Bilingual health education: An essential tool to prevent violence against women

Safety and Support in My Language Project Findings

Acknowledgement of Country

The authors of this report are proud to **acknowledge that the land to which we migrated, and on which we work and live, was and always will be Aboriginal land.** We pay our respects to the Traditional Owners and Elders of the land on which our offices are located, the Wurundjeri people of the Kulin nation. We also pay our respect to all First Nations people, and their cultures, and connections to Country and waterways.

About this Report

This report was written by the Multicultural Centre for Women's Health (MCWH), **a feminist organisation led by migrant and refugee women** to achieve equity in women's health and wellbeing.

The publication of this report and the Safety and Support in My Language (SSMyL) Project were supported by the Victorian Government.

> *"This project was unique as it was the first Prevention of Violence Against Women project implemented by MCWH to include individual interviews and focus groups following the bilingual health education sessions. These interviews and focus groups were also led by bilingual health educators. It provided a really rare opportunity to gather evidence on what women learnt from the sessions, and any services and family violence services gaps they identified" - Bibiana Huggins, SSMyL Project Officer*

Bibiana Huggins, who was responsible for project implementation, extends her gratitude to MCWH Health Educators Gagan Cheema, He Li, Huda Al Saba, Manasi Wagh-Nikam, Rachel Chung, and Wafa Ibrahim, for their important contributions and for lending their cultural, linguistic, and intersectional feminist expertise not only to health education and interviews, but also to the research design and analysis.

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Executive Summary

Research shows that family violence against migrant and refugee women is at least as prevalent as in the general population, but migrant and refugee women are less likely to access appropriate family violence support at an early point (Vaughan et al. 2016).

In 2020-21, the **Safety and Support in My Language (SSMyL) Project** addressed this issue by providing bilingual education about family violence in Mandarin, Arabic and Hindi to 35 migrant women from seven different cultural backgrounds based in Victoria. The project aimed to increase migrant and refugee women's understanding of family violence and healthy relationships, the links between gender inequality and family violence, and how to recognise early signs of violent or abusive behaviour, in a culturally appropriate setting.

Following the health education sessions, the project conducted bilingual focus groups with participants to ascertain their service use preferences, their experiences using the family violence service system in Victoria, and what they gained from their participation in the project. The project found that:

1. Bilingual health education makes information about family violence accessible

Bilingual health education makes information about family violence clearer and more meaningful for migrant and refugee women. Trained bilingual educators clarify key concepts, discuss issues within the context of women's lives, and provide **relevant and understandable information and resources.**

2. Bilingual health education effectively raises awareness of the links between family violence and gender inequality

Gendered inequality is a key driver of violence against women. Bilingual health educators can better explain the links between gendered inequality and family violence in the preferred language of participants. Learning that family violence is a shared social issue, rather than an isolated, individual experience is powerful. It is especially relevant to migrant and refugee women whose migration status can increase their isolation and dependence on male partners or extended family members.

Bilingual health education creates a space for women to **discuss gender equality in a culturally safe and meaningful manner.** In some languages there is no direct translation for terms such as gender equality, so bilingual health education enables discussion of key concepts within their cultural context.

3. Bilingual health education increases migrant and refugee women's understanding and confidence navigating services.

Evidence shows that migrant and refugee women are less likely to access family violence services at an early stage, which can mean they face longer and more severe or escalating abuse. Participants in bilingual health education sessions reported **increased confidence in identifying family violence and navigating support services if needed.**

"After attending the session, I feel more confident in identifying all types of family violence especially the financial and spiritual types. Also, I feel more confident in navigating the support services." (Arabic-speaking participant)

"After attending this session, I feel more confident in evaluating my relationship with my partner [and] knowing early warning signs. I am also more confident in navigating the support services. Before this session, I was blaming myself if anything happened. This session has changed my attitude as it is not my responsibility alone."

(Arabic-speaking participant)

4. Bilingual health education strengthens migrant and refugee women's leadership and advocacy capabilities.

Bilingual health education empowers migrant and refugee women to **advocate and raise awareness about family violence within their social networks.** This is critical, as migrant and refugee women commonly access health information and support through family and community.

Almost all participants said they would now try and help other women, by sharing their new knowledge about the links between gender inequality and family violence and providing information and contacts of family violence services.

