

# **ON YOUR OWN:**

## **Sexual and reproductive health of female international students in Australia**

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**October 2011**

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**Suggested citation:**

Poljski C. 2011. *On Your Own: Sexual and reproductive health of female international students in Australia*.  
MCWH: Melbourne.

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## ACKNOWLEDGEMENTS

The Multicultural Centre for Women's Health (MCWH) acknowledges the financial support provided by the Lord Mayor's Charitable Foundation for the implementation of the Women's Health Connect and Creating Healthier Pathways Projects (collectively referred to as the MCWH female international student program). Many thanks are also owed to Ansell Healthcare Australia (in particular Alison Arnot-Bradshaw and Lisa Lai) and Marie Stopes International Australia (especially Melinda Gibbs and Claire Maloney) for their donations of condoms and sachets of lubricant to the program, and to De jour Sanitary Products (particularly Helen Kirmond) for donations of tampon sample packs to the program.

Numerous agencies, educational institutions, organisations and services were represented in the MCWH female international students (FIS) program. Support for the FIS program was extensive, but the contribution of three individuals demands greater acknowledgement. Thank you to Gary Lee, the International Student and Youth Project Officer at the City of Melbourne, who was an enthusiastic supporter of the FIS program from its inception. Gary recruited student representatives for the advisory committee; allowed the MCWH Project Officer to use City of Melbourne spaces for advisory committee meetings and student activities, such as focus groups and pilot health education sessions; widely promoted the FIS program to international student contacts and networks; and invited MCWH staff members to promote MCWH and provide health information to female students at Lord Mayor's Student Welcome events. Gary's ongoing support for the FIS program facilitated greater collaboration between MCWH and female students, student services and educational institutions, which in turn contributed to the program's success. Thank you also to another FIS program supporter from the beginning: Siew-Kim Lim, the Student Welfare Coordinator at the Carrick Institute of Education. With Siew-Kim's keen support and tireless efforts, student focus groups and pilot health education sessions for female students were held at Carrick Institute. These student activities provided the MCWH Project Officer with a better understanding of how to progress the FIS program beyond the pilot stage. Siew-Kim also arranged additional health education sessions for female students when the FIS program expanded in 2010. Finally, many thanks to Mary Pozzobon from OSHC Worldcare, also supportive of the FIS program from the beginning, and who was always helpful in clarifying numerous questions related to Overseas Student Health Cover and student health access entitlements.

A huge thank you to the following for their contribution to the FIS program: members of the advisory committee; key stakeholders and female students who participated in the consultation; bilingual health educators who provided health education to female students; presenters in the BHE training program; agencies, educational institutions and services that hosted MCWH health education and information activities for students; and the female students that participated in these activities. The enthusiastic participation and support of all these key players has increased understanding of culturally-appropriate health promotion programs for female international students in Australia. This knowledge will go a long way towards ensuring that future health promotion initiatives meet the specific needs of these students.

Appendix 1 lists all the participants of the MCWH FIS program.

## ACRONYMS

BHE	Bilingual health educator
DIAC	Department of Immigration and Citizenship
DOHA	Department of Health and Ageing
FIS	Female international student
GP	General Practitioner
ISANA	International Education Association
MCWH	Multicultural Centre for Women's Health
OSHC	Overseas Student Health Cover
STI	Sexually transmitted infection
VIRWC	Victorian Immigrant and Refugee Women's Coalition

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**DISCLAIMER**

The views expressed in this report are solely those of the Multicultural Centre for Women's Health and should not be attributed to the Lord Mayor's Charitable Foundation.

## EXECUTIVE SUMMARY

The Multicultural Centre for Women's Health implemented a health promotion program that aimed to build the capacity of female international students in the City of Melbourne to improve their health and wellbeing, with a focus on sexual and reproductive health.

Research, including a key stakeholder consultation and literature review, was undertaken to identify the key sexual and reproductive health issues affecting female international students in Australia, and to determine culturally-appropriate health promotion strategies for students. Research findings guided the development of education activities, which included the provision of multilingual health education and information to female students at educational institutions, student services and events. Program evaluation was also undertaken.

Unplanned pregnancy, abortion, sexually transmitted infections and violence affect the female international student population. These health issues are symptomatic of limited sexual health literacy, poor access to health services, and dynamics of the immigration experience.

A multi-faceted approach is required to improve the sexual and reproductive health of female international students in Australia. Key players in the international education industry need to better exercise their duty of care to international students. Governments—local, state/territory and federal—and educational institutions should provide funding for international student health promotion programs. Educational institutions also need to assume responsibility for the implementation of these programs, which should include: delivery of mandatory gender-specific health education sessions during orientation periods; reinforcement of health messages throughout study periods via social media and international student leaders; and distribution of multilingual written health information at student services and events. Consistent information about Overseas Student Health Cover (OSHC) should be provided across all OSHC provider websites. Gender-specific mentoring programs, social events and recreational activities that foster interaction between international students, domestic students and the wider community, would ease international students' isolation and loneliness. Statewide collaborative networks of agencies, educational institutions and international student-friendly health and community services would promote information-sharing about student-accessible services and programs, and could improve student referrals. Additions and revisions to the OSHC Deed, and the incorporation of the *Minimum Standards for International Student Welfare* into legislation are also required. Improvements to data collection on abortions and sexually transmitted infections would provide a more accurate account of the prevalence of these health issues in the female international student population.



## CHAPTER 1: INTRODUCTION

Although recent changes to student visa regulations and violent attacks against international students have seen the number of student enrolments decline, education services remains Australia's largest export industry, contributing \$18.3 billion to the Australian economy in 2010 alone (Australian Education International, 2011). The international education industry has also contributed significantly to the size of the temporary female immigrant population in Australia. From 1 January 2008 to 31 December 2010, 320,460 student visas were issued to women aged 16 years and over from non-English speaking countries, with half of these visas for women from three countries: China (27.7%), India (15.6%) and South Korea (6.8%). Other significant countries of origin include Thailand and Vietnam (DIAC, 2011).

The health of female international students in Australia has assumed greater significance in recent times. There is expressed concern about high rates of unplanned pregnancy and abortion (Healy and Bond, 2006; Kalsi et al, 2007; Shepherd, 2009), as well as discrimination and violence in accommodation settings, educational institutions, relationships and workplaces (Burke, 2010; Deumert et al, 2005; Forbes-Mewett and Nyland, 2007; Graycar, 2010; Nyland et al, 2009; VIRWC, 2009). These findings indicate the need for culturally-appropriate health promotion programs for female international students.

### 1.1 Background to the MCWH female international student program

The Multicultural Centre for Women's Health (MCWH) is a women's health organisation committed to improving the health of immigrant and refugee women across Australia. The centre is for all immigrant women, including refugees and asylum seekers, women from emerging and established communities, and women temporarily settled in Australia.

As part of its mission, MCWH provides health education and information to immigrant and refugee women in workplaces and community settings. The MCWH health education program follows a holistic, peer education model known as the *woman-to-woman approach*, which is participatory in design and respects women's experiences and knowledge. Trained bilingual health educators (BHEs) conduct health education sessions for women in the preferred languages of the participants, covering a range of health issues, with a focus on sexual and reproductive health. The centre provides health education to women in 26 languages.

The MCWH female international student (FIS) program was a response to poor sexual and reproductive health outcomes in the female international student population. The FIS program involved the consecutive implementation of two projects from May 2009 to May 2011: the Women's Health Connect and Creating Healthier Pathways Projects. Collectively, the projects aimed to build the capacity of female international students in the City of Melbourne to improve their health and wellbeing, with a focus on sexual and reproductive health. However, each project had different components and objectives. Research was integral to the Women's Health Connect Project, the objectives of which were to:

- Conduct a literature review to identify key sexual and reproductive issues, including their contributing factors, in the female international student population in Australia;

- Consult with key stakeholders who deliver health, education and welfare-related services to female international students, or who possess an understanding of international student health and welfare, to identify key sexual and reproductive health issues affecting students and to determine culturally-appropriate health promotion strategies for these students;
- Consult with female international students to ascertain their health education and information needs and to obtain their feedback on the MCWH model of health education; and
- Pilot multilingual health education sessions, based on the MCWH model, with female students.

