

# Hobart Women's Health Centre



## MIGRANT AND REFUGEE WOMEN'S HEALTH PROJECT

### REPORT 2006/2007

Carolina Valencia  
Project Officer  
Hobart Women's Health Centre  
PO Box 248  
North Hobart  
[www.hwhc.com.au](http://www.hwhc.com.au)

**S T E P S**™  
EMPLOYMENT AND TRAINING  
SOLUTIONS  
[www.stepstas.com.au](http://www.stepstas.com.au)

## Contents

|  |    |
|--|----|
| Preface .....  | 4  |
| Summary .....  | 5  |
| Recommendations .....                                  | 7  |
| Background.....  | 8  |
| Outline.....   | 10 |
| Goals and Aims and Strategies .....                    | 10 |
| Project Steering Committee .....                       | 10 |
| Consultations .....                                    | 12 |
| Community Groups Consulted.....                        | 13 |
| Agency Consultations.....                              | 14 |
| Networking.....  | 15 |
| Funding Submissions .....                              | 15 |
| Report on Consultations.....                           | 16 |
| Demographics .....                                     | 16 |
| Migrant and Refugee Women .....                        | 16 |
| Service Providers .....                                | 17 |
| Scope of the Project .....                             | 18 |
| Language .....   | 18 |
| Interpreters.....                                      | 18 |
| Cultural Differences.....                              | 19 |
| Groups not Consulted.....                              | 19 |
| Discussion.....  | 21 |
| Understanding of (Western) Health Care Systems .....   | 21 |
| Mental Health.....                                     | 24 |
| Migrant and Refugee Women's Different Experiences..... | 26 |
| Service Providers .....                                | 26 |
| Operational Structure .....                            | 26 |
| Funding Submissions .....                              | 28 |
| Conclusion.....  | 30 |
| References .....                                       | 31 |
| Appendix A .....                                       | 33 |
| Regional Activities .....                              | 33 |
| Appendix B.....  | 35 |
| Glossary of Abbreviations & Terminology .....          | 35 |
| Appendix C.....  | 36 |
| Community Profiles and Participant Information.....    | 36 |

## Acknowledgements

I would like to acknowledge the support of the following people, who've helped the project along in many different steps of its journey:

*Rebecca Eli*, for her help with interpreting, promoting the project and connecting me with the right people;

*Terhas Fre Bayru*, a constant ear and great adviser, providing solutions to obstacles the project faced;

*Yabbo Thompson*, for her knowledge in consultations, report writing and editing which were invaluable to many aspects of the project;

*Jenny Kerrison* arrived at the perfect time to support the project with data analysis and interpretation, as well as report writing skills;

STEPS Employment and Training Solutions for the financial support to make the project possible;

*Martine Delaney and Julianne Campbell*, my sincere appreciation is extended to you both for the wonderful editing and patience and;

Last but not least, the *Hobart Women's Health Centre* for support of the project and a willingness to move forward in the directions required to better serve migrant and refugee women in southern Tasmania.

Carolina Valencia

Project Officer

Hobart Women's Health Centre

8 March 2007

## **Preface**

We are pleased to publish the latest in a series of reports urging a commitment from both State and Federal Governments to improving the ways in which we address issues facing migrant and refugee women in relation to their health and wellbeing. A total of 14 state-wide bi-cultural and multicultural women's health projects informed the Campbell report in 2001, which in turn led to the Collins report in 2002, and now this report in 2007. This represents over 10 years of continuous consultation and development of recommendations into the health and wellbeing of migrant and refugee women in Tasmania. (References for the 14 reports can be found at the end of the *References* section)

Projects involving consultation such as this inevitably generate information and other activities that are outside the scope of the project itself. This was particularly true for the Migrant and Refugee Women's Health Project and as such it was decided that whilst this information may not be directly relevant to the report it was still important for it to be acknowledged and made available. This information has been presented in Appendix A and titled 'Regional Activities'.

*Project Steering Committee*

*Migrant and Refugee Women's Health Project*

*2006/2007*

## Summary

### Project description

The Migrant and Refugee Women's Health Project was initiated by a range of stakeholders and builds upon past research conducted by the Hobart Women's Health Centre (HWHC) and Women's Health Access Program, DHHS.

The Project goal was to:

Improve access to quality health services for Tasmanian migrant and refugee women through the establishment of permanent regional migrant and refugee women's health worker positions.

The project aimed to achieve this through:

- Consultation with migrant and refugee women, service providers and other key stakeholders to identify changes in needs, service delivery and demographic data since publication of HWHC most recent research in 2002.
- The utilisation, support and expansion of existing networks of migrant and refugee women, service providers and other key stakeholders to inform and progress further development of the project.
- Researching appropriate funding options and preparation of (submission of) funding application(s).

### Key findings from the Consultation

This project's findings reflect that of the previous Tasmanian studies outlined in the Background to the Project. Health issues concerning migrant and refugee women cover a range of areas such as physical and mental health but are also affected by a lack of awareness of available health care providers and of (Western) health care philosophy and systems.

Service Providers also spoke about specific health issues they encounter in their work and targeted ways of addressing these. The difficulties of working in this area, particularly from a non-government organisational perspective, were highlighted and strategies were offered to deal with the limitations of working in often isolated and under resourced agencies. Service providers voiced a need for a more coordinated approach and pointed to examples from other health sectors such as youth, where a 'peak body' with state wide representation has been developed. The project findings reinforce the recommendation for regional migrant and refugee women's health workers to perform this coordinating function, however, they also suggest some refinement is needed in terms of an appropriate structure within which the role would operate.

## **Networking**

This project was able to utilise and expand on existing networks of people and organisations with an interest in migrant and refugee women's health. These networks included the project steering committee with members from each region of the state, migrant and refugee women, service providers, government and non-government organisations and other key stakeholders. Input from all network members has informed the recommendations contained in this report.

## **Funding Submissions**

### *Settlement Grants Program Department of Immigration and Citizenship (DIAC)*

A grant application was submitted to DIAC in order to fund two migrant and refugee women's health workers in Launceston and Hobart for a period of three years. The migrant and refugee women's health workers role will be to build upon the work achieved during this current project.

### *Women's Development Fund*

The DIAC settlement grant requires that the applicant (HWHC) have inbuilt systems and strategies to support workers, therefore, a second grant application was submitted with the Women's Development Fund to acquire specific cultural awareness training in this area for HWHC workers.



## Recommendations

- Hobart Women's Health Centre continues to work with the Project Steering Committee to progress the establishment of a Tasmanian Migrant and Refugee Women's Health Worker.
- Hobart Women's Health Centre, with the Project Steering Committee, progress work to further refine the structure of the model within which the Migrant and Refugee Women's Health Worker position will operate.

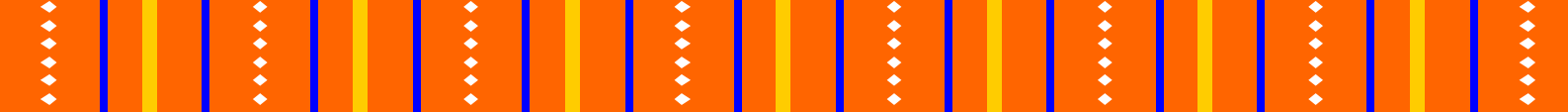
## Background

Formulation of an Australian women's health policy first occurred in the late 1980s after consultations with over one million women by the (then) Commonwealth Department of Community Services and Health. This resulted in the *National Women's Health Policy*, followed soon after by the *National Women's Health Program*, designed to implement the recommendations of the *National Policy* (Schofield 2006 p 2). Importantly, the National Women's Health Policy adopted a social, rather than medical, approach to women's health. Within this approach, women were consulted on their prioritised health needs and it considered both the gendered nature of women's everyday lives and the disadvantages women can accrue. Finally, the policy was concerned with increasing women's participation in organisation and management of health services and research (Schofield 1998 cited in Schofield 2006 p 3).

