
# BREAKING THE BARRIERS:

## Migrant and refugee women's experiences of health care in Victoria

GENVIC
GENDER EQUITY VICTORIA

MULTICULTURAL CENTRE FOR WOMEN'S HEALTH

WOMHEn
Workforce of multilingual health educators

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Designed by Ali Miller, Pixel Jam Design.

Gender Equity Victoria is grateful to the multilingual health educators who undertook interviews.

This report was written to document the result of interviewing migrant and refugee women and key result of the WOMHEn project. For further information on the issues raised in this paper please email genvic@genvic.org.au



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PARLIAMO ITALIANO

# Acknowledgments

The WOMHEn Project was funded and supported by the Department of Fairness, Families and Housing (DFFH), Government of Victoria. The project was led by the Multicultural Centre of Women's Health (MCWH) and Gender Equity Victoria in partnership with Victorian Women's Health Services. Thanks and appreciation go to all the staff, health educators and out-reach workers who supported and conducted the WOMHEn project. Thanks and acknowledgement go particularly to the migrant and refugee women who shared their experiences and stories about how they have dealt with the impacts of the COVID-19 pandemic.

VICTORIA State Government | Families, Fairness and Housing

MULTICULTURAL CENTRE FOR WOMEN'S HEALTH

## Multicultural Centre for Women's Health (MCWH)

MCWH is Victoria's state-wide migrant and refugee women's health service, providing tailored, responsive, accessible and equitable health and wellbeing programs for migrant and refugee women across Victoria. MCWH led the WOMHEn project and consortia partnership providing project coordination, expertise on design of the in-language health education sessions, the design of the evaluation, as well as training for the multicultural health educators.

G+V GENVIC GENDER EQUITY VICTORIA

## Gender Equity Victoria (GEN VIC)

GEN VIC is the peak body for gender equity, women's health and the prevention of violence against women. GEN VIC has public, private and community sector membership representing organisations across Victoria that advance gender equity and hold values aligned with feminist principles. GEN VIC recognises that gender is a critical determinant of wealth, power and status in society and a powerful driver of health inequities. GEN VIC works collaboratively to improve women's status and health outcomes. GEN VIC co-led the project with MCWH by coordinating the community engagement and interview activities and led the writing of this report.

WOMHEn

Workforce of multilingual health educators

## Victorian Women's Health Services (WHS)

WHS provide a state-wide infrastructure to promote good health and wellbeing to Victorian women. Since 1988, WHS have been fundamental to the provision of health promotion and prevention projects and programs in Victoria. WHS counteract gendered health inequities by ensuring Victorian women have access to tailored, gendered, multilingual health information with which to navigate health care choices across the Victorian health system while also working to address the underlying systemic causes of women's ill-health.

The WHS located across metropolitan and regional regions are centres of excellence in gendered health promotion and prevention, winning awards for their innovations and achievements. With the funding provided for this project, regional WHS employed the multicultural health educators to address the needs of migrant and refugee women in their respective regions.

**Regional women's health services participating in this project were:**

Gen West
Women's Health in the South East
Women's Health Grampians
Gippsland Women's Health
Women's Health Loddon Mallee
Women's Health in the North
Women's Health East
Women's Health Goulburn North East

## Acknowledgment of Country

GEN VIC and MCWH acknowledges and pays respect to the Wurundjeri people of the Kulin nation, on whose land this report was written. Aboriginal sovereignty was never ceded. We recognise that we live on stolen land and benefit from the colonisation of the land now called Australia. We have a shared responsibility to acknowledge and end the ongoing harm done to its First Peoples and to work towards respect and recognition. We recognise that Aboriginal and Torres Strait Islander women are leaders who have created the path for our feminist activism and who continue to sustain us as we work towards achieving equity for all women.

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

GEN VIC

# Executive Summary

The WOMHEn project began in 2021 using in-language health education to address the barriers experienced by migrant and refugee women in accessing health education and information on COVID-19. In addition to providing access to in-language and culturally safe health education and information to migrant and refugee women in Victoria, the project also documented how the COVID-19 pandemic had impacted their lives. The Left behind report documents those impacts on migrant and refugee women's health, economic security, and social lives. WOMHEn was a grassroots initiative, led by multicultural health educators, who created culturally appropriate and safe ways to enable migrant and refugee women to feel more confident and empowered to talk about their concerns, to engage in conversations that in turn, assisted them to make decisions about their health.

From late December 2021 - June 2022, the WOMHEn multicultural health educator workforce continued this work by delivering health education sessions to migrant and refugee women in 18 different community languages. The project's objectives for the second phase were to address barriers to vaccine literacy and uptake, vaccine hesitancy, and service navigation of migrant and refugee women, including those who are carers, of childbearing age or pregnant, and living in rural and regional Victoria.

'By the end of the project, 3,287 migrant and refugee women had accessed a health education session of whom 1,631 of participants reported that they had increased their awareness of the health benefits of accessing COVID-19 vaccines after attending a health education session. Health educators followed up with some session participants to ascertain how many took action to book a COVID-19 vaccination. As a result, 659 (or 20%) migrant and refugee women reported booking or having a COVID-19 vaccination, including for their children.

In addition, 63 migrant and refugee women were interviewed one-on-one, in-language, by the health educator workforce who transcribed interviews into English. The objectives of the interviews were to understand further migrant and refugee women's experiences of accessing COVID-19 vaccines and the health care system. Evaluations of the health education sessions provided further insights about the experiences of migrant and refugee women who were involved in in-language health education sessions.

Analysis of the interviews revealed that many women had accessed COVID-19 vaccinations but they felt under-confident about vaccines and hesitant to access third doses, as well as distrust of vaccines, sometimes related to social media sources originating from their home countries. Around 18 per cent of migrant and refugee women who were interviewed reported vaccine hesitancy with concerns about side-effects of the vaccine, as well as fear of getting COVID-19 vaccines during pregnancy, and the effects of the vaccine on children. Most participants reported that finding health information on COVID-19 vaccines in their community language was not straightforward; 22 per cent of participants reported it was 'difficult', and 3 per cent described it as 'very difficult' because of the limited health information in their language or in plain English. This was exacerbated by fast-changing information communicated to the public on the efficacy and possible side effects of COVID-19 vaccines, boosters and COVID-19 vaccines for children.

In terms of access to health care, migrant and refugee women reported various forms of structural barriers such as difficulty in accessing interpreter services; financial barriers; lack of access to information on preventative health services; lack of culturally appropriate services especially in mental health services. The lack of confidence reported by some migrant and refugee women were also symptomatic of the many barriers they faced which prevented them from being able to make informed decisions about their health. The findings about women's confidence in accessing health care were mixed. One-third of women were confident; almost half of the participants reported being somewhat confident but nearly a quarter stated they are not confident in accessing health care. Common barriers cited include the costs of healthcare, getting transport to access healthcare services, and language barriers. Furthermore, half of the participants said they had not accessed any preventative health care services during the last year. The reasons include fear of getting the COVID-19 virus; lack of access to culturally appropriate services where they felt understood; long waiting times; cost and visa issues (such as being on a temporary visa) and being unaware of such services available for them.

The interviews also found that women who had found a General Practitioner (GP) who was conversant in their language appreciated the access to knowledge and care that these GPs provided. The in-language health education sessions introduced women to Women's Health Services which women did not know about previously. And while a high proportion of women interviewed had been vaccinated for COVID-19, for some, their reasons for doing so were more about the mandated requirement for vaccination to allow them or their spouse to work. Their uncertainties about vaccination lingered to the point that they weren't always accessing 3rd doses, and/or were delaying having their children vaccinated - some were hesitant and relied on in-language social media from their home countries. Many women did not have access to computers, so their capacity to develop digital literacy and assess the quality of information was limited. This emphasises the deep value of the work that WOMHEn project and in-language health educators did to gain the trust of women, and then provide a safe space for knowledge exchange and information provision. The WOMHEn project has provided evidence of the very positive impact of the in-language health education sessions: it

can help dismantle the many barriers faced by migrant and refugee women when accessing the health system.