Expanding on the findings of the Women's Health Connect Project, the Creating Healthier Pathways Project involved the provision of multilingual health education and information to female international students. More specifically, project objectives were to:

- Provide training to MCWH BHEs on international student health and welfare issues, Overseas Student Health Cover (OSHC) and student health access entitlements;
- Conduct health education and information activities for female students, including delivery of health education sessions at educational institutions and student services, and the provision of health information at international student events and student services;
- Collect data in relation to project activities to evaluate their impact; and
- Produce and disseminate a report so that the outcomes of both projects are widely known among key stakeholders.

An advisory committee was convened to ensure individuals with relevant expertise in student health and welfare guided implementation of the FIS program. Appendix 1 lists all the advisory committee members.

This report has four chapters. This chapter has provided a brief overview of MCWH and the FIS program. A comprehensive overview of program methodology is provided in Chapter 2. Program findings are discussed in Chapter 3. Key recommendations are presented in Chapter 4.

As the focus of the MCWH FIS program was female international students, this report highlights the key issues pertinent to these women. However, some program findings and recommendations are relevant to, and have broader implications for all international students. So, discussion of program findings moves between matters specific to female students to those relevant to all international students. Quotes, some of which are from women for whom English is not their first language, are included verbatim throughout the report to support program findings.

## CHAPTER 2: PROGRAM METHODOLOGY

The MCWH female international student program was a comprehensive health promotion initiative, involving research, education and evaluation.

### 2.1 Research component of MCWH female international student program

Extensive consultations with key stakeholders were undertaken to: identify key sexual and reproductive health issues affecting female international students; ascertain factors contributing to the occurrence of these issues; and determine culturally-appropriate health promotion strategies for these students. Three focus groups and 15 interviews were conducted with professionals with knowledge of and/or expertise in international student health and welfare. Overall, the consultation involved 35 participants from 16 agencies, educational institutions and organisations across Australia (see Appendix 1). Nursing, medicine (general practice), psychology, social work, health promotion and education were the main disciplines represented in the consultation. Appendix 2 contains the questions discussed during the consultation.

Female international students also participated in the consultation. Students were recruited with the assistance of a student representative on the advisory committee and via a private educational institution. The student consultation was also extensive, and included:

- Three focus groups were conducted in English—one each with Chinese, Iranian and Hindi-speaking students—to determine: attitudes towards and knowledge about women’s health; health information-seeking behaviours; previous exposure to health education; and health information and education needs (see Appendix 3). The MCWH Project Officer conducted the focus groups;
- Students completed a brief survey designed to collect data on basic demographics, health information-seeking practices, health access behaviours, and health education experiences (see Appendix 4);
- Subsequent to the focus groups, students participated in pilot health education sessions, based on the *woman-to-woman approach*, to provide feedback on the suitability of the MCWH model for international student health promotion initiatives. Three BHEs delivered seven health education sessions, covering sexual, reproductive and mental health, to the three groups of students. Three education sessions were delivered in Farsi (official language of Iran), while two education sessions were each delivered in Mandarin and Hindi (to students from India and Nepal).

The MCWH Project Officer attended all the health education sessions to seek student feedback on the MCWH model. Upon completion of the piloting process, the MCWH Project Officer also debriefed with the three BHEs individually to learn their perspectives on the applicability of the MCWH model to international student health promotion. Bilingual health educators also provided suggestions to increase the effectiveness of the approach with and appeal to students. Overall, 36 female international students from four countries (China, India, Iran and Nepal) participated in the consultation.

Finally, a brief literature review was also conducted to consolidate existing knowledge, however limited, about the sexual and reproductive health issues affecting female international students in Australia.

## **2.2 Education component of MCWH female international student program**

Using consultation findings, the education component of the MCWH FIS program was developed and implemented, and included: training for MCWH BHEs; delivery of multilingual health education sessions for female students in Melbourne at educational institutions and student services; and provision of multilingual health information to female students attending international student events and student services.

Given resource constraints, health education sessions were only available for delivery in: Cantonese, Hindi, Mandarin, Spanish, Thai and Vietnamese. These languages were selected on the basis of the number of female international students in Victoria (determined using figures from the Department of Immigration and Citizenship or DIAC), as well as the availability of BHEs, that were fluent in these languages. However, in order to ensure all female international students could participate in the FIS program, English was the main language in which health education and information was provided.

Before MCWH BHEs conduct health education sessions on any new topic, they are required to undergo training. The bilingual health educators enlisted to participate in the FIS program attended a one-day training program that covered international student welfare issues, particularly sexual violence and mental health, and student health access entitlements (including an overview of OSHC). Representatives from the Centre Against Sexual Assault (CASA House), Swinburne University of Technology (Student Development and Counselling) and OSHC Worldcare (OSHC provider) presented during the training program. Appendix 1 lists BHE training program presenters and BHE participants of the FIS program.

After the BHE training program, the FIS program progressed in earnest. From March 2010 until May 2011, BHEs delivered 17 health education sessions in four languages—English, Mandarin, Spanish and Vietnamese—to female students at six educational institutions and two student services. Education sessions were most commonly delivered in English (14 sessions), whilst one each was delivered in Mandarin, Spanish and Vietnamese. Bilingual health educators presented on a range of health topics in the education sessions, which ranged in duration from one to two hours, including sexual health (STIs, contraception, safe sex issues including consent), general women's health (breast health, menstruation and Pap tests), mental health (anxiety, depression) and international student-friendly services. Bilingual health educators also distributed multilingual written resources to students to complement information provided in the education sessions. The free MCWH Health Resource Kit—containing condoms, sachets of lubricant, tampons, lip balm, an information sheet about international student-accessible health and community services, an MCWH membership form and bookmark—was also distributed to student participants of the education sessions.

The FIS program also involved the provision of multilingual health information to female students at international student events and student services (see Images 1-3). Overall, BHEs attended five international student welcome events hosted by the Cities of Melbourne and Darebin where BHEs engaged with students, individually and in groups, to hear students' stories about their health experiences; provided tailored multilingual health information (written and verbal); and distributed the free MCWH Health Resource Kit to students accessing the MCWH stall at four of the five events. Multilingual health information was also distributed to female international students accessing a university health service where general practitioners (GPs) and practice nurses informed students about MCWH and the health education sessions, and provided

students with multilingual written information, sourced from the MCWH health resource collection, about women's health issues in four languages: English, Mandarin, Cantonese and Korean.



**Image 1: Elizabeth and Rachanee at the MCWH stall at the Lord Mayor's Student Welcome in 2010**

(Image courtesy of the City of Melbourne)

### **2.3 Evaluation of MCWH female international student program**

Evaluation of the MCWH FIS program involved a variety of methods. In addition to methods used during the consultation, surveys were also used to collect additional data during the education component. The student survey administered during the consultation was revised and administered to students that participated in health education activities (see Appendices 5 and 6). The student surveys were administered where it was logistically possible, so not all students reached through the FIS program completed surveys. Overall, 210 student surveys were completed during the FIS program's lifetime, yielding worthwhile data about student demographics, health information-seeking behaviours, previous exposure to health education, health information and education needs. Of these surveys, 35 were completed during the student consultation, 110 were completed after participation in health education sessions and 65 were completed at student events. Overall, 27 countries of origin were represented in the cohort of students that completed surveys, with China (21.4%), India (16.2%), Vietnam (8.1%), Colombia (7.1%), Nepal (7.1%) and Malaysia (5.2%) the most-represented countries of origin. Other countries represented in the cohort included Hong Kong, Indonesia, Iran, Sri Lanka, Chile, Singapore, South Korea, Thailand, Japan, Mauritius, Brazil, Germany, Pakistan, Cambodia, El Salvador, Netherlands, Peru, Saudi Arabia, Ukraine, Venezuela and South Africa. An additional 13 countries were represented in the cohort of approximately 240 students reached by the program, but who did not complete surveys. These countries included Armenia, Austria, Bangladesh, Botswana, Canada, France, Kenya, Maldives, Poland, Scotland, Sweden, Taiwan and United Kingdom.

Table 1 provides a demographic background of a cohort of student participants of the MCWH FIS program (taken from completed student surveys). Table 1 demonstrates that nearly two-thirds of these students were aged from 21-30 years (62.9%); nearly half (47.6%) were recently-arrived (based in Australia for less than a year); and most were enrolled in vocational training courses (41%) and at private colleges (53.8%).