In 1991 the Tasmanian Department of Health and Human Services (DHHS) formulated a mission statement for the health of Tasmanians which also acknowledges the important social aspects of health and wellbeing. "All Tasmanians have an equal right to health. They should have the opportunity to maximise their health regardless of their income, age, race, ethnicity, gender, religion, disability or geographic location". (Department of Health and Human Services cited in Orme and Goiser, 1993 p.38) Even though the DHHS has explicitly promoted equality in its health service delivery since this time, there are still some very distinctive disadvantages occurring for a number of population groups in Tasmania. Among these groups are migrant and refugee women. As with many marginalised groups, their health concerns and specific needs are not yet catered for within mainstream health services.

The Hobart Women's Health Centre (HWHC), a non-government organisation funded by the State, has been involved in researching the health needs of culturally diverse women since its inception in 1987. During this time and up until 2000, the HWHC had auspiced ten Bi-cultural and Multicultural Women's Health projects across Tasmania. In 2001 the HWHC produced a report titled *Report Into Bicultural Women's Health Recommendations* (Campbell, 2001) which analysed the data and information contained in the ten reports with the aim of determining common recommendations and developing a strategic plan based on the findings. The major recommendation to come out of the report states that, 'a full-time Migrant Women's Health Position with state-wide responsibility be jointly funded by State and Commonwealth member agencies of the Tasmanian Immigration Settlement Committee (TISC) for a period of no less than three years' (p.21).

Campbell's report was somewhat critical of both the relatively short-term nature of the projects included in the analysis and the lack of capacity to follow up and build upon the networks created during the life of the projects. Campbell also noted that the Western bio-medical concept of health was, in some cases, incompatible with the health concepts of other cultures (Campbell



2001, p.12). Campbell reported the projects revealed the need for health information and support, beyond preventive cancer screening such as pap smears and mammograms and into more diverse health areas (ibid). One of the main findings of this report was the need for further research into the health needs of migrant women - with this research informing policy development and strategic planning, ideally culminating in the creation of a more coordinated approach to the health needs of migrant and refugee women.

Based on the results of the abovementioned report the HWHC then secured funding to investigate the possibility of establishing a Migrant Women's Health position. A further report produced in 2002, titled *Creating a State-wide Migrant Women's Health Position* (Collins), explored what focus such a position would take, what models are available and what might be most appropriate to the Tasmanian context. Collins provided the HWHC with research on progress other states had made in regards to employing specific migrant health workers and also provided feedback from Tasmanian communities on how they envisioned such a position might work in their region. Collins concluded there should be three workers allocated to the North West, North and South of the state, with the hours allocated to these positions reflecting the workload required and the population of migrant women in each area (Collins 2002, p.14).

The HWHC continued to liaise with interested individuals and organisations and in 2005 made a successful submission to the Southern Training, Employment and Placement Solutions, (STEPS) Community Foundation to fund a 20 hour per week, 12 month project to move towards implementation of the Collins recommendation. This is the report of that project.

## Outline

### Goals and Aims and Strategies

Project Goal:

To improve access to quality health services for Tasmanian migrant and refugee women through the establishment of permanent regional migrant and refugee women's health positions.

Project Aims:

- Consultation with migrant and refugee women, service providers and other key stakeholders to identify changes in needs, service delivery and demographic data since publication of HWHC most recent research in 2002.
- The utilisation, support and expansion of existing state wide networks of migrant and refugee women, service providers and other key stakeholders to inform and progress further development of the project.
- Researching appropriate funding options and preparation of (submission of) funding application(s).

Project Strategies:

- Establish Project Steering Committee
- Conduct consultations with migrant and refugee women
- Actively seek and offer support and feedback on the project with networks of migrant and refugee women, service providers and other key stakeholders.
- Research appropriate funding options and prepare (submit) funding application(s)
- Project report launch

### Project Steering Committee

The steering committee was an integral part of the project working with the project officer in the decision-making process. It was considered essential that steering committee members provided state-wide representation. The steering committee's role was to guide and advise the project through all its stages, with all committee members providing valuable expertise in service provision and advocacy for migrant and refugee women.

The committee held monthly meetings to discuss emerging issues and research obstacles, as well as providing information to the project on new arrivals, key stakeholders and the work occurring in their respective work places and regions. The Southern committee met face to face once a month and, due to travel restrictions, the project officer met face to face with North and North West

committee members less frequently in the course of the project. The steering committee held state-wide video link meetings, which allowed members to interact more effectively without having to travel long distances.

**The project steering committee members were:**

| <b>Region</b>     | <b>Member</b>                   | <b>Agency/Organisation</b>   |
|-------------------|---------------------------------|--|
| <b>South</b>      | Deborah van Velzen              | Multicultural Health & Wellbeing Policy Officer<br>Department of Health and Human Services                               |
|                   | Yabbo Thompson                  | Bi-Cultural Community Health Program,<br>Relationships Australia Tasmania (Hobart)<br>Women's Health Centre Board Member |
|                   | Mary Blake<br>Sarah Dixon       | Department of Immigration and Multicultural Affairs  |
|                   | Claire Wiseman                  | Multicultural Tasmania   |
|                   | Terhas Fre Bayru                | Immigrant and Refugee Liaison Officer<br>Royal Hobart Hospital   |
|                   | Tess Tilbury                    | Women Tasmania   |
|                   | Laura Chapman                   | Adult Migrant English Service<br>TAFE Tasmania   |
| <b>North</b>      | Judith Nekemiah                 | Nursing Student<br>University of Tasmania  |
|                   | Stella Goiser                   | Ethnic Communities Council of Northern Tasmania  |
|                   | Gaylene Worthington<br>Jo Magee | Women's Health North   |
| <b>North West</b> | Gloria Kennedy                  | Community Member   |
|                   | Linda Woodridge                 | Circular Head Rural Health Centre  |
|                   | Rachel L Morris                 | Devonport City Council   |
|                   | Jenny Barker                    | Women's Health North-West  |

## Consultations

Before developing the current project's consultation methodology, the project worker studied earlier research by the HWHC. Four years after the HWHC's last report on these issues, Tasmania's migrant and refugee demographics had changed to some degree particularly in relation to refugee populations in Hobart and Launceston. Consultation with emerging communities was viewed as an essential step in updating information the HWHC had previously collected.

In preparing for the consultative process, the project officer established an updated database of migrant communities in the North, North West and South, as well as key contacts to aid in connecting with migrant and refugee women in different areas. Letters of invitation were sent to all contacts, informing them of the project and inviting them to participate, as well as asking for information to be passed on to women in their communities. In addition a flyer was designed to advertise the project to services and to inform women of its objectives.

The project's target group included women (females over 12 yrs) of migrant and refugee backgrounds. Consultations occurred in Hobart, Launceston, Devonport, Burnie, Wynyard and Smithton. Consultation sessions generally involved groups of no more than twelve women and in a small number of instances women were consulted individually.

A questionnaire was developed to explore issues such as migrant and refugee women's understanding of health and the health care system; migrant and refugee women's access to health information and more generally issues affecting health and wellbeing. The questionnaire was used by the project worker as a guide to the consultation rather than given to participants to complete. The questions helped shape discussions, allowing the consultation to proceed with a more informal flow than a formal interview or examination. Women were also given the opportunity to speak about topics not raised within the questionnaire.

## Community Groups Consulted

In total, the project consulted with 144 women from 40 different cultural groups, across the three Tasmanian regions. The women consulted were mostly middle age or older, with some younger participants in the south of the state.