- Most Arabic and Hindi-speaking participants said they felt confident to share information from the education sessions with friends and family.
- Most participants stated feeling more **"empowered"** and **"determined"** to make changes and spread knowledge in their homes and communities.

100%

of Arabic and Hindi-speaking participants preferred education in their language rather than in English.

69%

of all participants said the lack of bicultural workers in the family violence system is a major barrier to access support and information.

55%

of all participants said that health information delivered in English or with interpreters was difficult to follow.

100%

of Arabic-speaking women received information about the links between gender equality and family violence for the first time.

86%

of all participants learned that family violence is not only physical but can also be emotional and financial.

77%

of Hindi and Mandarin participants stated that they had learned much more about gender equality and healthy relationships through the project.

Project background and context

In 2021, **51.5% of people living in Australia are born overseas or have a parent born overseas**. Women born in a non-English speaking country make up 21.5% of the Australian population, numbering 2,630,729 (ABS 2021). Research shows that family violence against migrant women is at least as prevalent as it is in the general population, with the added concern that **migrant women are less likely to access appropriate family violence support at an early poin**t (Vaughan et al. 2016). Studies suggest that migrant women experience violence more severely and for more prolonged periods of time than non-migrant women (Lum et al. 2016), yet they are less likely to receive the services they need (Vaughan et al. 2020).

Following the Royal Commission into Family Violence (RCFV), the Victorian Government committed to developing a family violence system that is responsive, timely, accessible, and inclusive. However, the system remains inaccessible to many migrant and refugee women. Recent research has shown that while family violence reports increased among the general population after the RCFV, this was not the case for migrant women where reporting remained low (Satyen et al. 2020).

Models of care that utilise bilingual educators to work alongside the family violence system, show increased engagement with, and easier navigation of, the system among migrant women. Such programs safely, and in culturally appropriate ways, provide information to women about family violence and the available support system, without women feeling pressure to disclose their situation.

The Multicultural Centre for Women's Health (MCWH) is a migrant and refugee women's health service based in Victoria, which has been in operation since 1978, and is uniquely suited to address this issue. MCWH provides **tailored, responsive, accessible, and equitable health and wellbeing programs for migrant and refugee women across Victoria**, as well as specific research, policy and training programs across Australia.

MCWH runs **education programs that break down access barriers by offering in-language outreach education programs delivered by trained peer educators**, to ensure migrant women can access information and support where it works best for them: where they work, live, study and play. Our tested MCWH health education model takes **a feminist intersectional and woman to woman approach** to health education.

MCWH designed and implemented the SSMyL Project to **respond to the lack of bilingual health education targeting migrant and refugee women to prevent family violence**. It aimed to:

- strengthen migrant and refugee women's understanding of family violence and healthy relationships in a culturally appropriate setting,
- build their understanding of the links between gender inequality and family violence, and recognise early signs of violent or abusive behaviour.

> MCWH runs education programs that break down access barriers by offering in-language outreach education programs delivered by trained peer educators, to ensure migrant women can access information and support where it works best for them: where they work, live, study and play.

Interviews and focus groups conducted in this project provided insights highlighting the findings presented in this report.

Violence against migrant and refugee women in Australia

Investigations of violence against migrant and refugee women in Australia are limited (Block et al. 2021), and researchers note that there is **currently no clear or consistent data available on the extent of violence against migrant and refugee women** (Vaughan et al. 2016, Webster et al. 2019). However, a detailed study of migrant and refugee women's experiences of violence was undertaken in 2015-16 called the ASPIRE Project, which took a participatory and intersectional feminist approach to the research and interviewed women in a range of metropolitan and regional areas in Victoria and Tasmania. The project found that migrant and refugee women's experiences of violence, support and help seeking were impacted by four core contexts: their **immigration context, family context, geographical context, and service system context.**

The analysis of these contexts highlighted how risks of violence can be exacerbated by women's increased dependence on their partners and families through **visa restrictions, increased social isolation, racial discrimination, limited services for migrant and refugee women in rural areas, under resourced family violence services, disconnection between family violence and settlement services, and challenges to women's independence through the lack of health, social, and economic opportunities available on temporary visas.** Furthermore, according to the Migrant Refugee Women Safety and Security Survey (Segrave, Wickes and Keel 2021, p. 9), women on temporary visas report even higher levels of violence. This includes migration related abuse, financial abuse, controlling behaviour, and threats.