Bilingual health educators also completed evaluation surveys after health education sessions (see Appendix 7) and debriefed with the MCWH Project Officer after education activities to discuss the health and welfare

issues raised during their engagement with students, as well as health information provided to students and student receptivity to health education. Additional evaluation methods also included analysis of email feedback received from student participants and key stakeholders after program activities.

**Table 1: Demographic background of a cohort of student participants of the MCWH FIS program (taken from completed student surveys)**

<b>Demographic</b>	<b>Number of students</b>	<b>% of students</b>
<b>Age</b>		
16-17 years	7	3.3
18-20 years	42	20.0
21-25 years	68	32.4
26-30 years	64	30.5
31+ years	29	13.8
<b>Total</b>	<b>210</b>	<b>100.0</b>
<b>Relationship status</b>		
Single	105	50.0
In a relationship	101	48.1
Not indicated	4	1.9
<b>Total</b>	<b>210</b>	<b>100.0</b>
<b>Time spent studying in Australia</b>		
0-11 months	100	47.6
12-23 months	62	29.5
24-35 months	25	11.9
36-47 months	12	5.7
48+ months	9	4.3
Not indicated	2	1.0
<b>Total</b>	<b>210</b>	<b>100.0</b>
<b>Enrolment: type of course</b>		
Victorian Certificate of Education	2	1.0
English language course	14	6.6
Foundation studies	29	13.8
Undergraduate degree	10	4.8
Postgraduate degree	26	12.3
Vocational training course	86	41.0
Not indicated	43	20.5
<b>Total</b>	<b>210</b>	<b>100.0</b>
<b>Enrolment: type of course</b>		
High school	2	1.0
TAFE	10	4.8
Private college	113	53.8
University	77	36.6
Not indicated	8	3.8
<b>Total</b>	<b>210</b>	<b>100.0</b>

## 2.4 Key outcomes of the MCWH female international student program

The MCWH FIS program was a successful student health promotion initiative. Approximately 450 female international students from 40 countries participated in the FIS program over a two-year period, but the exact figure is likely to be higher as data about the number of students accessing the university health service, and who were informed about MCWH and provided multilingual written information, was not collected. Overall, 11 agencies, educational institutions and organisations hosted FIS program activities (see Appendix 1).

The health education sessions were particularly well-received. For the majority of student participants (78.6%), these education sessions represented their first exposure to health education in Australia. Of the 110 students that participated in the education sessions (excluding pilot education sessions):

- Nearly two-thirds (59.1%) reported the education sessions were *excellent*, while just over a quarter (28.2%) reported the education sessions were *very good*;
- Over three-quarters (77.3%) considered general women's health (breast health, menstruation, Pap tests) the most useful topic presented in the education sessions, followed by sexual health (STIs, contraception, safe sex) (71.8%) and mental health (anxiety, depression) (41.8%).

Overall, female students, as well as staff in the educational institutions and student services that hosted the health education sessions, were highly satisfied with the education sessions:

*'I think students lack an understanding of their anatomy, so this session was very educational.'* (FIS 1)

*'Sessions like today are a great help. Thank you very much for your time and support for international students.'* (FIS 2)

*'Class today in Spanish was an excellent idea.'* (FIS 3)

*'Just wanted to give you some feedback from my students regarding the women's health session that was run last week. The response from the students was very positive indeed and their only real issue was that they wished the session went for longer as they found it very informative. The girls are hoping that more sessions like these will be available in the future.'*

(Representative from a private educational institution 1)

The most significant effects of the health education sessions were increased student awareness of health issues, interest to learn more about these issues, and willingness to undergo screening procedures:

*'Some girls did request more information and it was great that (BHE) was able to drop off pamphlets and information sheets to them soon after the sessions and we did have a few girls who came in to ask about where to go to do some tests, which is fantastic.'* (Representative from a private educational institution 2)

Overall, the key outcomes of the MCWH FIS program included:

- Completion of an extensive consultation process involving 15 interviews and three focus groups with representatives from 16 agencies, educational institutions and organisations from across Australia, and three focus groups with 36 female international students;
- Provision of health education and information in eight languages (Cantonese, English, Farsi, Hindi, Mandarin, Spanish, Thai and Vietnamese) to at least 450 female students from 40 countries via the delivery of 24 health education sessions (including seven pilot education sessions) at educational institutions and student services, and MCWH stalls at five international student events;
- Distribution of 350 MCWH Health Resource Kits to female students;
- Completion of 210 student surveys; and
- Collaboration between MCWH and six educational institutions, three student services and two local governments.



**Image 2: Elizabeth discussing women's health issues with female students at the Lord Mayor's Student Welcome in 2011**

(Image courtesy of Carolyn Poljski)

**Image 3: Rachanee providing tailored health information to a female student at the Lord Mayor's Student Welcome in 2011**

(Image courtesy of Carolyn Poljski)



## CHAPTER 3: PROGRAM FINDINGS

Findings from all MCWH FIS program components are reported in this chapter.

### 3.1 Sexual and reproductive health concerns of female international students

High rates of unplanned pregnancy and abortion are characteristic in the female international student population, a widely acknowledged fact within the international education industry in Australia. However, statistical evidence to support this commonly expressed concern is not publicly available. Given the extent of unsafe sex practices in this population of women (Rosenthal et al, 2006), sexually transmitted infections (STIs) may also be an issue. However, STI rates for international students are not available as STI notification procedures do not request details about patients' visa status.

Poor sexual and reproductive health outcomes in female international students may be due to their increased vulnerability to violence. While media and community attention has focused on male international students and their experiences of violence in public settings, violence against female international students has remained largely invisible. Female students are more likely than their male counterparts to experience discrimination (even within the international student community), physical abuse, sexual harassment and social exclusion during their stay in Australia (Deumert et al, 2005; Rosenthal et al, 2006; VIRWC, 2009). Female students are particularly at risk of violence within personal relationships with male international students and local men (Gloz and Smith, 2004). Female students living in Australia with partners who are secondary visa holders—that is, men who are not studying themselves and are only allowed to stay in Australia on the condition their relationship remains intact—may have an increased risk of violence due to the shift in power dynamics in their relationships. Men who feel uncomfortable about the altered power dynamics—their partner can have them deported—may try to assert their authority and demonstrate their masculinity through controlling behaviours and violence.

Female international students are also at risk of violence in accommodation, educational institutions and workplaces. Female students have been offered cheaper rent, higher grades and employment in return for sexual favours (Burke, 2010; Forbes-Mewett and Nyland, 2007; Graycar, 2010). The lack of affordable housing for international students means that many students share accommodation with numerous other people, usually fellow students (Turcic, 2008). In these cases, the risk of violence, especially of a sexual nature, is increased where female students are forced to share rooms with male students.

The prevalence of violence against female international students is unknown as accurate data is not available. Students are reluctant to report violence to police because of: their negative impressions of police in their country of origin; fears that a complaint will affect their application for permanent residency; concerns that their partner—if he is the perpetrator of violence and a secondary visa holder—will retaliate against their family overseas in the event he is deported; reliance on their partner for financial support if their partner is a secondary visa holder and working in Australia; or because of a lack of knowledge about avenues for complaints.

## **3.2 Factors contributing to sexual and reproductive health outcomes in female international students**

Poor sexual and reproductive health outcomes in female international students are symptomatic of limited sexual health literacy, poor access to health services in Australia, and the dynamics of the immigration experience.

### **3.2.1 *Limited sexual health literacy***

Limited sexual health literacy is universal in the general community (Grulich et al, 2003), but compared to Australian-born students, international students know less about sexual health issues such as STIs (Song et al, 2005). Female international students possess little knowledge about reproductive anatomy, contraception, safe sex (including consensual sex), STIs, menstruation (particularly the most fertile time in the menstrual cycle), menstrual disorders (amenorrhoea and its relationship with mental health, dysmenorrhoea), pregnancy, abortion, Pap tests (rationale, when to commence). Perhaps due to the rising incidence of breast cancer globally, female students are generally aware of this condition, but do not know how to perform breast self-examination. Also, female students do not possess the skills required to participate in the sexual decision-making process, such as the discussion of safe sex and contraception options, and so are powerless or reluctant to reject pressure to engage in sexual activity.