### Community Groups from each region involved include:

|                   | <b>Migrant</b>  | <b>Refugee</b>   |
|-------------------|---|--|
| <b>North</b>      | Philippino<br>Italian<br>Polish   | Burundian<br>Sudanese<br>Madi Sudanese<br>Sierra Leonian<br>Ethiopian<br>Eritrean<br>East Timorese<br>Somalian |
| <b>South</b>      | German<br>English<br>Kurdish<br>Mauritian<br>Philippino<br>Swiss<br>Dutch<br>Italian<br>Malaysian<br>Greek<br>Chinese | Ethiopian<br>Sudanese<br>Sierra Leonian<br>Liberian  |
| <b>North West</b> | Indian<br>Sri Lankan<br>Bangladeshi<br>Colombian<br>Chinese<br>Chilean<br>Salvadorian<br>Peruvian<br>North American   | Iraqi<br>Iranian<br>Ex-Yugoslavian   |

## Agency Consultations

Workers from a 27 organisations were interviewed as part of the consultation. Service providers were asked to comment on issues they see as affecting migrant and refugee women's health and wellbeing and the best ways of addressing these issues.

### Agencies and Individuals represented in addition to the Project Steering Committee

| Agency/organisation   | Region     | Worker                                    |
|---|------------|---|
| Circular Head Community Health Centre                                       | North West | DHHS                                      |
| The Zone  | North West | Devonport City Council                    |
| Phoenix Centre  | North      | MRC -North                                |
| Phoenix Centre  | South      | MRC - South                               |
| Colony 47   | South      | Al Hines                                  |
| MRC South   | South      | Tony Waller, Rachel Pybus,<br>Susan Fieke |
| MRC North   | North      | Karen Le                                  |
| Relationships Australia Tasmania  | South      | Peter<br>Yabbo Thompson                   |
| The Link  | South      | Deborah Siddall                           |
| Centacare   | South      | Kirsty Solling                            |
| Bi-Cultural Community Health Program  | South      | Rebecca Eli                               |
| Bi-Cultural Community Health Program  | North      | Filementu Ana                             |
| Women Tasmania  | North West | Susan Powell                              |
| Midwife/Consultant  | South      | Jenny Kerrison                            |
| University of Tasmania  | South      | Roberta Julian                            |
| Women's Health- DHHS  | State-wide | Morven Andrews                            |
| Women's Mid Life Service - DHHS   | South      | Rachel Atkins                             |
| Youth Health DHHS 'On The Move' CaLD Youth Health Interagency Working Group | South      | Simone Zell                               |

## **Networking**

Throughout the project's consultation process many existing networks were utilised and new ones formed. These networks include the project steering committee with members from each region of the state, individual migrant and refugee women, community groups, service providers, government and non-government organisations and other key stakeholders. All have provided support for the project and have informed the recommendations contained in this report. The networks and partnerships were also integral to the preparation of funding submissions seeking to secure future funding to further the project. The HWHC will continue to work with the individuals and organisations mentioned above to progress the aims of the project.

## **Funding Submissions**

### **Settlement Grants Program Department of Immigration and Citizenship (DIAC)**

The Settlement Grants Program (SGP) is funded by DIAC. Under the program non-government organisations are contracted to address gaps in service provision to newly arrived humanitarian entrants and other selected migrant groups with specific needs. The aim of the Settlement Grants Program (SGP) is to deliver services which assist eligible clients under the SGP (permanent residents who have arrived in Australia during the last 5 years as humanitarian entrants, and family stream migrants or dependants of skilled migrants with low English proficiency) to become self-reliant and participate equitably in Australian society as soon as possible after arrival. A grant application was submitted to DIAC in order to fund two migrant and refugee women's health workers in Launceston and Hobart for a period of three years. Past research that the HWHC has conducted (Collins, 2002), recommended that there be three workers, one in the North, Northwest and South, however, after concluding the consultations, considering current demographic information and gaining a better understanding of current support networks and health services in each area, it was decided to apply for funds to cover only two regions at this time.

The DIAC settlement grant requires that the applicant (HWHC) have inbuilt systems and strategies to support workers. A second grant application was submitted with the Women's Development Fund to acquire specific cultural awareness training in this area for HWHC workers.

### **Women's Development Fund**

A grant application was submitted to the Australian Government Office of Women. The grant program focuses on seed funding to build capacity within women's organisations.

The grant focused on providing cross cultural training to strengthen and increase HWHC workers capacity to understand the issues that affect migrant and refugee women living in the Tasmania.

The Training is aimed at providing the following outcomes:

- Understanding the health issues that affect migrant and refugee women living in Tasmania.

- Enhance understanding and skills in cross-cultural communication.
- Greater confidence in supporting and working with migrant and refugee women when accessing the HWHC and other services within the community.
- Increase in self-awareness and own cultural values, which acts to break down barriers and encourage the creation of trusting relationships with migrant and refugee women.
- Enhance mutual understanding with migrant and refugee women thereby increasing HWHC's capacity to provide effective health care, referrals and health.
- Create a cultural awareness training package for all current employees, as well as future employees of the HWHC.

Unfortunately neither of these funding submissions were successful at this time. The HWHC will continue to liaise with the reference group and broader networks to access future funding opportunities.

## **Report on Consultations**

### **Demographics**

In relation to demographic data the report noted two main changes since the Collins report was published in 2002. The findings reflect data from DIAC which demonstrates firstly, a steady increase in humanitarian entrants arriving in Tasmania, and secondly, an increase in skilled migrants and their dependants. This has meant Tasmania has seen a slow but persistent increase of culturally diverse residents over the past 5 years (2006, p. 12-16).

### **Migrant and Refugee Women**

Migrant and refugee women's responses to questions exploring issues such as, general concepts of health and wellbeing; levels of understanding of the (Australian) health care system; migrant and refugee women's access to health information, and more broader issues affecting health and wellbeing are outlined below:

- Health and wellbeing is affected by mental health issues related to the stress of resettlement, separation of families and recovering from trauma and torture.
- Mental health issues are exasperated by social and geographical isolation.
- Migrant and refugee women receive primary health care almost exclusively from General Practitioners and have little knowledge of alternative health services available;
- Many health service providers have limited knowledge of the cultural and conceptual issues affecting their interactions with migrant and refugee women.

- Cultural barriers limit access to health information particularly in relation to sexual health related topics.
- Social and geographical isolation are major barriers to accessing appropriate health information.

One major difference between responses from migrant and refugee women was that migrant women believe they are experiencing average levels of wellbeing but below average levels of mental health, while refugee women believe they experience well below average levels of wellbeing and equally concerning levels of mental health issues. The other difference noted between the groups was that refugee women on average have a lower level of understanding of the notion of health care when compared to migrant women, particularly as a (human) right, and had lower levels of understanding of the (Western) health care system in Australia.

### **Service Providers**

Service provider's responses to questions exploring ways of delivering more effective health services to migrant and refugee women are outlined below:

- The development of a peak body, to ensure a coordinated approach to the wide range of issues affecting the lives and wellbeing of refugee and migrant women.
- Service delivery to migrant and refugee women, across a range of health and other life issues, is currently limited by a lack of an effective, coordinated approach.
- The need for increased levels of networking, partnerships and mutual support between service providers and organisations working in the area.
- Continued support, review and improvement of existing Commonwealth, State and non-government services.
- Awareness raising amongst service providers and migrant and refugee women about the different concepts surrounding health care and health consumer rights between cultures.
- Migrant and refugee women's health must be placed within a broader framework of health and wellbeing that acknowledges the effects of discrimination.
- Provision of cultural awareness training for service providers to encourage the development of trusting relationships and deeper levels of understanding between workers and migrant and refugee women.
- Greater awareness of mental health issues and the stress related to resettlement, separation of families and recovering from trauma and torture.
- Greater availability of general health information on topics such as nutrition, contraception, cancer screening tests, birthing, pain management, exercise, sleep, dental health.
- Increased access to English language skills.