“After the session,
I know that looking
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home is work as well,
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It is well established that family violence services in Australia struggle to provide equitable support to migrant and refugee women due to funding restrictions, and funding conditions that exclude some women based on postcodes and visa status.

Barriers to accessing family violence support and services

In addition to highlighting the contexts of violence for migrant and refugee women, the ASPIRE Project found that **migrant and refugee women often accessed support at a later point, often only when women's experiences of violence had reached a crisis point.** Researchers noted that this crisis point generally entailed an increase in the severity of violence and threats, and a woman's fear for her safety or that of her children.

It is well established that family violence services in Australia struggle to provide equitable support to migrant and refugee women due to funding restrictions, and funding conditions that exclude some women based on postcodes and visa status. Service providers are also impacted by inadequate resourcing, many of them reporting to have performed duties outside of their roles in order to provide necessary additional support to migrant and refugee women. (ASPIRE 2016; Vaughan et al. 2020a).

Improving equitable family violence support for migrant and refugee women therefore necessitates structural and systemic change. For example, Vaughan et al. 2020b note that the following factors prevent migrant and refugee women from accessing and/or seeking help from mainstream family
violence services:

- lack of multilingual information
- services' inconsistent use of interpreters
- financial barriers
- social isolation
- potential backlash from social networks
- threats of deportation
- experiences of discrimination
- mistrust of authorities
- residency rights/visa conditions
- pressure and/motivation to maintain the family unit
- eligibility for services and impacts on migration

Project methodology

The SSMyL Project was conducted from June 2020 to February 2022 with 35 women of migrant and refugee backgrounds from the northern and eastern suburbs of Melbourne (City of Hume, City of Whitehorse, and City of Moreland).

The project took a **feminist and intersectional approach**, and MCWH Health Educators participated and advised throughout all stages of the project. Three participatory workshops were held where Health Educators collaborated on interview questions, research design, and data analysis. Health Educators were asked to **translate and tailor three MCWH education modules on the topics of Gender Equality, Healthy Relationships, and Family Violence, to suit participant needs.** Health Educators added their own case studies, examples, videos, and referral services to existing modules which made information more accessible and meaningful for women in their groups. Health Educators were provided with training, ongoing support and resources on how to respond to family violence disclosures, how to manage backlash and resistance, and how to conduct interviews and focus groups.

A total of six MCWH Health Educators were engaged to deliver online bilingual health education sessions in Arabic, Chinese and Hindi using the tailored modules. Following each session, interviews and focus groups with participants were conducted. The aim of follow-up interviews and focus groups was to find out what women had learned from health education sessions, whether they would be more likely to contact family violence services earlier, and what impact they had on women's lives.

Bilingual health education sessions

MCWH Health Educators are trained and experienced educators who use their unique expertise to apply a feminist and intersectional lens to gender equality, healthy relationships, and family violence education. **All MCWH Health Educators are bilingual or multilingual, and have an experience of migration to Australia from another country.** Sessions are run in the chosen language of the participants who are attending.

The sessions were divided into three main topics:

- Gender Equality,
- Healthy Relationships, and
- Family Violence

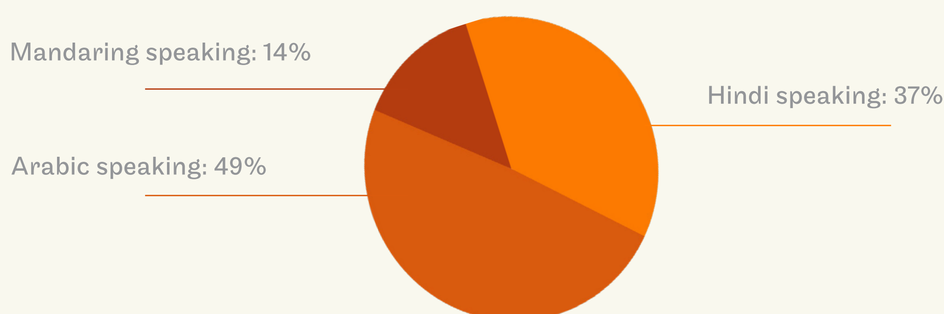
Gender Equality sessions encouraged **brainstorming on the differences between sex and gender, gender roles and norms, gender equality/ equity, and women's rights.** Healthy Relationships built upon the Gender Equality module to assist women in **identifying and differentiating signs of unhealthy** (control, threatening, fear) **and healthy relationships** (respectful, safe, communication). The third and final session on Family Violence provided participants with information and case studies on different forms of violence, women's rights to live free from violence, and family violence support services, including a service system navigation map. Bilingual health education sessions were delivered to women's groups of partner organisations from the north and eastern suburbs of Melbourne.