Sexual health is taboo in many cultures. Whilst health education is available in other countries—74.5% of student participants of the MCWH health education sessions had received health education in their country of origin—sexual health is not comprehensively covered, thereby contributing to low levels of sexual health literacy. Where sexual health education is provided, the level and quality is variable. In some countries, structured family planning education is available, as in China where, as part of the one-child policy, such education is compulsorily provided to couples registered to marry. In other countries, education about reproductive anatomy and physiological processes, such as menstruation, is usually provided in biology classes in schools and universities. This education is rarely gender-specific, with male teachers providing information in a didactic and rigid manner to female and male students collectively. These conditions affect the ability of female students to engage with the information presented, as the presence of male students make asking questions intimidating and uncomfortable. For female international students who have not participated in sexual health education in their country of origin, their only source of sexual health information has been their mother as often medical practitioners typically failed, or were reluctant to discuss sexual health issues during consultations.

Female international students also demonstrate limited understanding of, and reluctance to participate in, sexual health promotion initiatives. For students that come from countries with health systems focused on treatment rather than prevention, disease-specific health promotion campaigns are perceived as only being relevant to people affected by the highlighted condition. In the context of sexual health promotion, female students view sexual health as simply being relevant to married women as only these women are supposed to have sex. For female students from countries where a woman's reputation is largely determined by her sexuality, they are aware their reputation as a 'good girl' hinges on not engaging in, or being seen to engage in, sexual activity before marriage. Participation in sexual health promotion programs publicly reveals an interest in or concerns with sexual health, which suggests engagement in premarital sexual activity or

willingness to do so. Accordingly, some female students are reticent to participate in sexual health promotion programs as it is incongruous with the 'good girl' image. Reluctance to partake in these initiatives only serves to maintain students' poor knowledge of sexual health issues.

### **3.2.2 Poor access to health services**

Student utilisation of health services in Australia is low compared to service utilisation in their country of origin. The majority of student participants (85.7%) of the MCWH FIS program reported accessing health services in their country of origin, while only 34.3% had done so in Australia. Additionally, student dissatisfaction with health service delivery in Australia is high (City of Melbourne, 2011).

Overseas student health cover is mandatory for student visa holders and their dependants for the duration of their stay in Australia. The OSHC Deed is a legal agreement between the Department of Health and Ageing (DOHA) and registered health insurance funds that provide OSHC (DOHA, 2011a and 2011b). The OSHC Deed sets minimum coverage requirements that OSHC providers—of which there are five in Australia—are required to meet for all kinds of OSHC policies. These policies must cover access to basic medical treatment similar to that which Australian citizens and permanent residents are covered for under Medicare. Under OSHC, international students and their dependants are covered for in-hospital medical services, out-of-hospital medical services, surgical implanted prostheses, some prescription medicines, and emergency ambulance transportation.

Numerous barriers related to OSHC affect student utilisation of health services in Australia. Many international students do not understand their OSHC policies, nor are they aware of any additional health care costs they may be required to pay (Smith and Kay, 2010). Health insurance funds provide information about their OSHC policies, including claims processes and gap payments, on their websites, but only three funds provide multilingual information which could enhance student comprehension of OSHC policies. Variation also occurs across OSHC fund websites in the amount and type of additional information provided that could facilitate students' health access, such as an explanation of the Australian health system and details of direct-billing GPs, medical specialists and hospitals. These inconsistencies mean that students will invariably miss out on vital information that could facilitate their access to health services. Whilst some OSHC insurance representatives visit educational institutions during orientation and study periods to inform students about OSHC policies, study obligations, work commitments and settlement issues impede student capacity to actively understand what is covered under OSHC until they require urgent health care.

Differing processes for the payment of health care costs also impacts on student utilisation of health services. Health insurance funds have direct-billing arrangements with health services, allowing international students to show their OSHC membership card when accessing these services and the OSHC provider will be sent the invoice for the consultation. Students may be required to make a gap payment at the time of access. Where there are no direct-billing arrangements, students are required to pay for health care costs upfront and then claim on their OSHC policy. This arrangement is not possible for students experiencing financial pressures, thereby affecting their health service access.

A recent change to the OSHC Deed has serious implications for the sexual and reproductive health of female international students and the partners of male international students. This change, effective from 1 July 2011, precludes OSHC providers from paying benefits to overseas students or their dependants for the treatment of pregnancy-related conditions in the first 12 months after arrival in Australia, except when emergency treatment is required (DOHA, 2011a). This change forces female students and the partners of male students who experience an unplanned pregnancy within their first 12 months in Australia to pay for their own abortion. The cost of a first trimester abortion ranges from \$700 to \$900, but increases for terminations performed beyond the first three months of pregnancy. Financial pressures or cultural beliefs will prevent some women from procuring a termination, forcing them to either cease their studies to return to their country of origin to proceed with their pregnancy—possibly affecting their capacity to resume studies in Australia at a later stage—or to proceed with their pregnancy whilst studying or living in Australia, most likely with insufficient or no antenatal care because of their inability to pay for full maternity services required. Many female international students who have a baby in Australia experience great difficulties in combining studies with motherhood, so they return to their country of origin with their newborn infant and leave their baby with family members before returning to Australia to resume their studies. Subsequently, these students experience separation anxiety and depression, which in turn affects their ability to study. For some female students, pregnancy is not an option, so women may take drastic measures to end an unplanned pregnancy if they are not able to fund an abortion. For women who wish to have a baby whilst in Australia, such as the partners of male international students, simply because motherhood has always been on their agenda irrespective of their residence base, access to antenatal care options during pregnancy is likely to be seriously impeded where there are financial pressures.

International students possess limited understanding of the Australian health system. Many students come from countries with specialised health systems, where there is less emphasis on primary care, direct access to specialised care, and more focus on treatment than prevention. In Australia, the reverse is true: a strong focus on primary care, as delivered by GPs, and more attention to prevention. However, students believe only specialists provide high-quality health care, and so doubt the capacity of GPs to fulfil their health needs:

*'I went to a GP and explained my problem and she tried to solve my problem with herself and her knowledge. I was a little wondered because when I was in (country of origin) I go directly to the specialist to solve my problem. I was not sure about her recognition, so she sent me to the hospital to see a specialist, but still in the hospital I think I didn't visit a real specialist—it was kind of maybe a GP again.'*

(FIS 4)

This limited understanding of the GP role may affect student access to GPs. Similarly, poor awareness of the role of GPs may result in student dissatisfaction with health care provided by GPs. However, not all students are unhappy with GPs:

*'I had a problem and I went to the GP. He was very good for me and he did all the things that I did in (country of origin) with the women's specialist. Very good. I also had some tests, blood tests, Pap smear test. It was interesting for me that the GP gave the Pap smear test.'* (FIS 5)

The availability of health and community services for international students is variable. Some students have better access to services than other students. Generally, public educational institutions, such as universities, are better equipped to cater for student health needs via university medical or nursing clinics and counselling services. Whilst some private educational institutions are able to provide welfare assistance to students, many do not, leaving students on their own to navigate services in the health and community sectors. Government-funded services specifically for international students are available, but staff members in these services are not qualified to fully address complex health and welfare issues, such as unplanned pregnancy or domestic violence. In these cases, referral to other services may be necessary, but is problematic due to fragmentation in the network of international student-friendly services:

*'Services are not very friendly to international students generally and the services that are international-student friendly are not all on one network. They are all scattered, so we have different people trying to do different things with international students. I think a more collaborative effort would do better work.'*

(Key stakeholder 1)

Additionally, health and community services outside of educational institutions create their own access rules. Whilst some services are bound by funding body rules, which may preclude access by people on temporary visas, other services create their own rules, which may allow access by anybody, regardless of their visa status. This situation creates confusion for students who are navigating services on their own, as well as for referring service providers, all of whom may relinquish the search for assistance.

### **3.2.3 Freedom and isolation of the immigration experience**

Upon immigrating to Australia, international students experience freedom and isolation. It is these dynamics of the immigration experience, combined with limited sexual health literacy and poor access to health services, which increase female students' susceptibility to poor sexual and reproductive health outcomes.