- Increased awareness of service providers of the importance of using interpreters.
- Increased access to transportation.

## **Limitations**

### **Scope of the Project**

Whilst the scope of the project, in terms of the consultation with migrant and refugee women, was to gauge any major changes in the past four years, it proved to be difficult to focus only on this aspect. Given the opportunity with a migrant and refugee women's health worker, women wanted to discuss current personal issues with an expectation that the project worker could do something towards addressing the problem. Clearly this is a group in our community with great unmet needs and it would have been simply disrespectful once engaging with women not to acknowledge, and if possible address, the other information to come out of the discussions. A considerable amount of time was diverted to assisting individual women which in turn detracted from time available to the broader project.

### **Language**

A number of obstacles were encountered during consultations, which either impeded the flow of information or tended to direct the process in certain ways. For instance, all consultations were conducted in English which created a barrier as English was not the first language any woman consulted. This problem was exacerbated by the lack of a project budget allocation for interpreters.

The English language skills of participants varied greatly and did not necessarily reflect the length of time they had been living in Tasmania. Some migrant women, who have lived in Tasmania for more than fifteen years, still experience difficulties with English, particularly in expressing subtleties. Consultations with refugee women were similarly affected, even when interpreters were present. In some instances, double interpreting was required, as well as cross-language interpreting, where the language used to communicate information was a woman's third or fourth acquired language and often the one in which she was least fluent.

These language obstacles raise issues such as the level of comprehension of translated information, the possibility of misinterpretation by the worker or participants, and of information being lost during translation.

### **Interpreters**

With limited resources the project was able to use interpreters only in particular consultations with recently arrived women. All interpreters were also bi-cultural health workers. This was helpful in the consultation process, since these workers were knowledgeable in regards to the health issues raised, as well as being sensitive to the personal health topics discussed. They were also invaluable

in sharing knowledge about cultural *faux pas*, and in providing the project officer with explanations when particular questions were either not acknowledged or not answered.

Without interpreters, often participant responses were obtained only through a complex series of interpretation by other participants, with the final answer being several dialects removed from the speaker's own.

### **Cultural Differences**

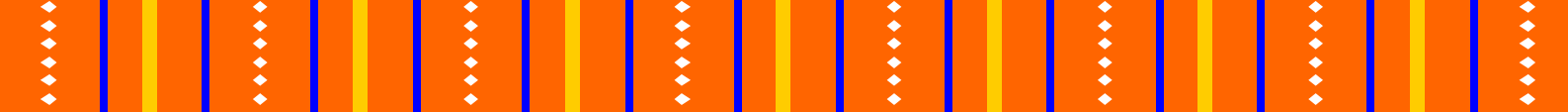
Issues women chose either not to speak about, or respond to, during consultations primarily concerned sexual and reproductive health. Migrant women generally demonstrated more willingness to discuss these issues, however, for many refugee women, it was apparent this was the first occasion on which they had been directly questioned on such topics. This posed a difficulty for consultations as some women felt offended and upset that such personal questions were being asked. This clearly highlights the importance of culturally aware consultation processes.

While situations such as the one above can be uncomfortable, it does provide opportunities to gain a greater level of knowledge and understanding for both the worker and participants. Discussions within consultations often moved on to other health issues, however, in the main, particular cultural beliefs were obstacles to gathering specific women's sexual and reproductive health information.

In addition, in some cultures personal issues can only be discussed with older people; this particular cultural practice proved difficult throughout the consultation process. In one instance the project worker and interpreter both lacked essential status markers such as marriage, age and children. Discussion of sexual health issues was not possible with that group of refugee women.

### **Groups not Consulted**

One of the difficulties with consultative research is that it cannot be said to represent the voices of all migrant and refugee women. This is particularly true of Tasmania with hard to reach target communities in relatively small town and city populations and who are geographically dispersed around the island. Women were contacted through a variety of ways, however, unless there was someone to act as a key contact to support the project by promoting and explaining the purpose of the research, it was much more difficult to involve them in the consultation. The ability to connect and identify with key people was also limited by time constraints. Furthermore, the community in question may consist of no more than two or three families or the "contact" person may have been self-appointed to the position and not be accepted as such by their community. As this project required the participation of migrant and refugee women, there was a risk that respective community leaders, particularly if male, may have found distributing the information and invitations difficult or viewed the consultations as unimportant.



It was acknowledged that some of the community groups and individuals have been involved in research and similar consultations in Tasmania over the past ten years which increases the risk of 'consultation fatigue' and may limit the number of women willing to be involved. According to a recent guide published by the Division of Multicultural Affairs, South Australia, researchers must work in ways that ensure the process is meaningful for both the agency and community group, "consultations must be genuine" in order to bring about real change and be effective (Apostolakis, 2007. p.7-16).

A further limitation in terms of gaining a deeper understanding of migrant and refugee women's health needs was the fact that the groups were seldom homogenous. Most migrant women's groups were multicultural in nature, with participants having varied lengths of residency in Australia. This was similar for the refugee women's consultations with some groups multicultural in nature and the length of residency also varying considerably. It is important to note that this may have affected the information collected as it tended to homogenise the groups of women creating a tendency to make the assumption that all women in a particular group held similar views on the health issues discussed.

Other migrant and refugee women not included in this report are the most recent arrivals. Since completion of the consultations to the writing of this report, new communities have begun to settle in Tasmania, including the Karen from the Thai-Burma border, Congolese families and a growing number of Afghanis and Liberians in the North of the State.

## Discussion

Information gathered during the consultation phase of the project supports the findings of previous Tasmanian studies into the health needs of migrant and refugee women. The consultations, aimed at identifying changes in needs, demographic data and service delivery since publication of HWHC most recent research in 2002, indicate that specific health needs of migrant and refugee women in Tasmania have not changed except for an increase in demand because of increasing numbers.

Consultations covered a range of areas including physical, emotional and mental health with women continuing to highlight specific health issues such as nutrition and exercise, pain management, cancer screening and contraception for example. The consultations also highlighted the difficulties mentioned in previous research concerning the reliance on General Practitioners, lack of awareness of alternative health care providers and a lack of understanding of (Western) health care philosophy and systems.

Demographically there has been a steady increase in humanitarian entrants arriving in Tasmania and an increase in skilled migrants and their dependants leading a slow but persistent increase of culturally diverse residents over the past 5 years. This indicates the need for increasingly expanded (more culturally diverse) services. In terms of service delivery there has been some increase through the further development of the state-wide Bi-Cultural Community Health Program.

The consultations, particularly with service providers, offered valuable information in relation to revisiting models within which a migrant and refugee women's health worker position may operate to increase the effectiveness of service delivery (see service provider discussion p. 25).

Whilst it was not the intention of this project to investigate and make recommendations relating to specific migrant and refugee women's health issues, two particular themes became apparent during analysis of the consultations. These were to do with notions of (Western) health care and concerning levels of mental health problems. These issues are presented below as important factors to consider when working with women directly and in terms of programme development.

### Understanding of (Western) Health Care Systems

The feedback from consultations demonstrated the difficulties migrant and refugee women experience when accessing health care are directly related to a limited understanding of health consumer rights, health promotion principles and of Western clinical health models within Australia. The National Health Strategy issue paper concluded it was not sufficient for services to simply translate material into the migrant or refugee women's language, but health promotion had to go beyond this and take into account a range of relevant issues – "levels of literacy, cultural beliefs and values about health and illness prevention, knowledge of the Australian health system and

structural barriers to health promotion and illness prevention services" (National Health Strategy Issue Paper No 6 1993, p108).