Participant demographics

A total of **35 women from migrant and refugee backgrounds** participated in health education sessions. Specifically:

- Sessions were delivered in Arabic to a women's group in Melbourne's northern suburbs (City of Hume LGA). The sessions were delivered online via videoconference to an average of 17 women between 30 to 45 years.
- In partnership with a multicultural community centre in Melbourne's eastern suburbs (City of Whitehorse LGA), sessions were delivered online in Mandarin to an average of 5 women between 33 to 63 years.
- Sessions were delivered online in Hindi with three women's groups in Melbourne's northern suburbs (City of Hume and City of Moreland LGAs) reaching an average of 13 women between the ages of 25 to 45 years.

Participants according to language spoken



Language	Participant average across all three sessions	Age range
Arabic	17	30-45
Mandarin	5	33-63
Hindi	13	25-45
Total (%)	**35**	**25-63**

It is important to note that **the women in this study brought unique contexts and levels of experience relating to family violence, which influenced their understanding and familiarity accessing family violence services.** The Mandarin-speaking group and one Arabic-speaking woman were survivors of violence and had experience in accessing family violence services. Some Arabic-speaking and Hindi-speaking groups noted that they had received information about family violence, but it had been in the English language or provided through interpreters. Women who participated in the Arabic-speaking group were mostly newly arrived in Australia and expressed difficulties with family violence information provided in English. In contrast, most Hindi-speaking participants had been in Australia for 10 years on average, with some women studying and working.

"Now I have learnt something about the family violence in a whole and systematic way; I know how to protect myself. In the past, I would not know how to protect myself as there was no chance to learn what family violence is."

Interviews and focus groups

In order to maintain **a participatory and migrant and refugee women-led approach to data collection,** interview and focus group questions were co-designed between project organisers and Health Educators. Of the 35 women who participated in health education sessions, 29 women participated in follow-up interviews and focus groups. The confidentiality of all participants was maintained through consent protocols and plain language statements that were translated by representatives from partner organisation and Health Educators.

Between August to September 2021, six individual interviews and four focus groups were conducted in Simplified Chinese, Arabic, and Hindi. They were conducted by different Health Educators from those who had facilitated the health education sessions to enable transparent discussions about what women had learnt during sessions. Their purpose was to provide the opportunity to migrant and refugee women **to outline service gaps that impacted their experiences.** Focus groups and individual interviews took place, as follows:

Focus groups	No. of groups	Individual interviews	No. of individual interviews
Hindi-speaking	2	Mandarin-speaking	5
Arabic-speaking	2	Arabic-speaking	1
Total participants	**23**	**Total participants**	**6**

All interviews and focus groups were conducted in women's preferred languages and online via Zoom. Health Educators transcribed in-language information into English and submitted translated transcriptions.

Key findings

The need for a bicultural violence prevention workforce

Research has shown that **bilingual health workers play an integral role in delivering health services and health education. Bilingual workers have been found to provide information in culturally empowering ways, and to clarify concepts, terminology, and provide essential context to information** (Lee, Sulaiman-Hill and Thompson 2014).

Recent findings from the Breaking the Barriers Report (GENVIC 2022) further support the importance of bilingual health education, showing that women greatly valued bilingual health education sessions because they were able to more critically engage with the information, feel more confident in their understanding of the issues, ask questions and get answers directly, and connect with other women in their community.

A violence prevention workforce focuses on awareness raising, education and promoting gender equality, to prevent violence before it starts. Women who participated in the SSMyL Project affirmed the importance of bilingual health education on topics related to preventing family violence and promoting gender equality for increasing their understanding and awareness.

100% of Arabic and Hindi-speaking participants stated a preference for bilingual education, rather than English.