The project also highlighted issues of health inequities and social exclusion. The data indicated that health system barriers, such as the lack of culturally relevant and in-language information, continue to impact on migrant and refugee women's confidence in accessing health care. The women interviewed stated the health education sessions enabled them to articulate their worries and concerns in-language to a woman health educator who was able to address their concerns. The health education sessions facilitated knowledge sharing and myth-busting through culturally safe and appropriate forums, which allowed migrant and refugee women to ask questions without judgement, so as to equip them with the information needed to make an informed decision about taking additional doses of the COVID-19 vaccination.

## THE SUCCESS OF THE SECOND PHASE OF THE WOMHEN PROJECT

**40** Employed 40 multilingual health educators across Victoria.

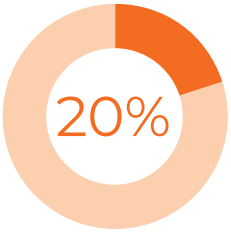
**63** Interviewed 63 migrant and refugee women on access to health care in Victoria.

**160** Delivered 160 vaccine health education sessions in languages other than English such as:

Marathi
MACEDONIAN
NUER **NEPALI** Dari Karen
**ENGLISH** *Swahili* **FILIPINO**
Punjabi **HAZARAGI** Arabic *Hindi*
*Urdu* **VIETNAMESE** Hakha Chin
MANDARIN GREEK Tagalog

**3,287** A total of 3,287 migrant and refugee women participated in **health education sessions** across regional Victoria and metro Melbourne.

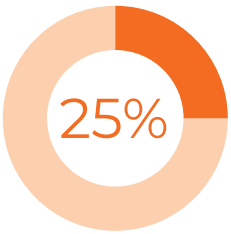

Approximately 50% (1,631) of women participated in health education sessions reported positive impacts.




659 (or 20%) migrant and refugee women reported booking or having a COVID-19 vaccination, including for their children.

## BARRIERS TO HEALTH INFORMATION ON COVID-19 VACCINES

The project interviewed **63 migrant and refugee women.** All women interviewed had **two doses of COVID-19 vaccines.** However, their experience revealed that finding health information on COVID-19 vaccines in their community language was not straightforward.




A quarter of women (25 per cent) interviewed described **accessing COVID-19 vaccines information as difficult.**

> "I ONLY GOT THE INFORMATION I WAS GIVEN (BY THE COMMUNITY). I DON'T KNOW HOW TO GO ON THE INTERNET AND SEARCH FOR RESOURCES IN HAKHA CHIN. IT'S NOT HARD TO GET, BUT IT WAS LIMITED."

## BARRIERS TO ACCESS HEALTH CARE SERVICES

### WOMEN REVEALED BARRIERS IN ACCESSING HEALTH SERVICES, INCLUDING:

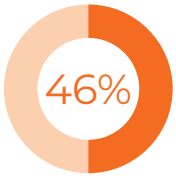
- Difficulty in accessing interpreter services
- Financial barriers
- Lack of access to information on preventative health services
- Lack of culturally appropriate services especially in mental health services

### HALF OF THE WOMEN (50 PER CENT) HAD NOT ACCESSED ANY PREVENTATIVE HEALTH CARE SERVICES DURING THE LAST YEAR. THE REASONS INCLUDE:

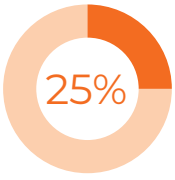
- Fear of getting the COVID-19 virus
- Lack of access to culturally appropriate services where they felt understood
- Long waiting times
- Cost and visa issues (such as being on a temporary visa)
- Being unaware of such services available for them

### ACCESSING THE VICTORIAN HEALTHCARE SYSTEM


felt confident




somewhat confident




not confident

### ACCESS TO MENTAL HEALTH SERVICES DURING PANDEMIC

Only a **quarter of women accessed mental health services** during pandemic. The overwhelmingly majority of 75 per cent did not access to mental health services due to **lack of language support;** lack of culturally **appropriate resources** to help access such services, and **cultural hurdles** and **taboos** around the concept of 'mental health.

> "I ACCESSED PSYCHOTHERAPY AS I WAS STRUGGLING TO MANAGE LONG-DISTANCE RELATIONSHIPS. I FELT MY PSYCHOLOGIST DID NOT UNDERSTAND THE CULTURAL PRESSURES AND COMMITMENT OF A RELATIONSHIP."

# Introduction

The Workforce of Multilingual Health Educators ('WOMHEn') project is an initiative of the Multicultural Centre for Women's Health ('MCWH') and Gender Equity Victoria ('GEN VIC') in partnership with Victorian Women's Health Services (WHS). In the first phase during 2020-2021, the project aimed to build regional health promotion and education capacity to meet the needs of migrant and refugee women to access health information about COVID-19. The project employed 50 multilingual health educators who spoke 20 languages across metropolitan and rural women's health services. The newly recruited health educators completed MCWH's accredited Multilingual Women's Health Education course and delivered in-language health education sessions with a reach to over 1800 migrant and refugee women across Victoria.

The WOMHEn project aimed to build the capacity of regional WHS to meet the needs of migrant and refugee women for reliable and culturally appropriate health information, promotion and prevention services. We know from previous studies and projects that migrant and refugee women in Victoria are disproportionally disadvantaged when accessing health care services and health information, leading to health inequities which are systematic differences in the health status of different population groups resulting in high social and economic costs both to individuals and societies.[1] A recent report from Multicultural Centre for Women's Health (MCWH) concluded that the Australian healthcare system doesn't adequately cater for migrant and refugee women when it comes to sexual and reproductive health.[2] Further, migrant and refugee women face barriers in accessing services; structural factors from the complexity of health systems and services; as well as socio-cultural and religious factors, mental health stigma and discrimination.[3] Migrant and refugee women also face obstacles from a lack of resources, time constraints, the cost of services, and lack of funding in services to meet their needs.[4]

1 World Health Organisation, Health inequities and their causes, 22 February 2018 accessed online at https://www.who.int/news-room/facts-in-pictures/detail/health-inequities-and-their-causes
See also Bearman PS, Moody J. Suicide and friendships among American adolescents. American Journal of Public Health. 2004;94(1):89–95

2 Multicultural Centre for Women's Health, *Data Report Sexual and Reproductive Health*, 2021 accessed online at https://www.mcwh.com.au/2021-sexual-and-reproductive-health-data-report-and-act-now-paper/

3 Fauk, Nelsensius Klau, Anna Ziersch, Hailay Gesesew, Paul Ward, Erin Green, Enaam Oudih, Roheena Tahir, and Lillian Mwanri. 2021. "Migrants and Service Providers' Perspectives of Barriers to Accessing Mental Health Services in South Australia: A Case of African Migrants with a Refugee Background in South Australia." *International Journal of Environmental Research and Public Health* 18 (17): 8906. See also Sullivan, C., Vaughan, C., Wright, J. (2020). Migrant and refugee women's mental health in Australia: a literature review. School of Population and Global Health, University of Melbourne. https://www.mcwh.com.au/wp-content/uploads/Lit-review_mental-health.pdf

4 Mengesha, Zelalem B., Janette Perz, Tinashe Dune, and Jane Ussher. 2017. "Refugee and Migrant Women's Engagement with Sexual and Reproductive Health Care in Australia: A Socio-Ecological Analysis of Health Care Professional Perspectives." *PLoS One* 12 (7) (07).

The WOMHEn project received a second round of funding to continue the work from November 2021 until June 2022. In this second phase, the project's objectives were to address barriers to vaccine literacy and uptake, vaccine hesitancy, and service navigation of migrant and refugee women, including those who are carers, of childbearing age or pregnant, and living in rural and regional Victoria. Similar to the first phase of the project, in-language health education sessions were conducted by 40 fully trained and accredited multilingual health educators. This approach to providing in-language health education with migrant and refugee women was a critical factor in the success of the WOMHEn project. In-language health education provides information that opens discussion and exchange between women and multilingual health educators. Health concerns and issues are considered and addressed in the context in which women experience their lives and health.