For some international students, the immigration experience is liberating. The distance between students and family members, removing scrutiny of students' behaviour, allows for sexual experimentation that may not be possible in their country of origin:

*'For international students, there is a lot of adventure during the first few days after arrival because that's when they are experiencing the first days of their freedom. Those are the times when you are not understanding pressure, so there is more time to experiment, more time to go out.'* (Key stakeholder 1)

However, students' lack of understanding of the consequences of their new-found freedom can have unexpected results:

*'They come to Australia and it's when they start crossing boundaries that they realise a whole new world and how do I deal with a new world and that's when potentially these unwanted pregnancies might happen.'* (Key stakeholder 2)

Conversely, the distance between international students, their families and other traditional social supports results in an immigration experience that is isolating and lonely, particularly during the early months after arrival in Australia (Sawir et al, 2007; Smith and Kay, 2010). Limited capacity and few opportunities to practice English language skills through interaction with locals, including domestic students, exacerbates feelings of loneliness, contributing to anxiety and depression:

*'Our first language is not English, and as a newcomer, we have no chance to speak to others. If we have some feelings, we cannot express us, so I think it's not a good thing.'* (FIS 6)

*'They are lonely. A lot of them chose the international education concept to come and meet Australians and know about their culture, but what they find when they get here is that the Australian community don't want to interact with them.'*

(Key stakeholder 3)

The isolation and loneliness inherent in the immigration experience for many international students is contributing to the ghettoisation of the international student community in Australia. The lack of interaction between international and domestic students, either due to limited English proficiency, poor social skills in international students, or disinterest or reluctance on the part of domestic students, means that international students only interact with other students from the same cultural group (Sawir et al, 2007). Whilst these groups provide students with the support they need to adapt to life in Australia, they also extend the distance between students and locals, further limiting opportunities for students to practise their English language skills and to develop connections with locals, thus reinforcing students' need for other international students for support and friendship. When these conditions prevail, female students are preyed upon by male students from their own cultural group. Far-removed from the scrutiny of family members and friends abroad, and exploiting their perceived freedom in Australia to disrespect women, male students target their female counterparts, especially those who are newly-arrived, and pressure them to engage in sexual relationships (Gloz and Smith, 2004). This pressure also exists for female students who willingly enter into relationships with male students. However, for many of these female students, these relationships—the kind of which many would never consider in their country of origin—are more of a necessity to ease their isolation and loneliness. Thus, these female students may succumb to pressure to engage in sexual activity—usually unprotected—whether they want to or not, so increasing their susceptibility to unplanned pregnancy and STIs. Female students are also targeted by landlords, employers and local men (Forbes-Mewett and Nyland, 2007; Gloz and Smith, 2004; Graycar, 2010).

International students in Australia experience significant financial pressures. Tuition fees and living costs are expensive. In many cases, these costs are higher than anticipated. Difficulty in securing work in industries that typically employ international students, such as cleaning, hospitality and retail, encourage some female students to resort to sex work to fund their stay in Australia. Prostitution is more lucrative than employment in these industries, and students are able to work around their studies (Moor, 2010; Pickering et al, 2009). Students work in legal and illegal brothels and can earn more money, but are most at risk providing unprotected sexual services. This is more pertinent in illegal brothels where operators coerce sex workers to engage in unsafe sex practices (Pickering et al, 2009).

### **3.3 Improving sexual and reproductive health of female international students**

For too long, the worth of international students has only been recognised in dollar terms. The ‘cash cow’ mentality greatly contributes to the pervasive abuse and exploitation of international students. As temporary residents in Australia with few protections, international students are particularly vulnerable and left on their own to fend for themselves in their host country. Meanwhile, key players—governments, educational institutions, landlords, employers, OSHC providers—appear content to profit from these students. The ‘cash cow’ attitude must be replaced immediately with one that respects the human rights of international students.

Given the significant financial contribution of international students to the Australian economy, it is reasonable to expect local, state/territory and federal governments to provide funding for health promotion programs for international students across Australia. In 2009-2010, on the basis that the student visa fee is \$550 and 269,828 student visas were issued (Knight, 2011a), the federal government earned \$148.4 million from student visa fees alone. It has been suggested that the federal government allocate a proportion of funds received for student visas to student wellbeing initiatives (Anderson, 2011). Implementation of such a scheme would demonstrate the federal government’s genuine interest in the health, welfare and human rights of international students.

A multi-faceted approach is required to improve the sexual and reproductive health of female international students, and should include communication and social marketing initiatives; social inclusion programs; organisational and workforce development; legislative and policy reform; and improved data collection.

#### **3.3.1 Communication and social marketing initiatives**

Communication and social marketing initiatives are integral to raising international student awareness about sexual health issues. The positive response to the MCWH FIS program demonstrates the need and demand for such student initiatives. Of the 175 student participants of the FIS program that completed student surveys (excluding participants in the pilot health education sessions), 93.1% reported that health education should be provided to female international students during their stay in Australia, further supporting the need for wider implementation of initiatives similar to the FIS program. According to these female students, health education should cover general women’s health (85.9%), sexual health (85.9%), mental health (79.8%), international student-friendly health and community services (72.4%), and reproductive health (pregnancy, childbirth) (63.8%). The value of FIS program strategies, namely distribution of multilingual health information at student events and delivery of health education sessions, was confirmed with 64.4% and 60.7% of the health education-supportive students respectively suggesting these very strategies be implemented in future student initiatives. Internet-based strategies, such as social media and general health websites (54%), and written information (41.1%) were also recommended strategies. Only a fifth (18.4%) requested health education be provided in their language, with over half (54.6%) and one-quarter (25.2%) respectively expressing preference for health education to be provided in English or indicating that it did not bother them.

Educational institutions, private and public, are the most appropriate settings for, and should assume responsibility for the delivery of health promotion programs for international students:

*'Universities need to be responsible for promoting safe sex practices and providing education sessions.'* (Key stakeholder 4)

Given the cost of tuition fees for international students, it is reasonable to expect educational institutions to invest a set proportion of student fees into the delivery of mandatory gender-specific health education sessions—which cover sexual, reproductive and mental health, OSHC policies and international student-friendly health and community services (including GPs)—for all international students during orientation periods. It is also important these education sessions highlight the relevance of key health messages to students' immigration experience and settlement in Australia, as well as to their health and wellbeing in the long-term, especially where students believe these messages to be irrelevant to them. Accordingly, trained bilingual health educators should facilitate these health education sessions. These health educators possess better understanding of cultural issues related to sexual, reproductive and mental health, and so are better equipped to respond to cultural attitudes and beliefs expressed during education sessions. Bilingual community workers are also considered more credible sources of health information for young people from immigrant and refugee backgrounds (McMichael, 2008), so it is more likely that international students would respond positively to culturally-relevant health education sessions. Representatives from OSHC providers should also present during these education sessions to fully explain OSHC policies and procedures to students.

A gendered approach is essential in health promotion initiatives for international students. Female students prefer this approach (Burchard et al, n.d; Riviere, 2009). Gender-specific health education sessions about sexual health, delivered by female health educators, allow young women to engage with information in a non-threatening environment to learn about the negotiation of safe sex practices with sexual partners (McMichael, 2008; Shepherd et al, 2000). However, health education sessions for female students that aim to empower them in their relationships with men will only be effective if gender-specific health education sessions, also focused on sexual health and delivered by male health educators, are conducted for male students. Whilst English is students' preferred language for health education, sessions should also be available in commonly-spoken languages in the international student community, particularly for newly-arrived students with limited confidence in their English language skills. Multilingual written health information should also be distributed to students at these education sessions to reinforce messages delivered.

Gender-specific health education sessions could also be delivered via student services where students might access support and assistance, or engage in recreational activities. Social media, a tool popular with international students, could be used to promote and encourage participation in these education sessions, as could student leaders. Typically, student leaders are international students who have been studying in Australia for a while, are more familiar with local services, and assist newly-arrived students adjusting to life in their new country. Respected female and male students from the international student community should be identified and trained to actively encourage their peers to participate in health education sessions and to reinforce key health messages to students. Incentives, such as refreshments, might also facilitate student participation in health education sessions delivered in student services, as might a health resource kit that provides students with items that enable application of newly-acquired sexual health knowledge. The health resource kit should be given to all students who participate in health education sessions.