When asked whether they had received education about gender equality, healthy relationships or family violence before, most Arabic-speaking and all Hindi-speaking participants noted that they had received some information about family violence before, but that it had been delivered in English or with an interpreter. All women in these groups stated a preference for bilingual education instead.

More than half (55 %) of all participants noted that health information delivered in English or with interpreters was difficult to follow.

Some participants said that receiving health education through interpreters made it difficult to concentrate over extended periods time, and information was not always easy to follow or understand.

In addition to receiving information in their preferred language, participants also described **the value of having the information delivered by someone who shares a similar cultural background, and is able to make content more relatable, use culturally relevant examples and case studies, understand cultural contexts, and navigate group dynamics.** Participants agreed that topics like gender equality, healthy relationships, and family violence are sensitive, and even with an interpreter, women were hesitant to speak about them openly. Women interviewed reported being more comfortable to speak about these topics with someone from their own culture. They stated that Health Educators from the SSMyL Project delivered information in a sensitive way and knew **how to make concepts relatable and help women make connections about how they could incorporate these into their everyday lives.** For example, while most women had heard of gender equality before, they gained new understanding of what gender equality meant in the context of family violence through Health Educator explanations. Participants also stated that **Health Educators facilitated a space for women to discuss topics in a non-judgemental and culturally safe manner.**

60% of Mandarin-speaking participants outlined the importance of bilingual family violence services.

When asked about positive experiences with family violence services, or what the services needed to know to improve support for women, 60% of Mandarin-speaking participants raised the importance of bilingual services. For instance, one participant stated that ***"in-language is good, as it is more clear to understand"***. Another participant noted the difficulty of understanding family violence jargon, particularly legal terms, and felt that a Chinese social worker would have been better able to support them in understanding concepts.

Hindi-speaking participants also talked about the importance of in-language information and called for more interpreters in family violence services. However, several participants interviewed spoke of difficulties using interpreting services when accessing family violence services.

"My experience with an interpreter is that the interpreting is not clear to follow, and the quality of the translation is poor. It is like, out of context, which made me even more worried."

Speaking about her past experience with a family violence service provider, one participant said:

> *"My experience with an interpreter is that the interpreting is not clear to follow, and the quality of the translation is poor. It is like, out of context, which made me even more worried."*

Importantly, this participants experience highlights that **having to communicate through an interpretation service can increase women's concern and anxiety in seeking help, and do not guarantee clear communication or understanding.**

Reluctance to communicate through an interpretation service was also raised as a deterrent for some participants who used telehealth services during COVID-19. One participant advised that she was no longer attending her specialist medical appointments during lockdowns due to telehealth services that used an interpreter on the third line. As the Health Educator who conducted this focus group reflected:

> ***"Women would be more likely to access services earlier rather than later if they could speak to someone in their language,*** *didn't have to repeat themselves too much, someone with whom they would feel more comfortable speaking with."*

Findings about migrant and refugee women's dissatisfaction with using interpretation services is an important illustration of a health service gap – where equal access to health information and service is impeded by Australian healthcare systems that privilege monolingualism.

Migrant and refugee women's narratives in this project demonstrate that **full comprehension of health information is not always achieved through interpreters, which can be a deterrent to seeking family violence support for some women.** In addition to interpretation services, a bilingual and bicultural workforce could explain concepts and discuss family violence concerns directly with women accessing services, which would support better access and equity.

The effectiveness of bilingual health education

Leading prevention programs in Australia have underscored gendered inequality, as it intersects with other forms of discrimination, as the key driver of violence against women. Accordingly, Change the Story: a shared framework for the primary prevention of violence against women in Australia (Our Watch 2021) notes that **changing the social norms, structures, and cultures which perpetuate gender inequality ensures the greater safety of women.**

77% of Hindi and Mandarin-speaking participants stated they had known very little about gender equality and healthy relationships prior to SSMyL Project health education sessions.

SSMyL Project health education sessions **raised awareness of underlying causes of violence** including harmful gender norms and gendered structural disadvantage and enabled the identification of early signs of violence through healthy relationships and family violence education.

100% of all participants in the SSMyL Project received education on gender equality and healthy relationships in the context of family violence for the very first time.

While many participants had heard of the terms 'gender equality' and 'heathy relationships' before, they reported not having known about how they related to family violence. It was noted that there was no direct translation for terms such as gender equality in some languages, and that health education sessions helped women understand where violence "stemmed from".