Whilst assertions made based on information gathered during this project are limited, information suggests that many of the issues are interlinked with levels of understanding of the health system and health as a human right. As local service providers state, 'if women have no way of engaging with the health information being promoted to them they will not gain any major benefit nor will it have any impact or meaning to their lives ... health promotion, the health system and health professionals are expecting refugee women to understand Western concepts of human rights and self determination without ever verbalising these concepts to the refugee women. (Al Hines, 19/12/2006) Without such a human rights framework or understanding of adequate health care as a human right, migrant and refugee women often find themselves disempowered and without the capacity to voice their complaints or address inadequacies in the system.

The majority of refugee women and many migrants arrive from countries with drastically under-resourced health systems and where the notion of health care as a human right is effectively non-existent. Without supportive education regarding the system and consumer rights and responsibilities, women are unlikely to obtain either appropriate health information or services. Appropriate health care requires a level of understanding from the consumer to demand information and services.

Related to the barriers created by a lack of awareness of the health care system are the different perceptions of illness/wellness, and the expectations placed on health care providers, that people coming from other cultures hold. As Chalmers states, a major barrier to accessing health services for migrants and refugees is the 'general issue pertaining to perceptions of illness ... unfortunately there is still a strong tendency to dismiss the effect that different forms of cultural knowledge have on the way health workers present and consumers receive and use health care information and services (2006 p 16).

In the area of birth control for example, Markovic states 'the cultural, ethnic and religious background of a woman may shape her attitudes towards family planning and abortion; the manual advises that women's health issues demand a sensitive approach and individual assessment' (2001, p.33). Another issue noted by Dutch researchers is the fact 'refugee women come from countries that have very different health systems, where practitioners may have similar titles (such as midwife) but have very different roles, training and responsibilities'. In addition, the researchers advise that 'nationality alone is not an accurate gauge of a woman's knowledge of child birth and the health system' (Ascoly, 2001 p.385). According to Markovic, while pregnancy and childbirth are significant events in the lives of all women, culture affects the norms related to

pregnancy and childbirth particularly when there are vast differences between and within cultures (Markovic 2001 p 37).

In 1993 a Tasmanian study by Orme and Goiser noted migrant women often expressed frustration at the lack of effective communication with health professionals. They recommended health care practitioners receive appropriate cross-cultural training and advised greater sensitivity needed to be shown to the health needs of migrant women (p.38). Dutch researchers have documented instances where refugees have not appeared to understand the central role of the general practitioner noting that refugees often believed their concerns were not taken seriously because they were not prescribed medication (Ascoly, 2001, p 389). Researchers in NSW have also found that some migrants feel their health needs are "overlooked by health professionals or not taken seriously because staff cannot be bothered listening to them" (Chalmers, 2006, p.46).

Lacking information about the health care system was highlighted by service provider Rachel Pybus. To her knowledge, young mothers are assigned a General Practitioner by the settlement worker assigned to them. Not knowing how to find another doctor, young women are then locked into using this one GP. If not receiving the health care they want from this doctor, they will often go without simply because they do not know how to change their GP.

Another issue she had noted was that young refugee mothers seemed dissatisfied if not prescribed medication by the doctor. "Medication is the answer" appeared to be their understanding of health care and, when the young mothers didn't receive any, they would leave very frustrated with the doctor. (Pybus 29/11/06) According to the Philippino Support Group, some families on skilled migrant visas are struggling to receive the health service they need. As an example, one family believed a doctor had to prescribe medicine; that treatment other than a prescription was not "real medicine" and of no value. (Philippino women 17/6/06).

The differences in the perceptions of health care between migrant and refugee women and their GP's was recounted often during the consultations with women feeling frustrated because they do not believe they are receiving appropriate treatment. It appears many migrant and refugee women perceive effective medical treatment as requiring the dispensing of some medication. When a doctor prescribes dietary change, counselling, physiotherapy or other interventions without medication, women believe they are not being treated properly or taken seriously. Furthermore, there was great concern expressed by a majority of migrant participants that general practitioners no longer had time to attend to their health concerns. According to the Polish Ladies Auxiliary, doctors now run an "express system" for their patients, not a health service (Polish Ladies Auxiliary 5/6/2005, Hobart). Migrant women living in the north of the state voiced similar concerns with a Launceston group feeling that doctors no longer have time to answer their questions (Tuesday Club 10/7/06 Launceston). Furthermore, it was reported that some refugee women complained of

spending long hours in emergency departments, as well as on long waiting lists to see a GP, without knowing of alternatives. (Ethiopian Women's Group 11/06/06)

Clearly longer consultations with GP's are essential, however this is not enough. When GP's are able to take the time to talk about preventative health there are still major barriers to overcome. One Northern group of refugee women had some knowledge of pap smears and cervical cancer, but were baffled by the notion the procedure was considered essential. (Multi-African group 4/6/2006); they did not understand why health professionals were telling them that the procedure 'had to be done' every two years. (Multicultural African women's group 4/6/2006) Another issue to emerge from the same group was the perception that cervical cancer was a white woman's illness and, hence, did not affect women of African origin; consequently, they believed they had no need to undergo pap smear examinations. (Multicultural African women's group 4/6/2006).

Language is, of course, another major barrier. Women in the North West, felt that health professionals were resistant to helping them and providing the information they required. They believed this was because English was not their first language, adding that because of their accents they would often avoid speaking on telephones and wait until able to speak to health professionals face to face (Multicultural Burnie women 12/9/06).

### **Mental Health**

Overwhelmingly migrant and refugee women consulted for this project talked about stress and anxiety and the effects this has on their overall levels of health and wellbeing. According to Udo-Ekpo, migrants and refugees have high expectations before arriving in Australia of a 'high standard of living, a good job, steady income and peace of mind'. However, in a majority of cases during settlement these expectations are 'replaced with unfulfilled expectations, racial discrimination and unemployment'. Udo-Ekpo goes on to say that 'this can cause great distress to the newly arrived, causing them to experience low self esteem, inadequacy, anger, resentment, fear, apprehension, confusion and stress which all directly affect their ability to function' in their new home (1999, p.140 -141).

Alcorso and Schofield, in the *National Non English Speaking Background Health Strategy*, describe the experience of migration and settlement as one where 'women are separated from their usual social networks and supports and as a result they find themselves in circumstances that are lonely and isolating and [eventually] emotionally distressing' (1991 p.61). They go on to describe the dislocating requirements of a new way of life, of having to conduct everyday activities in a foreign language, and in seemingly strange and incomprehensible ways. Alcorso and Schofield point to these as being significant factors to considerable mental and emotional stress and outline their findings that show a 'substantial decline in the often good health for which they [migrant women] are in fact selected; [however their] health declines rapidly post arrival and they experience

markedly greater rates of illnesses, both short term and long term' This portrayal of a negative spiralling pattern after settlement is also seen with refugee women who experience similar patterns of worry and anxiety that is often exacerbated by concerns over the wellbeing of family members in refugee camps or the stress of sponsoring family members to Australia.

Consultations with Tasmanian migrant and refugee women suggest a similar experience to that outlined in the research above. The emotional stress occurring during resettlement was discussed in some depth by ex-Yugoslavian women. They described their arrival in Australia as very difficult, very stressful, adding it was only with time that they could relax and feel they could trust people. One woman described herself as smiling on the outside to everyone but always hurting inside. (Ex-Yugoslavian women, 1/8/06 Burnie) Another member of this group stated that 'Coming from a war zone, it took two years to not have fear, [the] fears were exaggerated and simple things like not knowing where a road ended meant that we would take the road rather than ask for directions as we simply could not trust anyone'. (Smithton women, 1/8/06) Women also talked about making applications to the DIAC to have their family members reunited with them but described the wait as extremely arduous and the emotional pain almost unbearable, if the application is rejected. (Ethiopian women, 11/6/06 Launceston)

Stress and anxiety commonly manifested in a lack of sleep from worrying about concerns such as the welfare of family members in their country of origin, worrying about finding work, housing, transport issues, the emergence of eating disorders, bullying, discrimination and language difficulties. One woman summed up the general feeling by stating, 'If there are worries there is no sleep, and if I am happy sleep always comes (Tuesday Club 10/7/06 Launceston). Many women, especially refugees, experiencing these worries are also dealing with the longer term effects of trauma and torture. Young migrant and refugee women expressed a common feeling of guilt, arising from the knowledge of family members still in refugee camps overseas. (Elizabeth College, 4/6/2006, Guilford Young College 21/5/2006 & Iranian/Iraqi Young Women, 17/8/06 Devonport) and also reported difficulties related to lack of sleep.