In addition, interviews with 63 women captured women's voices about their barriers to accessing in-language health information on COVID-19 vaccines as well as their experiences in accessing health care services. This report documents analysis of the interview data. The data collected from the interviews provides valuable insights about migrant women's experiences, and how to make health care services and health information more equitable and accessible for migrant and refugee women and their families.

**FIRST PHASE DURING 2020-2021**

| | | | |
|---|---|---|---|
| 50 multilingual health educators | 20 languages spoken | 1800 migrant and refugee women across Victoria received in-language health education sessions | 75 women interviewed |

**2ND PHASE NOVEMBER 2021- JUNE 2021**

| | | | |
|---|---|---|---|
| 40 multilingual health educators | 20 languages spoken | 3,287 migrant and refugee women received in-language health education sessions | 63 women interviewed |

> THE DATA COLLECTED FROM THE INTERVIEWS PROVIDES VALUABLE INSIGHTS ABOUT MIGRANT WOMEN'S EXPERIENCES, AND HOW TO MAKE HEALTH CARE SERVICES AND HEALTH INFORMATION MORE EQUITABLE AND ACCESSIBLE FOR MIGRANT AND REFUGEE WOMEN AND THEIR FAMILIES.

# Key Recommendations

To redress inequitable access to health care services for migrant and refugee women and to improve access to health information and health care service for migrant and refugee women the following actions are recommended:

1. Continue to support the multilingual women-led workforce that delivers in-language health education employed as part of the WOMHEn project across Victoria.

2. Provide continuing funding and support for peer-based, community-led, multilingual women's health education and support programs across Victoria and connect them to health care services.

3. Ensure interpreting services are available across all health care settings, and that interpreters are equipped with skills to deliver gendered, inclusive and culturally appropriate services.

4. Train health professionals across all health care settings in gendered, cross-cultural awareness to improve migrant women's access to health care services.

5. Provide health information in multiple languages on a wider range of health issues, particularly gendered health issues such as mental health, sexual and reproductive health, and physical health including consultation with women from migrant and refugee communities to ensure appropriateness and accuracy.

6. Support innovative, tailored education and advocacy for mental health interventions by migrant women's organisations and delivered by trained multilingual health educators.

# 2 Project Activities

## 2.1 Recruitment, onboarding and training

The WOMHEn project received an extension of funding from the Department of Families, Fairness and Housing from November 2021 until June 2022. MCWH assisted the project partner WHS in recruitment of new health educators and project staff to add to the existing workforce, providing position descriptions and guidelines. Fourteen multilingual health educators were hired across WHS in Melbourne and regional Victoria, MCWH continued the Project Coordinator and Administration Officer positions and hired a Community Support Officer. Meanwhile. GEN VIC onboarded one Communications Coordinator and three Project Officers.

The newly recruited health educators undertook MCWH's accredited, six-week Multilingual Women's Health Education Training Course to qualify them to facilitate in-language health education sessions with migrant and refugee women's groups. Zoom Networking Sessions facilitated by MCWH continued health educators' engagement with each other and created a virtual space to share strategies for community engagement throughout the program.

Professional development training for multilingual health educators, organised by MCWH and facilitated by the Victorian Department of Health, covered the latest updates regarding the COVID-19 response, statistics, testing and COVID-safe practices, COVID-19 vaccination, and updates regarding the flu vaccine. Following training and professional support, multilingual health educators conducted community engagement activities to garner interest and uptake of health education sessions, mostly on the topic of COVID-19 vaccinations.

## 2.2 Health Education sessions

Health education sessions were organised to address vaccine literacy, hesitancy, and service navigation of migrant and refugee women, including those who are carers, of childbearing age or pregnant, and living in rural and regional Victoria. The program tailored information and service navigation support to women from migrant and refugee backgrounds, women in low socio-economic status (SES) communities, and to women who are vaccine hesitant.

MCWH developed an evaluation form for health education sessions completed by the health educators. The form collected data on session participants demographics, the impact of the health education session on the participant's confidence in getting a COVID-19 vaccine, and women's experience navigating the health system to access a COVID-19 vaccination.

Across the program, 160 vaccine health education sessions were delivered. 152 were delivered in a language other than English including Nepali, Swahili, English, Dari, Hazaragi, Hakha Chin, Mandarin, Macedonian, Hindi, Greek, Punjabi, Tagalog, Urdu, Vietnamese, Nuer, Filipino, Marathi, Arabic, and Karen.

A total of 3,287 migrant and refugee women participated in health education sessions across regional Victoria and metro Melbourne. Approximately 1,631 of participants reported that they had increased their awareness of the health benefits of accessing COVID-19 vaccines after attending a health education session. Health educators followed up with some session participants to ascertain how many took action to book a COVID-19 vaccination. As a result, 659 (or 20%) migrant and refugee women reported booking or having a COVID-19 vaccination, including for their children.

## 2.3 Interview and research methodology

### a. Interview design

GEN VIC led the project activity to collect interview data from migrant and refugee women about their confidence and barriers in accessing COVID-19 vaccines and other health care services. The report from Phase 1, *Left Behind*[5], identified that structural barriers for migrant and refugee women persist, preventing them from enjoying equitable access to health care services. Those barriers manifest as unavailable interpreter services, costs of health care, lack of knowledge about how to navigate the complex health care system, and a lack of culturally appropriate provision of health care services.

Using this prior knowledge, an interview schedule of 38 questions (Appendix 1) were developed, mainly consisting of open-ended questions designed to ensure that the interviews captured the complex and diverse experiences of migrant and refugee women of access to health information, health care services and COVID-19 vaccination. The interviews were enhanced by the ability of the multilingual health educators to use their insight and cultural sensitivity in their engagement with migrant and refugee women.

5 Gender Equity Victoria and Multicultural Centre of Women's Health, 'Left Behind: Migrant and Refugee Women's Experience of COVID-19', Melbourne: 2021 available at: https://www.genvic.org.au/wp-content/uploads/2021/10/LeftBehindWOMHEnReport61021FINAL.pdf

## b. Interview workshop

GEN VIC and MCWH co-facilitated a workshop that brought together multilingual health educators employed as part of this project. They were equipped with skills and knowledge relating to interviewing techniques, how to maintain confidentiality, and managing disclosures. Following the workshop, participants were provided with an interview and ethical guideline pack to ensure that they conducted interviews in accordance with best practice standards.

## c. Data collection

The multilingual health educators were tasked with recruiting migrant and refugee women in their communities for interviews, with 63 women recruited, some of whom had participated in health education sessions. The interviews were undertaken by the multicultural health educators in March 2022, in the refugee and migrant women's preferred language. They translated the interview data into English and provide the transcripts to GEN VIC for analysis and writing of this report.  Note that case studies used in this report use pseudonyms to protect the privacy of interview participants.

## d. Challenges and limitations

All interviews were conducted either in-person, phone or video-conferencing in accordance with public health restrictions. Where the interview was conducted remotely, the opportunity for the interviewer and participant to build rapport may have been inhibited by the lack of face-to-face contact and the sensitivity of the questions asked. Key timelines of the interview activity were disrupted by the outbreak of COVID-19 in regional areas resulting in delays in collecting some of the interview results. Despite the best efforts of interviewers, interviews conducted in a language other than English and then translated into English by the interviewer may have reduced accuracy, and details of the responses may have been lost in the process of translation.

# 3 Issues and key findings

This section reports on key findings from the interview data. Participant quotes are in *italics*.

## 3.1 Demographic data of the participants

A total of 63 migrant and refugee women participated in interviews. Table 1 shows that 70 per cent of the migrant and refugee women ('participants') were 25-45 years of age, while 28% were over 45 years old.