Following health education sessions, women stated that many of their understandings about gender and gender equality had been changed. One Mandarin-speaking participant, stated:

> *"After the sessions, I know that looking after children at home is work as well and women can learn to gain equality. We should also be respectful to each other. I was reminded that women are controlled by men through home duties."*

A participant from the Arabic-speaking group said that **learning about gender equality and equity were the most memorable aspects of the health education sessions, as their links with family violence had never occurred to her before.**

100% of all participants prior to health education sessions had understood violence against women as physical violence only and had not received information about social, emotional, psychological, verbal and financial abuse.

Women's understandings of family violence were also broadened during health education sessions, and their ability to identify and seek support for violence was strengthened. They know how to protect themselves, by knowing more about what constitutes family violence. One Mandarin-speaking participant stated:

> *"Now I have learnt something about the family violence in a whole and systematic way I know how to protect myself. In the past, I would not know how to protect myself as there was no chance to learn what family violence is."*

Another Mandarin-speaking woman noted that:

> *"For family violence, I thought that violence was only involving physical motions, I would never know that family violence can be getting hurt from psychological attacks or even just verbal language."*

When asked what some of the most memorable parts of the health education sessions were, some Arabic-speaking participants described learning that every person has the right to feel safe, and that, one woman out of four experience family violence. Both Arabic-speaking and Hindi-speaking groups identified information about non-physical forms of violence as new knowledge, and recalled information about power, control, and stalking being forms of violence as particularly relevant. Women from Arabic-speaking groups also noted that they gained new knowledge that family violence can occur between extended family members such as brothers, sisters and fathers, among others.

Gaining confidence about women's rights was also identified as important in feeling empowered to seek support and advocate for equality. For example, one Arabic-speaking participant stated:

> *"After attending the sessions, I feel more confident in evaluating my relationship with my partner, knowing early warning signs of seeking support and help would help both of us. I am also more confident in navigating the support services. Before this session, I was blaming myself if anything happened. This session has changed my attitude as it is not my responsibility alone. Any successful relationship needs efforts from both partners."*

Another Arabic-speaking woman similarly stated:

> *"After attending the session, I feel more confident in identifying all types of family violence especially the financial and spiritual types. Also, I feel more confident in navigating the support services."*

"For family violence, I thought that violence was only involving physical motions, I would never know that family violence can be getting hurt from psychological attacks or even just verbal language."

As these comments illustrate, women gained increased confidence to identify family violence and seek support for their own relationships through the sessions. Mandarin-speaking participants similarly expressed greater confidence in recognising unhealthy relationships and equal rights. As one woman noted:

> *"We can stand up bravely to gain healthy relationship and equality. I was pessimistic and without confidence on myself, but I should fight for the equality I should have."*

The need to centre migrant and refugee women's leadership

Centring migrant and refugee women's leadership is essential to the creation of meaningful and strengths-based approaches to violence prevention. Evidence from the SSMyL Project confirms the findings of the Left Behind Report (GENVIC and MCWH 2020) showing that women most commonly access health information through community avenues. Strengthening women's capacity to disseminate knowledge of family violence support services, gender equality, different forms of violence, and healthy relationships throughout the community, therefore mitigates existing systemic barriers that migrant and refugee women face in service access. It also empowers women to advocate, educate, and raise awareness about violence prevention in a way that enacts change in culturally appropriate manners.

Women participating in this study were asked whether there was anything new that was learnt, and whether they would share this with people they knew. Many women reported that learning about gender equality and its links to family violence was an important new knowledge, and this knowledge would be shared among friends and family.
A woman from the Arabic-speaking group explained having a conversation with her sister after the health education sessions in which she told her:

> *"Well, you have the same rights as your husband. There should be gender equality in every country; every country should practice gender equity. Women from Hindi-speaking groups also stated they would share information about gender equality during get togethers, parties, and at the temple if these conversations came up. One woman noted that it was essential to "Start spreading the taste/flavour of equity around!"*

Hindi and Arabic-speaking participants emphasised the importance of sharing and practicing learnings from the SSMyL Project health education

“We can stand up bravely to gain healthy relationship and equality. I was pessimistic and without confidence on myself, but I should fight for the equality I should have.”