According to the director of the Refugee Health Services in New South Wales, 'refugee health is a varied field across multiple disciplines and presenting complex issues' (Smith 2006, p.588). Bartolomei, Pittaway and Ekert are of the same opinion, from their perspective, 'refugees will often have complex and interlinked health and psychosocial health problems'. For this reason, the Centre for Refugee Research advocates for improved linkages between the range of health services upon arrival for refugees. (2006, p.8). The Centre for Refugee Research believes recent literature indicates a widespread lack of coordination and a frequently perceived failure of settlement services to adequately address the needs of resettled refugees, including vulnerable groups such as women at risk (Majka 2001, Robinson 1999, Waxman 1998 cited in Bartolomei,

Pittaway, Ekert 2006, p 6). Findings from this, and previous reports published by the HWHC, support the belief of a wide spread lack of coordination of health services to migrant and refugee women.

### **Migrant and Refugee Women's Different Experiences**

It is important to acknowledge that even though migrant and refugee women are often referred to as a homogenous group and have some commonalities; in general these are diverse groups of women who have different health requirements. Their experiences of migration and settlement in Tasmania are very different affecting their capacity to access health services and negotiate the health system.

One major difference between responses from migrant and refugee women in this study was that migrant women believe they are experiencing average levels of wellbeing but below average levels of mental health, while refugee women believe they experience well below average levels of wellbeing and equally concerning levels of mental health issues. The other difference noted between the groups was that refugee women on average have a lower level of understanding of the notion of health care, particularly as a right, and lower levels of understanding of the (Western) health care system in Australia than migrant women.

### **Service Providers**

Feedback from service providers, as with migrant and refugee women, reinforced recommendations from previous studies. From the perspective of service providers interviewed, health care for migrant and refugee women in Tasmania will only be effective if there is a coordinated approach. The need for mechanisms to monitor policy review and development and ensure community perspectives are represented was also highlighted. Words and phrases such as 'mutual support', 'networking' and 'sharing of resources' were a running theme. Youth workers from the North West felt that 'the lack of workers in the area with skills in cultural diversity is an obstacle because without support it is more difficult in turn to support young people through their settlement experience, ... we need more information and better liaison with Northern and Southern agencies and workers'.

When suggesting ways of addressing the current limitations, service providers pointed to existing 'peak body' models such as the Youth Network of Tasmania (YNOT), and the Alcohol, Tobacco and other Drugs Council of Tasmania (ATDC). For further information on YNOT and ATDC organisational structures go to <http://www.ynot.org.au/> or <http://www.atdc.org.au/>

### **Operational Structure**

Consultations from this project, along with the unsuccessful submission to the Settlement Grant Program – DIAC, suggest that before a subsequent grant application is developed, more work is

needed to refine, present and lobby for the structure under which the migrant and refugee women's health workers will operate, particularly in relation to governance, and the relationship the organisation will have with government.

The Collins (2002) report clearly states that a state-wide position to be in effect a total of 1.8 positions divided into three part-time positions, Hobart 0.8, Launceston 0.5 and Burnie 0.5. It also recommends that the positions be located with existing, appropriate community based services. Collins highlights the major theme to come from both interstate research and community consultations, 'that no single model for a health position is going to suit the variety of conditions in which migrant women live ... and that any model developed with a migrant women's health position in mind works best if it responds to local community conditions'. Whilst Collins acknowledges the importance of a regional and flexible approach to each role, she does not, however, go on to recommend an overarching governance structure.

Feedback gained during consultations for this project goes some way to defining the type of community based structure, or peak body, that may be appropriate to support the three regional positions. Tasmania already has many examples of successful models which are based around providing the governance structure and coordinating function required. The Youth Network of Tasmania (YNOT) and the Alcohol, Tobacco and other Drug and Council of Tasmania (ATDC) are two examples that were specifically mentioned in the consultations, however, further research is required to explore existing structures (particularly local) to determine the most appropriate for this project.

It is therefore recommended that the:

*Hobart Women's Health Centre continues to work with the Project Steering Committee to progress the establishment of a Tasmanian Migrant and Refugee Women's Health Worker,*

And that the;

*Hobart Women's Health Centre, with the Project Steering Committee, progress work to further refine the structure of the model within which the Migrant and Refugee Women's Health Worker position will operate.*

## Funding Submissions

The third aim of the project was to focus on harnessing the momentum of networks and facilitate the developmental work necessary to submit a successful funding application for a long term, sustainable position to perform a coordinating function in relation to service provision. The submission was based on previous findings contained in both the Campbell and Collins reports, which recommend that achieving this aim requires:

"A full-time Migrant Women's Health Position with state-wide responsibility be jointly funded ... for a period of no less than three years" (Campbell, 2001, p.21),

And that:

"The state-wide position to be in effect a total of 1.8 fte positions across the whole state divided into three part-time positions allocated on the following regional basis: Hobart 0.8, Launceston 0.5, Burnie 0.5" (Collins, 2002, p.14).

Findings from the Collins report, specifically looking for any changes over the past 4 years such as the increasing diversity of cultures and higher numbers of refugees, reinforce the need for a permanent migrant and refugee women's health worker. Findings from this report also suggest that there have been improvements in infrastructure related to direct service delivery such as the expansion of the state-wide Bi-cultural Community Health Program, These initiatives once again highlight the need for a state-wide coordinating role or peak body to focus on tasks such as:

- Improved integration of services
- Maintenance of partnerships and networks
- Facilitating ongoing links between short-term projects
- Acting as a clearing house on migrant and refugee women's health issues
- Ensuring the availability of up to date translated materials
- Ensuring up to date research and health information is available
- Providing input into and monitoring of relevant government policy
- Coordinating cross cultural awareness training to health providers
- Coordinating community health awareness sessions

In an effort to produce a funding application with greater chance of success and which was based on information gained from the current project it was decided to submit a proposal to DIAC's Settlement Grants Program to fund two positions based in Launceston and Hobart for a period of three years. As mentioned in the research methodology this submission to DIAC was not successful.

Two other funding submissions were submitted during the life of this project. Whilst not directly related to the report they were initiated and supported through the work conducted.

## **Community Support Levy: Charitable Organisations Grants Program**

### Australian Women Friendship Group

During the *Families in Cultural Transition Training* offered by MRC South, a number of Bi-cultural workers indicated that they were interested in working with newly arrived women in Hobart. One of these workers approached the HWHC with an idea to start a friendship group. The overall goal of the program is to provide an opportunity for newly arrived refugee women to meet Tasmanian women. The aim of the project is to build friendships that create support networks & address feelings of social isolation, depression and fear. The program will enable women to access information, practice English, improve their psychological wellbeing & strengthen their sense of belonging in their new home.

This submission was successful with \$3000 to support the Australian Women's Friendship Group to be based at the HWHC for a period of six months.

### **Tasmanian Community Fund**

Discussions with migrant and refugee women, along with service providers, led to the current project supporting a partnership between Women's Health North (DHHS) and the MRC Northern Tasmania to submit an application to the Tasmanian Community Fund in order to develop a project focussing on healthy living information specifically for refugee women living in Launceston. The result of this submission is unknown at the time of writing.

