other choice as there was not an Arabic interpreter present, and she didn't want to cause problems for the doctor.

'The child was terrified and went pale. He is eight years old, he understood the doctor, but I did not because I don't speak English and there was no interpreter provided.'
(Middle Eastern focus group participant)

As the above case demonstrates, health practitioners commonly use untrained interpreters such as family, friends and bilingual staff in three way communications. This is borne out of convenience but also out of having limited resources and understanding of the advantages of using accredited interpreters.

'Some GPs don't use a professional interpreter, because they are too busy. This means that the woman is not getting a thorough assessment. If services don't use interpreters, this can be very distressing and confusing for the woman and if materials aren't translated into specific languages, this can be equally confusing.'
(Key stakeholder - Nurse)

The findings of the study demonstrate that the issue of language and the use and availability of interpreters in the clinical setting continues to be an enormous challenge for women from a NESB in accessing health information. The Victorian and Australian governments provide funding for interpreter services. Australia is the only country in the world with a federally funded translating and interpreting service that provides a national, 24 hour, seven-days-a-week telephone interpreting service (Foundation House, 2012). Despite this, there are many occasions when health practitioners do not use qualified interpreters when seeing clients who are not proficient in English.

Often clinical interactions are conducted in the absence of adequate mutual understanding between women and health workers. Many consultations between health practitioners and clients not proficient in English proceed with no assistance.

'If services don't use interpreters, this can be very distressing and confusing for the woman and if materials aren't translated into specific languages, this can be equally confusing.'

(Key stakeholder - Nurse)

When patients with limited English require but do not receive the services of qualified health interpreters, their quality of care and related health outcomes are significantly compromised.

A study by Heaney and Moreham reveals that 'attempting to manage without help' is the fall back communication strategy for many health practitioners (46 per cent) when a qualified interpreter is not available (Heaney & Moreham, 2002).

While it may be more convenient for a family member or friend to act as an interpreter, this can be problematic. Family members may become privy to sensitive and potentially distressing information and particularly if a minor is used as an interpreter, this raises significant ethical concerns. Accuracy of information is also an issue when non-accredited interpreters are used. In a review of the international literature examining 'the impact of medical interpreter services on the quality of health care' substantial evidence was found to support the conclusion that when patients with limited English require but do not receive the services of qualified health interpreters, their quality of care and related health outcomes are significantly compromised (Johnstone & Kanitsaki, 2006).

In their research considering the links between culture, language and patient safety, Johnstone and Kanitsaki suggest that the health system needs to be improved via the development and deployment of systems and strategies, at both the organisational and individual levels, that would 'make it hard for people to do the wrong thing and easy for people to do the right thing' (Johnstone & Kanitsaki, 2006, p. 386). In other words, systematic processes need to be put in place that would make it difficult for an attending health professional to not use an accredited interpreter when engaging with a patient whose language and culture he or she does not understand (Johnstone & Kanitsaki, 2006).

Women in this study said that one of the most important things for them in making health decisions is that information is provided to them in their own languages. Aside from the provision of multilingual written information, this can only occur in a clinical encounter if a qualified interpreter is used. When professional interpreters are required but not provided, health practitioners can also suffer as they cannot provide the same diagnostic expertise and quality of care.

Bilingual staff and family members should not be used as interpreters in clinical consultations, due to the risks of poor and inaccurate communication. In non-acute cases, clients should be referred to community health or health organisations with bilingual and bicultural workers who are able to devote more time and resources to the woman.

'The community setting is a little bit different to GPs and big hospitals. I see women for 90 minutes and I have an interpreter for the full 90 minutes. Nearly all of my clients have an interpreter, it's unusual not to have an interpreter.'
(Key stakeholder - Community health nurse)

A number of major themes that impact immigrant and refugee women's SRH have been examined in this chapter.

- Accessibility of information and services
- Gender and cultural norms
- Pre-migration and migration experience
- Mental health
- Violence against women
- Socio-economic position
- Practical issues

The themes outlined above are influenced by a combination of cultural, political, structural and individual factors. This study demonstrates that religious and cultural practices impact the process through which SRH is navigated. Cultural and gender norms can influence ideas around treatment, illness and, in the case of mothers, child rearing. In addition, women's migration journeys and subsequent settlement experiences are important determinants of both physical and mental health.

Furthermore, a number of systemic issues within the health system negatively impact upon women's potential health and wellbeing. Inadequate funding, poor consultation time and a lack of awareness about best practice procedures for the appropriate use of interpreters all significantly reduce the possibility that women will receive quality health treatment.