***Table 1: Participant demographics***

| Age group | Percentage |
|---|---|
| 25-35 | 36 |
| 36-45 | 36 |
| 46-55 | 23 |
| Others | 5 |
| Total | 100 |

Table 2 shows that participants were ethnically diverse. Most participants identified as South Asian including Indian, Nepalese, Pakistani, Burmese and Afghan, followed by Filipino and Chinese participants.

***Table 2: Participants' ethnicity***

| Ethnicity | Participants (number) |
|---|---|
| South Asian (Indian/Nepalese/ Pakistani/Burmese/ Afghan) | 25 |
| Filipino | 14 |
| Chinese | 9 |
| Vietnamese | 3 |
| Greek | 3 |
| Karen | 2 |
| Middle Eastern | 4 |
| Indonesian | 4 |
| Macedonian | 1 |
| Congolese | 1 |
| Somali | 1 |
| Total | 63 |

Table 3 shows the majority of participants (79 per cent) had citizenship or permanent residency in Australia and 21 per cent were on temporary visas.

*Table 3: Residency status*

| Residency status | Participants % |
|---|---|
| Permanent Resident | 41 |
| Australian Citizen | 38 |
| Temporary resident | 18 |
| Other visa (working/bridging visa) | 3 |
| Total | 100 |

Table 4 shows the majority of participants had lived in Australia for more than 5-10 years.

*Table 4: Participants' length of stay in Australia*

| Length of Stay in Australia | Participants % |
|---|---|
| 1-5 years | 22 |
| 5-10 years | 41 |
| More than 10 years | 35 |
| Less than 1 year | 2 |
| Total | 100 |

Table 5 shows that the majority (72 per cent) of the participants reported they have access to Medicare. 12 per cent of participants had access to private health insurance, and 16 per cent participants had access to both.

*Table 5: Participants' access to health insurance*

| Access to public/private health fund | Participants % |
|---|---|
| The participant has access to Medicare | 72 |
| The participant has a private health insurance | 12 |
| The participant has access to both Medicare and private health insurance | 16 |
| The participant has neither access to Medicare nor private health insurance | 0 |
| Prefer Not to say | 0 |
| Total | 100 |

Table 6 shows participants' relationship status. More than half of participants had a spouse (63 per cent) or partner (5 cent), and 17 per cent were single. The remainder of participants identified as widowed, separated or divorced. Table 7 shows that the majority of participants had caring responsibilities for children (73 per cent).

*Table 6: Participants' relationship status*

| Relationship status | Participants % |
|---|---|
| Single | 17 |
| Married | 63 |
| Widowed | 5 |
| Domestic Partnership | 5 |
| Separated | 6 |
| Divorced | 2 |
| Prefer not to say | 2 |
| Others | 0 |
| Total | 100 |

*Table 7: Participants' caring responsibilities of children*

| Caring responsibilities of children | Participants % |
|---|---|
| Yes | 73 |
| No | 27 |
| Total | 100 |

Table 8 shows that more than half of the participants had completed a tertiary level of education (Bachelor and Masters), 11 per cent had primary school level of education and 12 per cent of women had completed their secondary level of education. A small fraction of women had never attended school.

*Table 8: Participants' level of education*

| Level of Education | Participants % |
|---|---|
| Primary | 11 |
| Secondary | 13 |
| Vocational | 8 |
| Bachelors | 27 |
| Masters | 29 |
| Prefer not to say | 3 |
| Others | 10 |
| Total | 100 |

# 3.2 COVID-19 vaccine status

## a. Reasons for obtaining COVID-19 vaccinations

All the participants reported that they have received two doses of COVID-19 vaccines which suggests that this group of women were not necessarily vaccine hesitant.

***Table 9: Participants' two-doses of COVID-19 vaccine status***

| Received two doses of COVID-19 vaccine | Participants % |
|---|---|
| Yes | 100 |
| No | 0 |
| Prefer not to say | 0 |

Several participants reported that their main reason for getting COVID-19 vaccines was to protect themselves, their families, communities.

"*I want to protect myself since I have an existing health condition, as well as to protect my 2 children.*"

"*I believe it is my civic duty and responsibility to protect myself, my household, and my community. It is the right thing to do.*"

"*To protect me from severe sickness and protect the people surrounding me, especially my elderly family members and young children.*"

"*I also want to go back into normal ways of life where I can go and visit anyone without fear that I might be infected.*"

Nevertheless, several participants also reported external factors for obtaining a COVID-19 vaccination particularly a workplace policy, either for themselves or their spouse, which required them to get vaccinated.

"*To protect my family from COVID-19 and it is a requirement in my husband's work to get vaccinated.*"

"*Like everyone else I was scared, hesitant and uninformed at the beginning. But I am a childcare worker and during these times I was the main provider of my family.*"

"*I am required to be vaccinated because I work in the hospitality industry. The COVID-19 vaccine is mandatory for the staff.*"

"*I have to get the vaccine as it was mandatory for occupation. I work as a nurse which is a high risk environment.*"

"*I could not afford to get sick and missing on the family income, as my husband has casual work and we could not afford to miss out on work.*"

## b. Reasons for hesitancy to obtain a third dose of COVID-19 vaccines

Table 10 shows that the majority of participants (80 per cent) had received the third dose of COVID-19 vaccine. Only a small number (18 per cent) stated they had not received a third dose of COVID-19 vaccine due to concerns about severe effects of the vaccine boosters or due to being pregnant.

***Table 10: Participants' 3rd dose COVID-19 vaccine status***

| Received 3rd dose of COVID-19 vaccine | Participants % |
|---|---|
| Yes | 80 |
| No | 18 |
| Prefer not to say | 2 |
| Total | 100 |

Of those who had not received a third vaccine dose, the reasons for hesitancy were varied:

"*I'm still considering whether it is worthwhile to take the booster considering the nature of Omicron and side effects of the vaccine from my previous experience with the two shots.*"

"*I am scared and unsure about how much damage the booster (will do) and whether it could cause death. There is not enough clinical evidence to convince me. I had no choice to get two doses because my workplace required me*"

"*I am pregnant and worried to get booster*"

"*I want to find out more information about the effects of the vaccine to the general public. Since I haven't gotten COVID yet, there was no urgency*"

"*After getting the 2 primary doses of Covid-19 vaccine, I got infected with the virus. I don't want to get the booster because I don't think that the vaccine protects against the virus.*"

"*I feel it was risky (getting a booster). I have read an article that many people experienced a lump on armpits after 3rd dose. Now I am very scared."*

"*I saw few people experiencing severe side effects so during early pregnancy. I avoided it.*"

The reasons given overall, reflected an underlying lack of knowledge to assist them to make an informed decision on their health.

## 3.3 Access to health information about COVID-19 vaccines

Participants were asked how they accessed health information on COVID-19 vaccines. Table 11 shows that the majority accessed multiple resources to help them make a decision. The most popular option was electronic sources (i.e websites, social media, podcasts, radio broadcast), while health care service providers were the second most popular source, followed by community members, and a community health centre. A fraction of women also reported receiving information from their workplace, bilingual health education sessions, or family and peers.

*Table 11: Participants' sources of vaccination information*

| Main source of COVID-19 Vaccine Information | Participants % |
|---|---|
| Electronic sources of information (e.g., Website, online news, social media, podcasts, television, radio broadcast, etc | 67 |
| Health care service providers (e.g., GP Clinic, dentists, hospitals, pharmacists and allied services) | 17 |
| Community members | 12 |
| Community health care centre | 4 |

However, most participants found that finding health information on COVID-19 vaccines in their community language was not straightforward. Table 12 shows that 39 per cent described finding health information as 'neither easy nor difficult'; 22 per cent of participants reported it was 'difficult', and 3 per cent described it as 'very difficult'. The data reflects the success of Victoria's efforts to provide information in various languages and through a wide range of sources. However, those resources were not accessible to 25 per cent of migrant and refugee women in this sample.