## Conclusion

This project represents a further step in the process of investigating and recommending the most appropriate way of addressing the health needs of migrant and refugee women in Tasmania. It has reinforced the findings and recommendations of previous reports in this area, and through the difficulties encountered, it has highlighted how easily individual workers can be overwhelmed with the unmet needs of their clients. Workers do not have the capacity to focus on the structural changes needed while the demands of direct service delivery are so great. There is a wealth of experience and knowledge that is continuing to grow amongst those working with migrant and refugee women and we must provide mechanisms to allow workers to share this information, to draw together the common themes, to support each other and harness this collective energy into strategic action. This report offers a way to do this through the creation of a peak coordinating body to support regional workers and until such a model is in place health care for this ever increasing number of Tasmanians will remain a serious issue for us all.

## References

- Alcorso & Schofield, (1991). *The National Non-English Speaking Background Women's Health Strategy*, University of Sydney, Australian Government Publishing Service Canberra.
- Apostolakis, (2007) "Why Didn't You Tell Us?" Because You Didn't Ask!" *Consulting with Culturally and Linguistically Diverse Communities: A guide for South Australian Government Agencies*. Division of Multicultural Affairs, Department of Premier and Cabinet. SA.
- Ascoly, Van Hels, A., & Keyzers, (2001). *Refugee Women, Pregnancy And Reproductive Health Care In The Netherlands*, Journal of Refugee Studies, Vol. 14-No. 4, Oxford University Press.
- Bartolomei, Pittaway, & Ekert, (2006). *Submission Regarding The Settlement Of African Humanitarian Entrants In NSW*, Centre for Refugee Research, University of New South Wales.
- Campbell, J., (2001) *Report Into Bicultural Women's Health Recommendations*, Hobart Women's Health Centre, Hobart.
- Chalmers, S., (2006). *Culture, Health and Parenting In Every Day Life*, Centre for Cultural Research, University of Western Sydney.
- Collins, A. (2002). *Creating a State-wide Migrant Women's Health Position*, Hobart Women's Health Centre, Hobart.
- DIAC, (2006). *Tasmania: Demographic Trends in Humanitarian Entrants*, Commonwealth of Australia, Canberra.
- DIAC, (2006). *Tasmania: Settlement Needs of New Arrivals*, Commonwealth of Australia, Canberra.
- Markovic, (2001). *Responding To Cultural Diversity In Women's Health: A Resource For Health Professionals*, Key Centre For Women's Health In Society, Melbourne.
- Orme & Goiser, (1993). *NESB Women As Consumers Of Health Care Services*, Migrant Resource Centre Tasmania, Launceston.
- Schofield, (2006). *Boutique Health? Gender and Equity in Health Policy*, Australian Health Policy Institute, Commissioned Paper Series 2004/08, University of Sydney.
- Smith, M., (2006), *Refugees In Australia: Changing Faces, Changing Needs*, Refugee Health Editorial, Medical Journal of Australia.
- Udo-Epko, L., (1999). *The Africans in Australia: Expectations and Shattered Dreams*, Seaview Press, South Australia.

## References for the 14 Projects Informing this Report

### Projects funded by Cancer Screening and Control Service and managed by HWHC

Colo, S., Casten, N. & Escobar, D., 1998. *Women's Bicultural Project – Bosnian, Italian and Salvadorian Communities*, Hobart Women's Health Centre, Hobart.

Ali-Shawi, Kecskemeti, V. & Wong, D., 1999. *Women's Bicultural Project – Arabic, Filipino and Chinese Communities*, Hobart Women's Health Centre, Hobart.

Soo, S., Gralek, B., Kristinsson, K. & Taylor, J., 2000. *Women's Bicultural Project - South East Asian, Polish, Northern Multicultural and North West Multicultural Communities*, Hobart Women's Health Centre, Hobart.

### Project funded by Health and Wellbeing Outcomes Unit and managed by the HWHC

Al-Shawi, W., & Wild, A., (1999) *Cross-Cultural Women's Health Project*. Hobart Women's Health Centre. Hobart.

### Projects funded by Cancer Screening and Control Service

Cortez, E., 1998. *Filipino Women's Health Project*, Women's Health Access Program, Burnie.

Gaetani-Black, J., 1999. *Italian Bi-cultural Position – Report*, Women's Health Access Program, Launceston.

Taylor, J., 1999. *Dutch/German Women's Health Project*, Women's Health Access Program, Burnie.

## **Appendix A**

### **Regional Activities**

During their involvement in the project steering committee members from each region reported projects and activities that are already underway or are seen as priorities for the immediate future.

#### **North West**

##### **Burnie**

- In 2007 the Women's Health Access Program – North West will run information sessions on the varied health issues affecting migrant and refugee women. These include menopause, arthritis and osteoporosis.
- A partnership with Devonport City Council's Youth Programs will be formed to introduce mothers and older sisters of young Iraqi and Iranian women to the Women's Health Access Program – North West.

##### **Smithton**

- In 2007 the Circular Head Rural Health Centre will organise a cultural awareness training session for all interested health professionals through the Department of Health and Human Services' Bi-Cultural Health Educators Program.

##### **Devonport**

- Devonport City Council Youth Program will commence a partnership with the Department of Health and Human Services - Youth Health Team to provide a pilot program to young migrant and refugee women on all aspects of healthy living, body image and sexual health. The program is to commence in 2007 and will include the setting up of a room exclusively for young women within the youth centre.

##### **South**

- Cancer Screening, Women's Health Access program - South and the DHHS Bi-Cultural Health Educators Program are working in partnership to deliver culturally appropriate women's health sessions to migrant and refugee women.
- The Women's Health Access Program – South is developing a young migrant and refugee women's healthy living program to start in 2007.
- The Hobart Women's Health Centre will coordinate the drafting of a recommendation that highlights the difficulties newly arrived women are experiencing in receiving adequate health care, including, accurately describing where the Integrated Humanitarian Support System

(IHHS) settlement responses may be lacking and can be addressed. All relevant parties related to IHHS settlement will be consulted in order to advocate for the health needs of newly arrived women.

- The Hobart Women's Health Centre will coordinate the drafting of a recommendation to all relevant training institutions, including the University of Tasmania, that highlights the support migrant and refugee women require when choosing to study nursing.
- The Hobart Women's Health Centre will coordinate the drafting of a recommendation to the Department of Health and Human Services, the Australian Medical Association and the Division of General Practitioners that all doctors must access professional development, acquire cultural awareness training and to seek support when working with migrant and refugee women.
- The Hobart Women's Health Centre will coordinate the drafting of a recommendation to support and inform service providers working in the area of sexual health education of the cultural sensitivities when discussing these issues with migrant and refugee women, particularly young women.
- The Hobart Women's Health Centre will research women's groups who are working with cottage industries so as to increase migrant and refugee women's access to these industries.

## **North**

- Women's Health Access Program - North are continuing to build networks with migrant and refugee women in Launceston through ongoing contact with women's groups. This work is aimed at promoting discussion around particular health needs and developing a greater understanding of the Australian health system and western concepts of health care.
- Women's Health Access Program – North are designing a health based strengths program to offer women exercise options and healthy living information.
- The Hobart Women's Health Centre will coordinate the drafting of a recommendation to doctors and midwives to initiate communication about Australian birthing practices and birth expectations to migrant and refugee women early in their pregnancy.