Messages delivered in health education sessions need to be reinforced throughout study periods to sustain international students' health knowledge in the long-term. Social media, currently utilised in student wellbeing initiatives (Anderson, 2011), and international student leaders, should be used for this purpose. Student services, particularly those that provide health care and welfare assistance to international students, should also be resourced with multilingual written health information to distribute to students during consultations:

*'We really need to ensure that the health centres at the individual universities and learning centres that [international students are] at are appropriately prepared to assist them in the first instance because they're obviously going to be the first point of call. They really need to be very well-prepared to assist students and provide them with the appropriate referrals.'* (Key stakeholder 5)

Student utilisation of health services may be facilitated with consistent information about OSHC. A universal template for OSHC information provision should be developed and applied to all OSHC provider websites, so that all websites consistently feature comprehensible and comprehensive information about: OSHC policies and procedures, including benefits payable and not payable, claims processes and gap payments; direct-billing medical practitioners and health services, hours of opening, languages spoken and gap fees; the Australian health system; and health and wellbeing. Information should be provided in several languages.

### **3.3.2 Social inclusion programs**

Educational institutions also need to assume greater responsibility in easing the isolation and loneliness that international students experience during their stay in Australia. Initiatives within educational settings that aim to facilitate social inclusion by fostering strong bonds between international and domestic students are desperately needed (Sawir et al, 2007). Mentoring programs that match local student mentors with international student mentees, with the aim of facilitating transition into academic and social life, can greatly improve international students' levels of interaction with domestic students, as well as their sense of community (Sidoryn and Slade, n.d). Gender-specific mentoring programs would be particularly useful for newly-arrived international students in the early stages of their studies to: assist them adjust to life in their new country and a study experience that may be vastly different to that in their country of origin; introduce students to student networks; and promote communication between international and domestic students. Mentors need to be trained and resourced to fulfil their role. Mentoring programs should also include social activities for all participating mentors and mentees. Schools, departments and faculties are ideally positioned to develop and implement mentoring programs based on students' needs and to widely promote and encourage participation. Student associations could also be involved in the development, implementation and/or promotion of student mentoring programs, but also need to arrange social events that encourage interaction between international and domestic students.

Local governments with a significant population of international students, such as the Cities of Darebin and Melbourne, provide many worthwhile and unique opportunities for students to engage with the local culture and the Australian community and to interact with other international students via student events and recreational activities. However, there is a need for these events to include domestic students to enhance relations between international and local students.

### **3.3.3 Organisational and workforce development**

Given the fragmentation in health and welfare service delivery to international students, there is a need to facilitate greater collaboration between agencies, educational institutions and international student-friendly health and community services. Various professional associations for representatives from agencies, educational institutions and student services do exist, but collaboration appears to be ad hoc. Statewide networks that bring together members of these associations could be developed to inform members of the international student-friendly services and programs available, which in turn could improve student referrals to health services and community organisations. Professional training and resourcing in relation to the implementation of culturally-appropriate health promotion initiatives for international students, as well as assisting students to navigate the Australian health system could also be provided within these networks. Staff members in educational institutions also need to be fully informed of student health promotion initiatives and be encouraged to promote student participation.

### **3.3.4 Legislative and policy reform**

The recent change to the OSHC Deed that precludes OSHC providers from paying benefits for the treatment of pregnancy-related conditions in the first 12 months after arrival in Australia is a breach of women's rights. This change poses grave risks to the sexual and reproductive health of female international students and the partners of male international students. The Department of Health and Ageing and OSHC providers need to understand that the overwhelming majority of international students are young people primarily aged in their late teens and twenties, a population that is typically, or likely to become, sexually active, and that the migration experience for many students increases their risk of poor sexual health and reproductive outcomes. This risk is more profound during the first 12 months after arrival in Australia when students are adjusting to a new life in Australia without their traditional social supports. Furthermore, this population is of childbearing age, with many female students and the partners of male students wanting to have children, irrespective of their residence base.

The immediate reversal of the change to the OSHC Deed—specifically clause 8.1(g)—is essential to improving sexual and reproductive health of female international students. It may be worthwhile including a compulsory premium in OSHC policies for all international students to cover costs related to sexual and reproductive health:

*'I don't think female students should bear the cost of contraception and pregnancy-related things. Essentially, the students that are coming in are of the childbearing age group and so with that insurance, maybe we actually need to be considering that it needs to cover for contraception and termination and pregnancy care and spread that across males and females and have that as a compulsory component. This is where a lot of women bear the cost, but they don't get pregnant by themselves. It's a team effort.'* (Key stakeholder 6)

The OSHC Deed should also mandate all OSHC providers to participate in international student health promotion programs to fully inform their student members of their health access entitlements under OSHC.

The Australian Human Rights Commission is targeting public and private educational institutions in the development of *Minimum Standards for International Student Welfare*. Still in draft form at the time of preparing this publication, the purpose of the Minimum Standards will be to protect the rights of international students (with a focus on consumer rights, health and safety, accommodation, employment, transport, immigration and information) and to highlight the minimum responsibilities of educational institutions towards realising students' rights. The mandatory provision of sexual health information during orientation is one highlighted responsibility (Australian Human Rights Commission, 2011). Given the increasing calls for educational institutions to better exercise a duty of care towards international students (Ethnic Communities' Council of Victoria, 2010), the Minimum Standards are welcome; however, to be truly effective, the Standards, which will be voluntary when finalised, need to be incorporated into legislation.

The final report of the Strategic Review of the Student Visa Program, commissioned by DIAC and the Department of Education, Employment and Workplace Relations, was released in September 2011 (Knight, 2011a). The aim of the review was to examine the effect of the student visa program on Australia's international education industry, with a view to strengthening the program and the industry (Knight, 2011b). The Review Team received 200 submissions, with several of these submissions highlighting key health and welfare concerns in the international student population and the strategies required to address these issues. The review was an ideal opportunity to acknowledge the inextricable link between improving the international student experience—including maintaining student health—and strengthening the quality of the international education industry in Australia. Disappointingly, the final report fails to highlight this connection. Whilst the final report briefly acknowledges the cultural benefits that international students bring to Australian society, the report perpetuates the 'cash cow' mentality in primarily recognising the financial benefits of international students to the Australian economy. Thus, the report's recommendations seek to improve the financial viability of the international education industry. There are no recommendations for student wellbeing initiatives. Nor is there any reference to health promotion programs in the Council of Australian Governments *International Students Strategy for Australia* (COAG, 2010). The only reference in the Strategy to improving student health is via student safety initiatives, community engagement and stricter OSHC rules.

The lack of federal government commitment to improving the health of international students is regrettable, and demonstrates poor leadership to the Australian international education industry. There is a need for all key players in the industry—local, state and federal governments, educational institutions, OSHC providers, landlords, employers—to better exercise their duty of care to international students and to respect students' human rights. Greater consideration of students' human rights would improve the international student experience and so contribute to the strengthening of the international education industry in Australia.

### **3.3.5 Improved data collection**

The prevalence of STIs and unplanned pregnancies in female international students is unknown. State/territory and federal health authorities responsible for the collection of data on abortions and STIs should include *visa status* on notification forms. Categorising health statistics by visa status will provide a more accurate account of abortions and STIs in female international students. This information will benefit the development of culturally-appropriate sexual health promotion initiatives for this population.

### **3.4 Conclusion**

In response to poor sexual and reproductive health outcomes in the female international student population, MCWH implemented a comprehensive health promotion initiative for these students in Melbourne. Program findings demonstrate that unplanned pregnancy, abortion and violence are characteristic in this population of women. Various factors contribute to poor health outcomes, including limited sexual health literacy, poor access to health services, and the dynamics of the immigration experience. A multi-faceted approach is required to improve sexual and reproductive health of female international students and needs to feature communication and social marketing initiatives; social inclusion programs; organisational and workforce development; legislative and policy reform; and improved data collection.