*Table 12: Level of difficulty in accessing COVID-19 vaccine information*

| Level of difficulty accessing COVID-19 vaccine information | Participants % |
|---|---|
| Very easy | 14 |
| Easy | 22 |
| Neither easy nor difficult | 39 |
| Difficult | 22 |
| Very Difficult | 3 |
| Total | 100 |

Those women who found access to information either 'difficult' or 'very difficult' reported that they had to rely on community members, community platforms or family members to obtain health information on COVID-19 vaccines, mainly due to the inaccessibility and/or absence of information in their language from official sources. Some participants chose to get information from their GP who speaks their language while others relied on social media sources from their home country. Others found that they had to navigate through government pages in English to find information in their own language.

*"I only got the information I was given (by the community). I don't know how to go on the internet and search for resources in Hakha Chin. It's not hard to get, but it was limited."*

*"COVID-19 vaccination information provided on mainstream media is mostly in English. I relied heavily on Wechat – a Chinese instant messaging and social media platform. I prefer to use Mandarin to get the latest news on COVID-19. "*

*"No one has ever told me that information in my language is easily in reach. (So) I talk to my children and doctors to get information."*

*"Finding information about Covid19 vaccination was frustrating until I sought information from my Arabic speaking friendly GP. "*

*"No one has told me which website to access the required information. I was unsure how to navigate through the government websites to get the information on COVID-19."*

*"I received information in my language only from my husband, friends and family in India. There was no written information in my language that I could read and understand here."*

Participants found that that information available online was not always updated or was difficult to understand due to poorly worded translations. For those who are not digitally savvy, these problems were additional to the language barriers they face.

*"There are only limited government websites having the in-language information. On top of that, I find most of the information is lacking the details and not very updated."*

*"There is (information) but not easy to find information in our language."*

*"It is hard to find information in the language since most of the data is in English. (Also), it is a hard time to scroll on the website."*

*"I have a few friends who don't understand English. It was really hard for them to get the information (about COVID-19 vaccines). There was no information, nor any person hired by the government to give information about vaccination in the community language."*

*"We got the in-language information only after 1.5 years (of the pandemic). Not everyone in our community is well-read. It was impossible to get information in these languages (Pashto, Baluchi or Punjabi)."*

*"It was so much effort to get the most updated information, mainly when constantly changing."*

*"It is difficult because I am not computer literate, and I also have intermediate English proficiency. I don't know where to access that information since all information here is in English."*

*"The information is frequently changing, and it's not communicated to my community in my language on time. Also, that's a lack of explanation of "why", e.g. why the policies, the mandates, the recommendations, etc."*

*"The translation (of COVID-19 vaccines information) is a bit complex for me to understand and uses some terminology that I never heard of. It will be better if they use simple everyday language."*

## CASE STUDY
## Manjot*, 27 old woman on a temporary visa

Manjot, a 27-year-old woman from India, is currently on a temporary resident visa, planning to stay in Australia for five years with her partner and children. Although she had two doses of the COVID-19 vaccination, she was hesitant to get another booster dose.

*"I was infected with coronavirus despite having the two doses of the COVID-19 vaccination,"* she said.

Manjot believed that the booster does not protect against the virus and could not find relevant health information in her language.

Manjot relied on her husband and family in India to get information on COVID-19 vaccines.

"*There is no written information in my language that I could read and understand. There was also no in-language information on the Television (news),"* Manjot said.

Manjot acknowledged that the in-language peer health education sessions conducted by health educators have been helpful for her to gain trust and confidence. She wanted the government to put equitable investment into in-language peer-to-peer support for migrant and refugee women.

*not the participant's real name

## 3.4 Accessing health care services to obtain COVID-19 vaccines

While all participants had obtained some level of COVID-19 vaccination they had found it challenging to access COVID-19 vaccines. Health services and systems were difficult to navigate, and there was limited availability and access to service providers who spoke their language, health information in their language, and interpreter services. For those who don't have access to Medicare, women faced challenges in accessing COVID-19 vaccine at the vaccination centre.

"*I found it challenging in navigating and understanding the health care system as it is complex.*"

"*I found it very challenging because I cannot understand English. But unfortunately, we don't have GP who can speak our language.*"

"*At the vaccination appointment, I was given printed information pamphlets about the vaccine and its side-effect. However, because it was in English, I did not have sufficient time to read through it thoroughly and understand everything fully.*"

"*The most challenging is not enough explanation in the Arabic language. If we call for an interpreter, it is for a short time.*"

"*I found it somewhat challenging. For example, some vaccination centres only offer services to those with a Medicare card, which I don't have.*"

### CASE STUDY
### Chodren*, 47-year-old woman speaking Hakha Chin

Chodren, a 47-year-old woman originally from Burma, has lived in Australia with her husband and child for five years. Owing to fears of getting ill and thereby having no one to take care of her children, Chodren chose to get COVID-19 vaccines, including the booster. However, Chodren relied on social media, community and church leaders to get health information, including COVID-19 vaccines, due to a lack of health information in her preferred language, Hakha Chin. This became more problematic when she tried to access health care services because there were often no interpreters available to support her.

"*I am not confident with my English, so I often have to take one of my daughters with me. Not every clinic or health care service offers interpreting services. When I am being referred to a specialist or a new place, I always get very anxious*," she said.

* not the participant's real name.

In addition to the language barriers, one participant reported cultural barriers to accessing health care. Using her initiative, she found her local WHS provided a culturally safe and appropriate approach for COVID-19 vaccine administration.

"*For the women in our community, including myself getting appointments was very hard. If we did not have vaccinations organised in our place of worship, we could not get vaccinated. We needed women to vaccinate women (due to religious reasons). GenWest and Western health provided female nurses so we could be vaccinated.*"

Many participants reported that they had easy access to the COVID-19 vaccination due to friendly services available for them such as the vaccination hub and their GP who could speak their language.

"*The good thing about the vax hub, is they prioritized the vulnerable ones as they consider my husband's health condition.*"

"*It was positive because I have an Arabic speaking GP.*"

"*I went to see my GP and it is easier to get vaccinated from my GP.*"

"*At first, I found it difficult to make an appointment for vaccinations online as I am not very good with computers, and I do not understand English well. Then I went to see my GP and it is easier to get vaccinated from my GP.*"

"*I had access to my doctor who spoke my language and she booked me in and advised me so I didn't experience a hurdle or barrier. She was very helpful.*"

## 3.5 Obtaining COVID-19 vaccines for children

Participants with children voiced their concerns about the side effects of COVID-19 vaccines for children which made them reluctant to get their children vaccinated. Participants expressed distrust about the efficacy of COVID-19 vaccines and its effect on their children's physical health.

*"I am concerned about the side effects of vaccination (for children)."*

*"I am hesitant to get COVID-19 vaccines for children."*

*"I choose not to vaccinate my children because I believe it is my right and my personal choice."*

*"I am afraid that the vaccine may cause harmful side effects to my children. I choose to hesitate to vaccinate my children because I want to wait for more people to get vaccinated."*

*"My children have not been vaccinated. I was 8 months pregnant when I got vaccinated. My baby's weight was 2.2 kgs when I got the vaccination. In the past, I have had babies who weighed more than 3 kgs. In the ultrasound 3 days before vaccination, the baby's weight was 3.2 kg, and a normal heart rate. But in the last month baby did not gain any weight and the baby's birth weight was 3.2kgs. Therefore, I am not getting my children vaccinated. The vaccination data is only 2 years old. There is no data which convinces me."*

Meanwhile, participants who tried to access COVID-19 vaccines for their children reported challenges. This was due to systemic barriers, including the lack of clear information about the vaccination program and unavailable local health service staff that speak their language.