## Appendix B

### Glossary of Abbreviations & Terminology

|             |   |
|-------------|---|
| <b>AMES</b> | Adult Migrant English Service                             |
| <b>ATDC</b> | Alcohol, Tobacco and other Drugs Council of Tasmania Inc. |
| <b>BCHP</b> | Bi-Cultural Community Health Program                      |
| <b>CaLD</b> | Culturally and Linguistically Diverse                     |
| <b>DCC</b>  | Devonport City Council                                    |
| <b>DHHS</b> | Department of Health and Human Services                   |
| <b>DIAC</b> | Department of Immigration And Citizenship                 |
| <b>FGM</b>  | Female Genital Mutilation                                 |
| <b>HWHC</b> | Hobart Women's Health Centre                              |
| <b>IHHS</b> | Integrated Humanitarian Support System                    |
| <b>MRC</b>  | Migrant Resource Centre                                   |
| <b>YNOT</b> | Youth Network of Tasmania                                 |

#### Migrant

The term 'migrant' in article 1.1 (a) should be understood as covering all cases where the decision to migrate is taken freely by the individual concerned, for reasons of 'personal convenience' and without intervention of an external compelling factor.

Commission on Human Rights resolution 1997/15

A person who is outside their country of origin. Occasionally this term is used to cover everyone outside their country of birth (including people who have been Canadian citizens for decades). More often, it is used for people currently on the move or people with temporary status or no status at all in the country where they live. It tends to be applied to people at the bottom of the economic ladder. For example, we don't often hear of migrant businessmen.

Canadian Council for Refugees [www.web.ca/-ccr/](http://www.web.ca/-ccr/)

#### Refugee/Humanitarian Entrant

International law defines a "refugee" as a person who has been forced to flee from and/or cannot return to their country due to a well-founded fear of persecution, including war or civil conflict.

1951 Convention Relating to the Status of Refugees

A refugee is a person who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of (his) nationality, and is unable to or, owing to such fear, is unwilling to avail (him)self of the protection of that country..."

Article 1, The 1951 Convention Relating to the Status of Refugees

## Appendix C

### Community Profiles and Participant Information

| Nationality       | Group Name               | Number | Age range | Time in Australia | Region | Informative details  |
|-------------------|--------------------------|--------|-----------|-------------------|--------|--|
| <b>Polish</b>     | Polish Ladies Auxiliary  | 20     | 60-90     | 10-60 years       | South  | The Polish Ladies Auxiliary meets regularly to converse in Polish and to socialise. Most women at the consultation were aged between sixty to ninety years old and have resided in Australia for up to sixty years. One woman in the consultation had arrived only ten years ago, but was supported by her family. The group is supported by the Polish Welfare Centre |
| <b>Italian</b>    | Elderly Italian Women    | 4      | 70-80     | 50-60 years       | South  | Italian Welfare Centre supports elderly Italian migrants with recreational activities.   |
| <b>Philippino</b> | Philippino Support Group | 4      | 20-50     | 2-20 years        | South  | The Philippino support group is part of a much wider Philippino organisation that has branches all over Tasmania. The group supports Philippino women on a range of levels.  |
| <b>Iraqi</b>      | Iraqi Woman              | 1      | 30        | 5                 | South  | This Iraqi woman migrated to Australia and is now working as a nurse; the project officer sought her input to the project because of her valuable position of being a migrant and working in the health sector.  |

| Nationality          | Group Name                               | Number | Age range | Time in Australia | Region     | Informative details  |
|----------------------|--|--------|-----------|-------------------|------------|--|
| <b>Multicultural</b> | MRC Multicultural Craft Group            | 9      | N/A       | 8 months-26 years | North      | The Multicultural Craft Group meet regularly at MRC North to work on craft activities, such as jewellery making, the consultation occurred while they working.                           |
| <b>Multicultural</b> | MRC Tuesday Club                         | 8      | 60-80     | 15-50 years       | North      | The Tuesday Club meets regularly at MRC North, they meet on a social basis, but also organise activities. The club is for older migrant women.   |
| <b>Multicultural</b> | Ethnic Communities Council               | 8      |           |                   | North      | The consultation with the Ethnic Communities council was most valuable since the members that were consulted all had years of experience in the area of consultation with migrant women. |
| <b>Multicultural</b> | Wynyard Women of the World               | 5      | 48-60     | 15-44 years       | North West | The Wynyard Women of the World group meet on a regular basis and work on community activities.   |
| <b>Thai</b>          | Thai Women                               | 4      | 46-55     | 7-20 years        | North West | The Thai women living in the Wynyard area meet on a social basis, they have contact with Women's Health North West.  |
| <b>Multicultural</b> | Indian, Sri Lankan and Bangladeshi women | 3      | 36-45     | 2-10 years        | North West | The three women consulted meet on a social basis, one of the three women is also a general practitioner.   |
| <b>Multicultural</b> | Burnie Multicultural women's group       | 6      | 41-48     | 4-17 years        | North West | The multicultural group meet on a social basis, they are not part of any other groups in the area. All women work or study full time.  |

| Nationality          | Group Name                                    | Number | Age range | Time in Australia | Region     | Informative details   |
|----------------------|---|--------|-----------|-------------------|------------|---|
| <b>Multicultural</b> | Multi-cultural Smithton women                 | 6      |           |                   | North West | The multicultural Smithton women were all consulted separately due to commitments and time restrictions, the women meet on a social basis.                            |
| <b>Multicultural</b> | Young Women ESL Guilford Young College        | 5      | 15-17     | 18 months-3 years | South      | This consultation was organised with the help of the Guilford Young College ESL program teacher, the young women were eager to share their thoughts                   |
| <b>Multicultural</b> | Sierra Leonian and Sudanese Women             | 4      | 30-40     | 9 months -7 years | South      | This group was predominately made of interpreters and bi-cultural workers. It was a valuable consultation where the women spoke on a professional and personal basis. |
| <b>Multicultural</b> | Young Women ESL Elizabeth College             | 13     | 17-25     |                   | South      | The young women in this group were also keen in sharing their experiences; the consultation was arranged through Elizabeth College ESL program.                       |
| <b>Sudanese</b>      | Sudanese (Madi) Women                         | 4      | 20-50     | 2-3 years         | South      | This group meet on a social and family basis, they were very keen to organise activities, which were productive.  |
| <b>Multicultural</b> | Introduction to project at AMES to CALD women | 20     |           |                   | South      | This session attracted many women. Information on health and other services was distributed and consultations were then organised for women from specific languages.  |

| Nationality                | Group Name   | Number | Age range | Time in Australia   | Region        | Informative details  |
|----------------------------|--|--------|-----------|---------------------|---------------|--|
| <b>Burundian</b>           | AMES<br>Burundian<br>women                                       | 5      | 20-40     | 6 months-1<br>year  | South         | The consultation had a bi-cultural worker as an interpreter.   |
| <b>Sudanese</b>            | AMES<br>Sudanese<br>women  | 2      | 20-50     | 7-5 years           | South         | The consultation had a bi-cultural worker as an interpreter.   |
| <b>Multicultural</b>       | AMES Tour of<br>Women's<br>Health<br>Centre for<br>CALD<br>women | 6      |           |                     | South         | This tour was arranged after several consultations with women at AMES. After a tour of the HWHC a decision to start exercise classes was made.     |
| <b>Multicultural</b>       | MRC<br>Multicultural<br>African<br>Women's<br>Group              | 9      | 20-40     | 4 months-2<br>years | North         | This group was newly formed prior to the consultation, MRC north aimed to start a women's group for the women accessing the service.               |
| <b>Ethiopian</b>           | Ethiopian<br>Women   | 4      | 30-60     | 3-6 years           | North         | This group was newly formed prior to the consultation, MRC north aimed to start a women's group for the women accessing the service.               |
| <b>Ex-<br/>Yugoslavian</b> | Ex-<br>Yugoslavian<br>Women living<br>in Burnie                  | 2      | 40        | 3-4 years           | North<br>West | The Ex-Yugoslavian women consulted commented on how they were once part of a bigger community but now most have left Tasmania for jobs interstate. |