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

The negotiation of SRH for immigrant and refugee women is complex. Common Threads has drawn on the experiences of four different cultural groups of women to highlight the concerns and challenges that immigrant and refugee women face in this area of health.

This research highlights the need to address both clinical practice and social and cultural issues within migrant communities and wider society to ensure that women can be informed about, and exercise their right to access appropriate services.

To overcome the challenges that were identified in this research, a multifaceted approach is needed. Emphasis needs to be placed on providing equitable healthcare service delivery so that immigrant and refugee women are able to access culturally appropriate sexual and reproductive health services. In other words, resources must be distributed and processes designed in ways most likely to move toward equalising the disparity of health outcomes between different social groups. This can only be achieved if immigrant and refugee women's health is conceptualised within a 'social determinants of health' framework: one that recognises women's complex and multiple identities as well as the political and socio-economic realities of their lives. Furthermore, the promotion of a holistic model of care that values immigrant and refugee women's experiences, knowledge and culture should be at the core of health policy and practice.

IT IS RECOMMENDED THAT:

- A social determinants and gender equity framework be embedded in approaches towards national policies that impact on immigrant and refugee women's health and wellbeing. Interventions and policies need to recognise and account for the diversity of women's lives and health needs. This includes cultural, religious and linguistic diversity, disability, sexual identity, age, geographic location and socio-economic status.
- Comprehensive research and gendered data collection of health outcomes according to ethnicity (region of birth, ancestry, country of birth and/or language groups) be undertaken at the national level to build up an evidence base.
- MCWH develop a best practice guide for working with immigrant and refugee women in the area of sexual and reproductive health.
- A qualified interpreter be used in clinical consultations when and wherever possible. It is preferable to use bicultural and bilingual health workers, particularly in health promotion. This ensures that information provided is exchanged in a culturally relevant and appropriate way. Multilingual health information should also be provided to women in a number of different mediums.
- Immigrant and refugee communities be consulted regularly in order for the health system to learn appropriate strategies that will increase the capacity of all women to access sexual and reproductive health services.
- Mainstream services work in partnership with immigrant and refugee communities as well as ethno-specific services and multicultural organisations to learn and exchange healthcare needs and delivery; provide cross cultural training with health professionals and service providers; and provide culturally appropriate and relevant preventive health education. Gendered, cross cultural approaches and initiatives should be implemented nationally within health services.
- Health providers develop, in partnership with multicultural community organisations, social inclusion initiatives and service delivery that considers the ways in which immigrant and refugee women create community and relate to the broader community.
- Information and resources about sexual and reproductive health be available in a range of media and technologies, and be disseminated widely via bilingual workers to assist women to make informed decisions. Any materials should specifically recognise the needs of immigrant and refugee women.
- Funding for women's services, in particular immigrant and refugee women's services, is retained and increased.

APPENDICES

APPENDIX 1:

COMMON THREADS ADVISORY GROUP MEMBERS

- Dr. Salma Al-Khudairi,
  Multicultural Centre for Women's Health, VIC
- Professor Pranee Liamputtong,
  La Trobe University, VIC
- Dr. Celia McMichael,
  La Trobe University, VIC
- Jacinta Waters,
  Royal Women's Hospital, VIC
- Natalija Nesvadba,
  Mercy Hospital for Women, VIC
- Bich Ha,
  North Yarra Community Health, VIC
- Dr. Daniela Costa,
  private practice, SA
- Dr. Katherine Vasey,
  Monash University, VIC
- Vivienne Strong,
  NSW Health, NSW

AGENCIES REPRESENTED IN THE KEY STAKEHOLDER CONSULTATION

- Centre for Ethnicity, Culture and Health, VIC
- Mercy Hospital for Women, VIC
- Royal Women's Hospital, VIC
- Cancer Council of Victoria
- Family and Reproductive Rights Education Program, VIC
- Family Planning, NSW
- SHine, SA
- Southern Health Victoria
- Banyule Community Health, VIC
- Alfred Hospital, VIC
- ISIS Primary Care, VIC

APPENDIX 2:

KEY STAKEHOLDER CONSULTATION QUESTIONS

The main consultation questions included:

1. What are the most common groups/ demographics of women who access your services?
2. Commenting on knowledge, attitudes and practices, what are the key sexual and reproductive health issues for immigrant and refugee women? You can be culture specific.
3. In your experience how has culture/ experience influenced women's knowledge, attitudes and practice in regards to sexual and reproductive health?
4. To what extent do immigrant and refugee women recognise the importance of sexual and reproductive health to their overall wellbeing?
5. How might the migration experience influence immigrant and refugee women's health?
6. What are the information seeking behaviours of immigrant and refugee women in Australia? How and where might they seek health information?
7. What information needs to be provided to immigrant and refugee women about sexual and reproductive health?
8. In your experience/opinion, what are the best ways to share information with immigrant and refugee women?
9. In what ways do you think your organisation is competent to work with immigrant and refugee women or to provide appropriate information?
10. What are the difficulties for immigrant and refugee women in accessing sexual and reproductive health services in Australia?
11. What are some of the challenges that you face when working with women from immigrant and refugee backgrounds?
12. How do you approach/ overcome these challenges?
13. What successful health promotion strategies have you used for women from diverse backgrounds?
14. What might encourage immigrant and refugee women to participate in health promotion activities?
15. Any other comments?

APPENDIX 3:
FOCUS GROUP DISCUSSION QUESTIONS

THEME 1: MEANINGS, BELIEFS, PERSONAL VALUES

Discussion about women's health:

- Discuss personal meanings and interpretations
- What does it mean to be healthy?
- What are some of the factors that enable women to be/feel healthy?
- Main health issues affecting women?
- What do you do when you are not feeling well?
- What do you do in order to stay healthy?

Sexual and reproductive health:

- Discuss personal meanings and interpretations
- Prompts: sexually transmitted infection, pregnancy care - after you have the baby, breast screening, pap tests, rights, culture, contraception, family planning, violence, sexuality, traditional cutting
- Who do you speak to/ where do you go if there is an issue with your sexual/ reproductive health?
- In what ways do you maintain health in this area?

THEME 2: ACCESS TO INFORMATION

- Health information - where/ what/ how
- Prompts: where do you go?
- What kind of health information?
- How is it presented? Clear and sufficient?
- Country of origin and Australia - same kind of information? Same experiences? Problems? Challenges? Successes?
- Could you find what you wanted? What information needs to be provided for immigrant and refugee women?

THEME 3: ACCESS TO SERVICES

- Health Services - where/ what/ how
- Prompts: what kinds of services?
- Talk about experiences - good practice, draw out positive examples
- Talk about feelings and experiences around difficulties and challenges
- Country of origin and Australia - same experiences? Problems? Challenges? Successes?

THEME 4: FEEDBACK AND SUGGESTIONS

Suggestions about how to make services better for immigrant and refugee women - from this, discuss what might encourage women to participate in health promotion activities?

APPENDIX 4:

FOCUS GROUP PARTICIPANT CONSENT FORM

Multicultural Centre for Women's Health

COMMON THREADS INFORMATION SHEET AND CONSENT FORM

I understand that:

- I am participating in a 2 hour focus group in ..... run by a Health Educator of the Multicultural Centre for Women's Health
- I can say as much or as little as I like during the focus group
- I can stop participating if I feel uncomfortable
- personal information will be collected, but this information will always be kept CONFIDENTIAL
- everything that is said in the focus group will be kept totally CONFIDENTIAL
- the focus group will be recorded to enable the Health Educator to take notes of the sessions afterwards, but these notes will be kept totally CONFIDENTIAL, (I will let the Health Educator know if I do not wish to be recorded)
- the notes taken during or after the focus group are for the purpose of learning what issues and needs should be addressed to ensure that health professionals are more culturally aware in terms of immigrant and refugee women's sexual and reproductive health
- only the Health Educator, the Project Worker at the Multicultural Centre for Women's Health, will see these notes and know I attended the sessions
- the information collected during the focus group will be presented in a general way in a report to help learn about the best way to provide culturally appropriate services and programs to immigrant and refugee women
- my contribution to the focus group may help the development of health promotion for immigrant and refugee women
- if I would like written information in my language regarding health and wellbeing, the Health Educator and Project Worker will try to find suitable information, but they cannot promise that this information can be found

I FULLY UNDERSTAND THE INFORMATION GIVEN TO ME ABOUT THE FOCUS GROUP AND I AGREE TO PARTICIPATE.

Write your name here	*Sign your name here*	*Date*

☐ Bilingual health educator to complete:
Participant did not want to sign consent form but wants to participate in focus group

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"We should know that diversity makes for a rich tapestry, and we must understand that all the threads of tapestry are equal in value no matter what their colour."
Maya Angelou (American author & poet)

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