*"It was not easy accessing health care services to get Covid-19 vaccination due to my son's special needs. The language barrier made it harder for me."*

*"I cannot understand English and most the information was in English, it is challenging. We do not have GP can speak our language."*

*"The message is not that clear. I went to the clinic and waited long time then the doctor told me 12-16 years old children don't have booster shot."*

Two participants whose children have disabilities reported traumatic experiences in accessing COVID-19 vaccines for their children.

*"My experience with having my five-year-old son vaccinated at a state-run facility in January was a traumatic one as the nurse left the syringe hanging in his arm. My son has dual diagnosis of Down syndrome and autism."*

*"The waiting and lining up for such a long time were disruptive, my son has a disability and although he was on the priority list, I struggled to find local services online. When I eventually booked for him, I didn't get a confirmation message."*

## 3.6 Access to health care services during the pandemic

Participants were asked which health care services they accessed (for any reason) last year during the COVID-19 pandemic and were given multiple option questions to choose more than one option. Table 13 shows that almost all participants accessed a GP Clinic; more than half accessed a pharmacy; and 27 per cent accessed a dentist. 14 per cent accessed a local community health centre while another 30 per cent accessed an emergency department or nurse on call.

*Table 13: Participants' access to primary health care services*

| Accessing health care services | Participants % |
|---|---|
| GP Clinic | 98 |
| Pharmacy | 62 |
| Dentist clinic | 27 |
| Community health centre | 14 |
| Nurse on call | 9 |
| Emergency Department | 21 |
| Other | 16 |

Many participants experienced long waiting times to access primary health care services and were concerned about being exposed to the COVID-19 virus during those wait times.

*"The long waiting period to book an appointment with a GP if family members caught any flu-like symptom. Last year, I accessed the emergency unit for kids, and I waited there for 6 hours to get my kids examined. It's hard to cope in that situation."*

*"My two daughters had their teeth out through general anaesthesia, but the local hospital could not do it. We had to travel 2 hours each way and were scared to stay in accommodation because of the virus".*

*"One time, my son had a high temperature, and it gave us a fright. It seemed like such a big risk just to access a service that was meant to keep my family healthy".*

Meanwhile, participants reported language barriers when accessing primary health services. They not only struggled to understand complex health terminologies but also could not explain their symptoms and needs to the health care professionals. Often time, they also had to rely on a family member to aid them with interpretation.

*“Since English is not my first language, I still have struggled with understanding health care terminology. I still prefer to ask someone more knowledgeable in accessing the services”.*

*«I do not speak English, and it is hard for me to communicate with the health care providers. I am unable to communicate my sickness to the doctor. I feel like I am unable to navigate the health care system. It is just too hard.»*

*“When the GP is an English speaker, we need to go with our husband. As most women in my community are non-English speakers, we need an interpreter.”*

Nevertheless, several participants spoke positively about accessing primary health care services during the lockdown due to being registered with Medicare, good doctors, good nurses and access to interpreters. Some had mixed experiences as a result of the impact of various factors such as COVID-19 regulations and procedures, culturally appropriate services and medical protocols.

“*My experience was mixed. I was not very happy with the wait times at emergency, and GP could not schedule face to face appointments for the small things that could have been managed at General practices. I liked the telehealth appointments for non-urgent medical appointments”.*

*“They were very helpful and accommodating but hard to book and need to wait for two weeks”.*

*“It is a positive experience overall. They ask people to wear masks to keep everybody safe inside the Centre, and the staff follow all the COVID safe rules where possible”.*

## 3.7 Accessing preventative health services

Participants were asked whether they had accessed any preventive health care services in the last year during the pandemic and were given multiple option questions, which enabled them to choose more than one option. Table 14 shows that half of the participants said they had not accessed any preventative health care services during the last year. Nineteen per cent accessed cervical cancer and diabetes screening, 9 per cent accessed sexually transmitted infection screening 7 per cent accessed mammography, 2 per cent accessed and bone density.

*Table 14: Participants' access to preventative health care services*

| Accessing preventative health care services | Participants % |
|---|---|
| Cervical cancer screening | 19 |
| Mammography screening | 7 |
| Diabetes screening | 17 |
| Bone density screening | 2 |
| Sexually transmitted infection screening | 9 |
| Other | 12 |
| None of the above | 50 |

The reasons why participants did not access preventative health care services varied, but most participants reported that they did not feel safe and feared getting the COVID-19 virus. Lack of access to culturally appropriate services was also a factor in preventing women from accessing preventative care as many women reported the need for services where they felt understood. Some also noted the long waiting times, cost and visa issues (such as being on a temporary visa) meant they could not access nor afford to access preventative health care services.

*"I have not accessed any preventive health care services. I don't speak English and need a translator."*

*"The language barrier made me feel unconfident to access preventative health care services. Moreover, I was so busy with my work, and I was worried about getting infectious with Covid whenever I went out."*

*"I am trying to avoid going to the hospitals or clinics if possible, during the pandemic to reduce the risk of getting Covid-19."*

*"The waiting time is incredibly discouraging. I am very aware that preventative tests save lives, but from previous experience and the pandemic pressure on our health system, I know that my turn will not come anytime soon."*

Two participants reported being unaware of the preventative screening they could access free of charge.

*"Oh... really? I had no idea, and I don't think I've ever done any of them (preventative health screenings). I go to the GP when I am sick. Thank you for explaining that to me."*

*"I don't know about them. I think they would cost money."*

*Those who were able to access preventative health screenings reported a positive experience.*

*"My care plan nurse and my doctor are very accommodating. They did not look after only my physical health but also my mental health. They are great people I met."*

*"When needed, I was lucky that the doctor spoke Greek,"*

*"Mainly positive because the health care providers made me feel comfortable. All the results came back in a timely manner."*

## 3.8 Accessing mental health services

Table 15 shows that a quarter of the participants accessed mental health services during the pandemic. The majority of participants had not accessed any mental health services, which is of concern, particularly when responses indicate that there was an unmet need. Reasons that women cited for not accessing mental health services included individual barriers such as language, but most importantly the structural barriers such as lack of culturally appropriate resources to help access such services, and cultural hurdles and taboos around the concept of 'mental health'.

***Table 15: Participants who accessed mental health services***

| Participants who accessed mental health services | Participants % |
|---|---|
| Yes | 25 |
| No | 75 |
| Total | 100 |

Participants who did access mental health services reported mixed experiences. Their concerns were mainly about in-language and culturally appropriate services.

*"The social workers helping me through when I am feeling down were amazing. They always offer support, and it is free."*

"*My experience was mostly positive for assessing the psychotherapy. However, I felt it would be great if I could have a psychologist who could speak my language. It would have made this a little bit easier.*"

*"Sometimes there were no interpreters available, and I find it very frustrating because I had to come back for another day while I work, which also affects my work."*

*"I accessed psychotherapy as I was struggling to manage long-distance relationships. I felt my psychologist did not understand the cultural pressures and commitment of a relationship."*

Participants who did not access mental health services were not aware of the available free mental health services for them.

*"I experienced post-partum depression when my son was born since I didn't have the same support system. I didn't seek help because I did not know until this interview that there were free services for me. It felt like I would be a burden to speak about my challenges when I need to focus on my family, especially kids."*

*"I needed help and support desperately, but I never went due to covid. I do not have information about the services. I know GP can refer me, but I do not have more information. There are also many issues with accessing mental health services in my community, especially with the rise in family violence."*

*"I was not aware of the mental health plan available at the GP. However, I will access that plan if needed as I have anxiety issues."*

## 3.9 Barriers and confidence accessing health care services

Participants were asked about their barriers and confidence in accessing health care services in Victoria. Table 16 shows that the cost of health care was the most significant barrier to access for more than half of the participants (65 per cent). This was followed by a lack of transport to access health care services (61 per cent) and language barriers (59 per cent). Nearly half of the women (45 per cent) reported that they did not know where to go to access appropriate healthcare services. Distrust in the healthcare system was also highlighted as a barrier (18 per cent). In addition, a fraction of women also reported other barriers, including increased waiting times and lack of cultural sensitivity when accessing health care services as well as difficulty in obtaining leave from work for health purposes.