## CHAPTER 4: KEY RECOMMENDATIONS

The following actions are needed to capitalise on the findings of the MCWH FIS program:

1. Key players in the international education industry—local, state and federal governments, educational institutions, OSHC providers, landlords, employers—need to better exercise their duty of care to international students and respect students' human rights.
2. Local, state/territory and federal governments should provide funding for health promotion programs for international students across Australia. Educational institutions should also invest in these student wellbeing initiatives.
3. Private and public educational institutions across Australia should be responsible for the delivery of health promotion programs for international students. These programs must include mandatory health education sessions delivered to all international students during orientation periods, and should:
  - a. Cover sexual, reproductive and mental health, OSHC policies, and student-friendly health and community services (including an explanation of GP roles);
  - b. Utilise trained bilingual health educators to provide information to students;
  - c. Be gender-specific and delivered by educators who are the same gender as participants;
  - d. Be delivered in English and commonly-spoken languages in the international student community;
  - e. Include distribution of multilingual written health information and health resource kits;
  - f. Be reinforced with social media and by international student leaders throughout study periods.
4. Gender-specific health education sessions could also be delivered in student services. Social media, international student leaders and appropriate incentives could facilitate student participation in these education sessions.
5. Respected female and male students from the international student community should be identified, trained and resourced to actively encourage their peers to participate in health education sessions and to reinforce key health messages to students.
6. Student services, particularly those that provide health care and welfare assistance to international students, need to be resourced with multilingual written health information to distribute to students during consultations.
7. All OSHC websites should consistently provide comprehensible and comprehensive information about: OSHC policies and procedures, including benefits payable and not payable, claims processes and gap payments; direct-billing medical practitioners and health services, hours of opening, languages spoken and gap fees; the Australian health system; and health and wellbeing. Information should be provided in several languages.

8. Social inclusion initiatives, such as gender-specific mentoring programs, social events and recreational activities that foster interaction between international students, domestic students and the wider community, should be implemented within educational institutions, via student associations and local governments.
9. Statewide collaborative networks for representatives from agencies, educational institutions and international student-friendly health and community services should be developed to promote information-sharing about services and programs available to students, and to improve student referrals. Professional training could also be available to network members.
10. Revisions to the OSHC Deed should be enacted to allow international students and their dependants insured access to treatment for pregnancy-related conditions from arrival in Australia. The OSHC Deed should also mandate all OSHC providers to participate in international student health promotion programs to fully inform their student members of their health access entitlements under OSHC. The *Minimum Standards for International Student Welfare* should be incorporated into legislation.
11. State/territory and federal health authorities responsible for the collection of data on pregnancy terminations and STIs should include *visa status* on notification forms, so accurate figures about these sexual health issues in female international students can be obtained.

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## **APPENDICES**



## **Appendix 1: MCWH FIS program participants: advisory committee members, consultation participants, training program presenters, bilingual health educators, host agencies, educational institutions and services for program activities**

### **Advisory Committee members**

An advisory committee was formed to ensure the MCWH FIS program was guided by individuals with relevant expertise in student health and welfare. Members of the advisory committee included:

1. Alison Dumaresq, Cambridge International College
2. Leah Harris, Cambridge International College
3. Mary Pozzobon, OSHC Worldcare
4. Regina Quiazon, Victoria University
5. Liz Round, Multicultural Hub

Three female international students were recruited to join the advisory committee. For confidentiality purposes, their names are not listed.

### **Consultation participants**

Consultations were undertaken with key stakeholders who deliver health, education and welfare-related services to female international students, or who possess an understanding of international student health and welfare, to identify key sexual and reproductive health issues affecting female students and to determine culturally-appropriate health promotion strategies for these students. The following agencies, educational institutions, organisations and services were represented in the consultation:

1. Berkeley Day Surgery
2. Carrick Institute of Education
3. Centre for Culture, Ethnicity and Health
4. Ethnic Communities Council of Queensland
5. Marie Stopes International Australia
6. Melbourne Sexual Health Centre
7. Monash University
8. OSHC Worldcare
9. QV Medical One
10. Royal Women's Hospital
11. Shine SA
12. Southern Cross Education Institute
13. Swinburne University of Technology
14. University of Melbourne
15. University of New South Wales
16. William Angliss Institute of TAFE

### **Training program presenters**

The one-day training program for MCWH bilingual health educators included the following presenters:

1. Jill Duncan, Centre Against Sexual Assault (CASA House)
2. Victoria Ellis, Centre Against Sexual Assault (CASA House)
3. Stephanie Brajkovic, OSHC Worldcare
4. Mary Pozzobon, OSHC Worldcare
5. Felicity Martin, Swinburne University of Technology (Student Development and Counselling)
6. Liza Ng, Swinburne University of Technology (Student Development and Counselling)
7. Katherine Yannakis, Swinburne University of Technology (Student Development and Counselling)

### **Bilingual health educators**

The MCWH bilingual health educators enlisted to provide health education and information to female international students were:

1. Sonali Deshpande
2. He Li
3. Mahdokht Mahboobi
4. Elizabeth Mazeyko
5. Rachanee Naksuk
6. Hien Tran
7. Yanping Xu

### **Host agencies, educational institutions and services for FIS program activities**

Several agencies, educational institutions and services hosted MCWH health education and information activities for female international students. These included:

1. Australian Institute of Technology and Education
2. Carrick Institute of Education
3. City of Melbourne
4. Darebin City Council
5. International Student Care Service
6. Monash University
7. Melbourne Institute of Business and Technology
8. Swinburne University of Technology
9. The Couch (International Student Centre)
10. Trinity College
11. University of Melbourne Health Service

## **Appendix 2: Key stakeholder consultation questions**

The main consultation questions included:

1. What are the key sexual and reproductive health issues in female international students (Comment on knowledge, attitudes, and practices)?
2. To what extent do female international students recognise the importance of sexual and reproductive health to their overall health and wellbeing?
3. How might the migration experience influence students' health knowledge, attitudes and practices? What other factors might contribute?
4. What health information-seeking behaviours might female international students practise in Australia? How and where might they seek health information?
5. What health promotion strategies have you used for female international students?
6. What information needs to be provided to female international students about sexual and reproductive health?
7. What health promotion strategies could be implemented for female international students?
8. What might encourage female international students to participate in health promotion activities?
9. What else needs to be done to improve the sexual and reproductive health of female international students?
10. Any other comments?



### **Appendix 3: Student focus group schedule**

Focus groups were held with female international students before their participation in pilot health education sessions in 2009. Questions asked in the student focus groups were as follows:

1. What does women's health mean to you? What issues are you familiar with?
2. What kind of health information have you sought in your country of origin? In Australia? Where have you sought or do you look for health information?
3. What health services have you accessed in your country of origin? In Australia? Have you experienced any difficulties accessing health services in Australia?
4. Have you participated in health education in your country of origin? In Australia?
5. What health information needs to be provided to female international students in Australia? What information would you like to receive?
6. What do you think about the MCWH model of health education (*woman-to-woman approach*)?
7. What other health promotion strategies could be used to educate female international students about women's health?
8. What might encourage female international students to participate in health promotion activities?
9. Any other comments?



**Appendix 4: Survey for female international students participating in focus groups and pilot health education sessions**

This survey was administered to female international students that participated in the focus groups and pilot health education sessions in 2009.