sessions in their homes. For example, one Hindi-speaking participant stated that it was important to: *"Start the conversation about equity from home, so we can achieve it in the society".*

Participants also noted that it was important **to be role models for children** who could always be watching, and that they would attempt to show children that they could, for instance, take on different job opportunities in the future, irrespective of gender: not just the jobs "that mummy and daddy had." Arabic-speaking participants similarly stressed the importance of treating and raising boys and girls in their families equally after the sessions. One woman relayed an example of how two siblings both worked in a factory and worked the same hours. She noted that once they finished the female sibling was expected to make dinner at home while the male sibling was able to relax. Many women in this focus group agreed that this was not fair, and that after "suffering" from gender inequality when they were young, they were: "determined to empower daughters to become strong and independent women."

Almost all women stated they would now try to help women experiencing family violence by providing them with information and contacts of family violence services. They would tell women that family violence is not an isolated experience, and that there are multiple organisations offering family violence support. Arabic-speaking participants also stated that it was important to continue the support to women experiencing violence, as they were often afraid to take the first steps to seeking support for fear of not being able to care for children and themselves on their own, for fear of what the community would say, financial fear, and also fear of being isolated from friends and family. As one participant stated:

> *"The session has given me the motivation to help other women who suffer from family violence because avoiding this serious problem could lead to disastrous consequences."*

While women from Mandarin-speaking groups expressed feeling ready to share knowledge about family violence and support other women, one woman noted she could not share this information as she had not been in Australia for long and did not have family or friends in this country. Another woman from the Arabic-speaking group stated that she would not take action against or talk about abuse with others for now, because she was also recently arrived in this country and only knew her husband and his family. These comments illustrate how **migration and resettlement can create specific and intersecting disadvantages for women who want to access information about family violence or seek support services.** The social isolation, lack of financial independence, fear of retribution from community members, and dependence on the perpetrator's family described by women in this project are exemplary of the types of factors that can prolong and lead to more severe violence for migrant and refugee women.

Conclusion

Evidence from the SSMyL Project interviews and focus groups demonstrates that bilingual health education has the capacity to improve women's awareness about family violence by making vital information accessible to migrant women without them needing to disclose their experiences of violence beforehand. **Bilingual health education enables migrant and refugee women to understand family violence more clearly, creates a space for women to discuss gender equality in a culturally safe and meaningful manner, increases migrant women's likelihood of contacting a family violence service and strengthens migrant and refugee women's leadership and advocacy capabilities.**

1. More investment needs to be made into bilingual programs

Bilingual health education and a bicultural violence prevention workforce are essential components as we work toward the development of a family violence system that is responsive, timely, accessible and inclusive. More investment needs to be made into bilingual programs, including those providing information to women about gender equality, family violence and the available support system in a safe and culturally appropriate way. It is also important that additional support is provided to multicultural community organisations as the primary place of contact for migrant and refugee women, to better support women experiencing violence.

2. Health education sessions improved women's chances of preventing and recovering from violence

SSMyL Project health education sessions, follow up interviews, and focus groups had a dual benefit for family violence prevention. Firstly, the health education sessions improved women's chances of preventing and recovering earlier from violence by increasing their awareness about gender equality, healthy relationships, and family violence. SSMyL education sessions increased women's abilities to identify the early signs of abusive behaviour including coercion, control, and emotional abuse. They increased women's awareness of their rights to respectful and safe relationships; as well as raised women's awareness on non-physical forms of violence and services support.

3. Early intervention initiatives increase women's safety

Supporting women to access response services earlier increases their chances of recovering after surviving violence and prevents women from crisis. Early intervention initiatives are therefore important to increase women's safety, and to utilise their knowledge to take leadership of family violence prevention and response in their communities.

4. It is vital to include migrant and refugee women in all aspects of the project design

By building women's knowledge and confidence on these topics, the SSMyL Project strengthened migrant and refugee women's leadership in preventing and responding to violence. The Diversity Council of Australia (2017) maintains that people of migrant and refugee backgrounds are consistently under-represented in leadership positions, and this includes in family violence prevention programs. The quality outcomes of the SSMyL Project, and the clear impact that the Project made on the participants involved, clearly demonstrates the value of involving migrant and refugee women in all aspects of project design, decision-making, implementation and evaluation.

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