*Table 16: Participants' barriers to access health care services*

| Barriers in access to healthcare services | Participants % |
|---|---|
| Cost | 65 |
| Transport to go to services | 61 |
| Language | 59 |
| Unaware where to go | 45 |
| Distrust in the healthcare system | 18 |

Table 17 shows that one-third of women participants were confident in accessing the Victorian healthcare system; almost half reported being somewhat confident; a quarter stated they were not confident.

*Table 17: Participants' confidence to access Victorian healthcare services*

| Confidence in access to Victoria's healthcare services | Participants % |
|---|---|
| Extremely confident | 11 |
| Very Confident | 19 |
| Somewhat Confident | 46 |
| Not so Confident | 23 |
| Not at all Confident | 2 |

## CASE STUDY
## Yasmin* from Somalia

Yasmin, who is in her early thirties, has been living in Australia for more than five years. She is separated from her husband and lives with her children. Despite having access to Medicare, she was hesitant to get the COVID-19 booster vaccine.

"*I am afraid of the side effects of the COVID-19 vaccine booster*," she explained. Although she obtained information about vaccination from various online sources, she preferred to receive information in-person. In addition, Yasmin struggled to get COVID-19 vaccine information in her first language, Somali. She believed that there was a poor response from the Victorian government in communicating vaccine information in her language to her community.

Yasmin found the lack of in-language support caused her to be misunderstood when accessing health care services. "*I don't understand the system (health care), and most doctors don't understand me*," she said. Yasmin suggested the government provide an inclusive healthcare setting with interpreter services to overcome the language barrier that migrant and refugee women often face.

* not the participant's real name.

## 3.10 Participants' collective voices: Improve equitable access to health care services

Participants were asked what would make access to health services easier for them. Table 18 shows that their responses with 'ensuring interpreters are available in all health care services settings' and 'providing health information in languages other than English' the two most important priorities, followed by 'empowering the workforce of community multilingual health educators with training opportunities'. Participants reflected on the benefits they received from in-language health education sessions.

*Table 18: Participants' views to improve equitable access to healthcare services*

| How to improve equitable access to healthcare services | Participants |
|---|---|
| Ensure interpreters are available in all health care settings | 94% |
| Ensure health information is available in multiple languages other than English | 94% |
| Put equitable investment towards in-language community health education | 80% |
| Empower the workforce of community multilingual health educators with training opportunities | 89% |
| Other | 24% |

In addition to the four priorities in Table 18, participants expressed other ideas including:

- health education program provides long-term solution for their needs;
- accessibility of in-language health information can be improved by creating diverse channels of information dissemination;
- ensuring health care professionals can communicate clearly to them;
- women's health services and programs at no cost, and culturally safe mental health programs.

"*Extend multilingual health educator program since long-term solutions can only sustain long term outcomes.*"

"*Create better channels to deliver in-language health information. For example, choose or create channels where the community members can easily find in-language information, such as telephone numbers for family violence support.*"

"*That all migrants, including with temporary resident visa, can access Medicare.*"

"*Make more services for women free (first 12 weeks of pregnancy check-ups) - Hospital for women only (or female-focused with health professionals being women also, especially in regional areas like Creswick, so they don't have to travel to Ballarat, Scarsdale*)."

*"Please put more funding towards women's health and mental health! The waiting time and the high cost is holding my family and me back."*

*"More clear information flow from GP or any health service providers should talk in an easy language making sure everybody understands the procedure/outcomes. "*

## CASE STUDY
## Supporting Karen women in the Loddon Mallee area

WOMHEn project partner, Women's Health Loddon Mallee identified Karen as the largest multicultural community in the Loddon Mallee area and one that faces barriers accessing COVID-19 vaccines and health information.

WHLM initiated a series of health education sessions delivered in the Karen language for women in the Karen community as it was found that face -to -face health education was the best wayto meet the needs of Karen women, many of whom did not have access to computers.

There was a challenge in recruiting Karen women to participate in the health education session. Flyers and posters were ineffective in promoting the sessions, which prompted the health educator to personally call the targeted women to inform them about the sessions. . To further encourage participation, lunch and a free rapid antigen test kit were offered to participants and gift cards were provided as a reimbursement.

Having a multilingual health educator made women feel more comfortable and confident to raise questions during health education sessions. In addition, the health educator addressed false information about COVID-19 vaccines and their side effects. Misinformation had been circulated among women from unreliable social media sources or friends and family. The delivery of the health education session went smoothly, and participants had up- to-date knowledge about Covid vaccination, rules, and restrictions.

Women in the group were also supported to access COVID-19 vaccines. In partnership with Bendigo Community Health, WHLM has supported the vaccine clinic program for the Karen community since June 2021. The accessible location and friendly staff speaking the Karen language became determining factors for Karen community members to access COVID-19 vaccines.

# Evaluation of in-language health education sessions

# 4

Evaluations of the health education sessions were collected and collated by the multilingual health educators. The evaluations revealed four key themes discussed below.

## 4.1 Women's first in-language health education session

For many migrant and refugee women, the WOMHEn project provided their first opportunity to participate in a health education session, and to engage with a health topic, in their preferred language. They also commented about the way the in-language nature of the session helped them more deeply understand the topic and engage with the material.

"*It is the first time we heard about Covid-19 information in Vietnamese. The session is very helpful. Now I can understand deeply and clearly the necessity to take the Covid vaccine.*"

"*I attended my first health education in language through this WOMHEn Project, and it was very helpful and easy to understand. I could solve all my queries first hand.*"

*"My first time to attend health education is about COVID-19 vaccine from WHE this year. And I am very satisfied with the way how educators explain to us. It was very clear."*

*"I have been here in Australia for almost 30 years, I've never experienced any health education session in language, and it is really amazing and very informative."*

## 4.2 Women value in-language health education

Participants reported that they found the health education sessions provided the COVID-19 vaccine health information they needed. Several women reflected on how the health education sessions have been helpful in accessing accurate, reliable and culturally appropriate health information. In addition, they stated that the health education sessions boosted their knowledge, answered their questions and provided a safe space for them to raise concerns.

*"I don't know whom to ask for help. Luckily, we have multilingual health educators in our community. They can assist me."*

*"Members of the Filipino community don't seem to respond to resources online. (Instead), they tend to listen to peers and friends. Peer education works, and the multicultural health education program has been vital in reaching those with vaccine hesitancy - slowly but surely."*

*"There was initially mixed messaging (about COVID-19 vaccines). However, the multilingual health educators and resources provided more accessible information and helped build trust within the community."*

*"Since we have multilingual health educators in our community, it is easy for me to ask for help if there are questions and information that I don't understand. Likewise, it is easy to ask for translation in Tagalog."*

*"I am happy that there are multilingual health educators in my community who conducted health education sessions in Tagalog. They helped me a lot."*

## 4.3 Knowledge gained for confidence and decision-making

Participation in in-language health education sessions provided migrant and refugee women with the knowledge they needed to make informed health decisions about COVID-19 vaccinations, increased women's knowledge about health issues, and how to access health care services. Some women reflected that they became more confident to uptake a third dose of COVID-19 vaccine for themselves as well as their children.