<p><b>1. How old are you?</b></p> <p>16 - 17 years <input type="checkbox"/></p> <p>18 – 20 years <input type="checkbox"/></p> <p>21 - 25 years <input type="checkbox"/></p> <p>26 – 30 years <input type="checkbox"/></p> <p>31 years or more <input type="checkbox"/></p>	<p><b>2a. What is your country of birth?</b></p> <p>_____</p> <p><b>2b. What is your ethnicity or cultural background?</b></p> <p>_____</p>																		
<p><b>3. Are you:</b></p> <p>Single <input type="checkbox"/></p> <p>In a relationship <input type="checkbox"/></p> <p>Other <input type="checkbox"/></p>	<p><b>4. How long have you been studying in Australia?</b></p> <p>Less than one year <input type="checkbox"/></p> <p>1 year <input type="checkbox"/></p> <p>2 years <input type="checkbox"/></p> <p>3 years <input type="checkbox"/></p> <p>4 years or more <input type="checkbox"/></p>																		
<p><b>5a. Are you studying at:</b></p> <p>Secondary school <input type="checkbox"/></p> <p>TAFE <input type="checkbox"/></p> <p>University <input type="checkbox"/></p> <p>Private college <input type="checkbox"/></p> <p>Other institution <input type="checkbox"/></p> <p><b>5b. Are you studying for:</b></p> <p>VCE <input type="checkbox"/></p> <p>An undergraduate degree <input type="checkbox"/></p> <p>A postgraduate degree <input type="checkbox"/></p> <p>Vocational qualification <input type="checkbox"/></p> <p>Other <input type="checkbox"/></p>	<p><b>6a. Have you ever received any form of health education in:</b></p> <table style="width: 100%; border: none;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">Yes</th> <th style="width: 10%; text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>Your country of origin</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Australia</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table> <p><b>6b. Have you ever looked for any form of health information in:</b></p> <table style="width: 100%; border: none;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">Yes</th> <th style="width: 10%; text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>Your country of origin</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Australia</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>		Yes	No	Your country of origin	<input type="checkbox"/>	<input type="checkbox"/>	Australia	<input type="checkbox"/>	<input type="checkbox"/>		Yes	No	Your country of origin	<input type="checkbox"/>	<input type="checkbox"/>	Australia	<input type="checkbox"/>	<input type="checkbox"/>
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<p><b>7. Have you ever visited a health service in:</b></p> <table style="width: 100%; border: none;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">Yes</th> <th style="width: 10%; text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>Your country of origin</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Australia</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>		Yes	No	Your country of origin	<input type="checkbox"/>	<input type="checkbox"/>	Australia	<input type="checkbox"/>	<input type="checkbox"/>										
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## Appendix 5: Survey for female international students participating in health education sessions

This survey was administered, where logistically possible, to female international students participating in the health education sessions in 2010 and 2011.

---

### 1. How old are you?

16 - 17 years

18 – 20 years

21 - 25 years

26 – 30 years

31 years or more

### 2. In which country were you born? \_\_\_\_\_

### 3. What is your main cultural background?

Chinese

Indian

Indonesian

Korean

Latin American (Spanish-speaking)

Malaysian

Nepalese

Thai

Vietnamese

Other (please state) \_\_\_\_\_

### 4. Are you:

Single

In a relationship (have a partner, or married)

### 5. Do you have children?

Yes, my children are with me in Australia

Yes, my children are overseas

No, I do not have children

### 6. How long have you been studying in Australia? \_\_\_\_\_

### 7. At which educational institution (college, university) are you studying? \_\_\_\_\_

### 8. What is the name of the course you are studying? \_\_\_\_\_

### 9. Have you ever visited a health service (clinic, medical centre, hospital, health information service) in (you can tick more than one box):

Your country of birth or origin

Australia

### 10. Have you ever looked for any form of health information in (you can tick more than one box):

Your country of birth or origin

Australia

### 11. Before this education session, have you ever received any form of health education in (you can tick more than one box):

Your country of birth or origin

Australia

### 12. What did you think of the MCWH health education session(s)?

Poor

Average

Good

Very good

Excellent

- 13. Which topics from the MCWH health education session(s) were most useful for you? (You can tick more than one box)**
- General women's health (breast health, menstruation, Pap tests)
- Sexual health (sexually transmitted infections, contraception, safe sex)
- Mental health (anxiety, depression)
- Other (please state) \_\_\_\_\_
- No information was useful for me
- 14. Which topics would you like to learn more about? (You can tick more than one box)**
- General women's health (breast health, menstruation, Pap tests)
- Sexual health (sexually transmitted infections, contraception, safe sex)
- Mental health (anxiety, depression)
- Other (please state) \_\_\_\_\_
- No topics
- 15. While studying in Australia, do you like to receive health education in:**
- Your own language  English
- It does not bother me  I don't like to receive health education
- 16. Do you think female international students should be given women's health information when they are studying in Australia?**
- Yes  No  I don't know
- 17. What women's health information should be given to female international students when they are studying in Australia? (You can tick more than one box)**
- General women's health (breast health, menstruation, Pap tests)
- Sexual health (sexually transmitted infections, contraception, safe sex)
- Reproductive health (pregnancy, childbirth)
- Mental health (anxiety, depression, relaxation)
- Health and community services in Melbourne accessible to international students
- Other (please state) \_\_\_\_\_
- I don't know
- Students do not need to be given health information when they are studying in Australia
- 18. What are the best ways to provide women's health education to female international students when they are studying in Australia? (You can tick more than one box)**
- Peer education (education from bilingual health educators)
- Internet (YouTube videos, information on Facebook, MySpace or general health websites)
- SMS text messages
- Written materials (brochures, posters)
- DVDs
- Through student events or services
- Other (please state) \_\_\_\_\_
- I don't know
- Students do not need to be given health information when they are studying in Australia

## Appendix 6: Survey for female international students visiting the MCWH stall at international student events

This survey was administered, where logistically possible, to female international students visiting the MCWH stall at the Lord Mayor's Student Welcome events in 2010.

---

**1. How old are you?**

- 16 - 17 years                       18 – 20 years                       21 - 25 years   
26 – 30 years                       31 years or more

**2. In which country were you born?** \_\_\_\_\_

**3. What is your main cultural background?**

- Chinese                       Indian                       Indonesian   
Korean                       Latin American (Spanish-speaking)   
Malaysian                       Nepalese                       Thai   
Vietnamese                       Other (please state) \_\_\_\_\_

**4. Are you:**

- Single                       In a relationship (have a partner, or married)

**5. Do you have children?**

- Yes, my children are with me in Australia                       Yes, my children are overseas   
No, I do not have children

**6. How long have you been studying in Australia?** \_\_\_\_\_

**7. At which educational institution (college, university) are you studying?** \_\_\_\_\_

**8. What is the name of the course you are studying?** \_\_\_\_\_

**8. Have you ever visited a health service (clinic, medical centre, hospital, health information service) in (you can tick more than one box):**

- Your country of birth or origin                       Australia

**10. Have you ever looked for any form of health information in (you can tick more than one box):**

- Your country of birth or origin                       Australia

**11. Do you think female international students should be given women's health information when they are studying in Australia?**

- Yes                       No                       I don't know

**12. What women's health information should be given to female international students when they are studying in Australia? (You can tick more than one box)**

- General women's health (breast health, menstruation, Pap tests)
- Sexual health (sexually transmitted infections, contraception, safe sex)
- Reproductive health (pregnancy, childbirth)
- Mental health (anxiety, depression, relaxation)
- Health and community services in Melbourne accessible to international students
- Other (please state) \_\_\_\_\_
- I don't know
- Students do not need to be given health information when they are studying in Australia

**13. What are the best ways to provide women's health education to female international students when they are studying in Australia? (You can tick more than one box)**

- Peer education (education from trained bilingual health educators)
- Internet (YouTube videos, information on Facebook, MySpace or general health websites)
- SMS text messages
- Posters/brochures
- DVDs
- Through student events or services
- Other (please state) \_\_\_\_\_
- I don't know
- Students do not need to be given health information when they are studying in Australia

**14. What women's health topics would you like to learn about? (You can tick more than one box)**

- General women's health (breast health, menstruation, Pap tests)
- Sexual health (sexually transmitted infections, contraception, safe sex)
- Reproductive health (pregnancy, childbirth)
- Mental health (anxiety, depression, relaxation)
- Health and community services in Melbourne accessible to international students
- Other (please state) \_\_\_\_\_
- None of these topics

**15. Would you prefer to receive health education in:**

- Your own language  English
- It does not bother me  I don't like to receive health education

**Appendix 7: Health education session evaluation form**

Bilingual health educators completed this evaluation form after delivering health education sessions for female international students.

---

**1a. How many students were present during the education session? \_\_\_\_\_**

**1b. What was the main cultural background of the students present?**  
\_\_\_\_\_

**2. What were the main topics presented in the education session?**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3. What resources (written, audio, visual, other) did you use during the education session?**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**4. What experiences did the students share about their health or that of their families and communities (including their level of health-related knowledge, current health practices, previous health education experience etc)? What were their main health concerns?**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**5. What questions did students ask during the education session?**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**6. Which messages did students indicate were most important and/or useful?**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**7. How did students indicate they might put the information presented into practice ie what health behaviours might they change and/or adopt?**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