*"Most of the information shared in my preferred language was about Covid-19, and I have received more knowledge and built up confidence in taking the vaccinations, but to vaccinate my kids, I am still thinking about."*

*"My knowledge of health issues has increased. I learnt how to take good care of my health. I learnt how to access health care services and I got more confident."*

*"Learning about COVID-19 vaccines for children in my language made me confident to vaccinate my kids."*

*"It was a very helpful and informative session that improved my knowledge of health issues, and it was provided in my language, which was very convenient for me. I want the government to keep supporting the community in this way."*

*"I attended only one session in my language and in that session all my queries were solved first hand and immediately, so we felt less anxious and more supported."*

*"Now I learn that COVID vaccines do not have live versions of the virus, so I am confident to get booster jab."*

*"My kid told me he really wanted COVID vaccine as most of his friends at school did, but I was worried about it. Now I got more confident after participating the session."*

*"During Covid Women's Health West (GenWest) did sessions in Urdu and that is the only time we ever got an in-language session. Women tend to say that we do not need any information as our husbands will tell us. But when the women from Women's Health West asked us, we realised that we don't know anything. Only during a session did I find out about that it is possible to get a mammogram for women under 40 and how to access it."*

## 4.4 Connecting with women, openness and non-judgemental communication

Migrant and refugee women reported that the fact that the health education sessions were in their preferred language facilitated open and non-judgemental communication and provided them opportunities to connect with other migrant and refugee women.

*"It has a great impact, especially for those in need, as you can speak to them in-person and in language. It is a great help to our community."*

*"It is very helpful and easy to understand. I am not ashamed to ask questions knowing if I am not grammatically correct."*

*"Yes, the Multilingual health educators help me understand the topic because it is explained in my language. I never hesitate to express my questions and share my experience with other Filipino women since I know that they will not judge me for my grammar."*

"*I am a stay-at-home mum, so I like to attend these sessions to meet people and to get out of the house once in a while. I do find them very helpful and I knew absolutely nothing. I didn't go to school to learn of these things so for me my experience has been only positive*."

*"The health education can not only provide health-related information but also enable the participants to meet other people from the same community and learn that they are not alone."*

## CASE STUDY
## Addressing digital literacy and a language barrier in Burmese Community – Western Melbourne

WOMHEn project partner GenWest collaborated with Djerriwarrh Community and Education Services to deliver education sessions on COVID-19 for women in the Burmese community. The partnership identified that the women in the community experienced several barriers to accessing health information, particularly on COVID-19 and COVID-19 vaccines. They were isolated during lockdowns, had limited digital literacy and had limited English fluency. Hence, the partnership decided to conduct a health education session delivered in Burmese in a face -to -face setting to meet the needs of women in this community.

During the session, the health educators found that despite all women who participated in the session having received COVID-19 vaccines, they had minimal information about the efficacy of vaccinations. Many of them shared that they received the COVID-19 vaccines out of fear of not being able to work or access services. The women said that they were hesitant to get COVID-19 vaccine boosters. One of the women said that the language and digital literacy barrier made her reluctant to book a COVID-19 vaccine booster appointment.

"*As I do not understand English, it was too much of a hassle taking the first and second doses of Covid-19 while booking the appointment and during vaccination. So, the two doses are enough for me. So, I don't want to take any more*," she said.

In addition, women reported that they had signed consent forms for their children to get vaccinated without genuinely understanding the content as it was in English. They also had minimal understanding of PCR and RAT tests as the instructions were in English. "*I do not know what a PCR test is and have never gone for one*", one woman said. Overall, women in the community struggled to find General Practice services who speak their language. On top of that, they had limited knowledge of Medicare benefits and concessions that might be applicable to them.

Through a health education session delivered in their preferred language, the women were able to freely ask questions, raise concerns and share their hesitancy without fear as they connected with peers with cultural and language similarities. The initiative created a safe space resulting in women in the community being more informed about their health choices. In addition, conducting the session in person allowed women in the community to access information without digital barriers.

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# 5 Conclusion

Migrant and refugee women in Victoria experience significant barriers to accessible health services, information and knowledge, which has been exacerbated during the COVID-19 pandemic.  Key barriers include language, cost, accessibility, and concerns about the cultural safety of services.

The WOMHEn project has built capacity in three main ways. First, through accredited training and ongoing support, the multilingual health educators have become equipped with the knowledge and skills required to effectively engage with their communities around women's health and to provide accurate health education to women about COVID-19 and vaccines. Second, the project has built the capacity of the migrant and refugee women who participated in health education sessions and the interviews to make informed decisions about their own health and the health of their children. Third, the project has built the capacity of regional Women's Health Services to respond to the needs of migrant and refugee women in their regions by providing in-language health education.

Through the project, our understanding of the needs of migrant and refugee women has grown, particularly in relation to COVID-19 and vaccinations, and migrant and refugee women's need for reliable, up to date, accurate knowledge and information in their language has been accentuated. Women have responded very positively to the safe spaces created by the health educators and it was more than likely the education sessions had a knock-on effect, with participants passing on the health information to their families and friends.

The WOMHEn project has demonstrated the value of relatively modest investments in facilitating equitable partnerships and collaborations between Women's Health Services and multicultural and ethno-specific groups. Once those relationships are established, they grow and develop, as do migrant and refugee women when they have access to the knowledge, they need about health care services to manage their own health and the health of their families. And over time, they are less 'left behind', and the barriers that women know stand between them and good access to available health care, will be overcome.

**To that end, the following recommendations are made:**

1. Continue to support the multilingual women-led workforce that delivers in-language health education as part of the WOMHEn project across Victoria.

2. Provide continuing funding and support for peer-based, community-led, multilingual women's health education and support programs across Victoria and connect them to health care services.

3. Ensure interpreting services are available across all health care settings, and that they are equipped with skills to deliver inclusive and culturally appropriate services.

4. Train health professionals across all health care settings in gendered, cross-cultural awareness to improve migrant women's access to health care services.

5. Provide health information in multiple languages on a wider range of health issues, particularly gendered ill-health issues such as mental health, sexual reproductive health, and physical health including consultation with relevant community members to ensure appropriateness and accuracy.

6. Support innovative, tailored education and advocacy for mental health interventions by migrant women's organisations and delivered by trained bilingual workers.

# 6 Appendix

# Appendix 1 - Interview questions

WOMHEn Project - Migrant and Refugee Women experience in navigating COVID-19 vaccination and health care system

## Instructions

*The interview should be conducted in the women's preferred language to allow deeper exploration of migrant and refugee women experiences. The Health Educator (Interviewer) is advised to identify a migrant and refugee woman who has lived experience of inequality in accessing health care services. The interviewer should then report the result of the interview to Gender Equity Victoria via survey monkey link and QR Code below*

*Link : https://www.surveymonkey.com/r/L3VY62L*

*Should you have questions, please contact Nurul Mahmudah at nmahmudah@genvic.org.au*

# Interview Questions

## A. Participant's Demographic Data

1. What is the participant's name?:

2. How old is the participant?:

3. What is the participant's country of birth?:

4. What is participant's gender identity?: ☐ Female ☐ Non-binary ☐ Prefer not to say

5. What is participant's ethnic/cultural identity?:

6. What is the participant's preferred language :

7. Does the participant have a disability(s)?: ☐ Yes ☐ No

8. What is the participant's citizenship / Residency status:
   - ☐ Australian Citizen
   - ☐ Permanent Resident
   - ☐ Humanitarian Visa Holder
   - ☐ Temporary resident
   - ☐ Bridging visa holder
   - ☐ Other visa (please specify)
   - ☐ Prefer not to say

9. How long has the participant stayed in Australia?
   - ☐ Less than 1 year
   - ☐ 1-5 years
   - ☐ 5-10 years
   - ☐ More than 10 years
   - ☐ Prefer not to say

10. Does the participant have access to Medicare or private health insurance?
    - ☐ The participant has access to Medicare
    - ☐ The participant has a private health insurance
    - ☐ The participant has access to both Medicare and private health insurance
    - ☐ The participant has neither access to Medicare nor private health insurance
    - ☐ Prefer not to say
    - ☐ Not sure

11. What is the participant's relationship status?
    - ☐ Single
    - ☐ Married
    - ☐ In de facto or domestic partnership
    - ☐ Widowed
    - ☐ Separated
    - ☐ Divorced
    - ☐ Other
    - ☐ Prefer not to say

12. Does the participant have children?: ☐ No ☐ Yes

13. What is the participant's completed level of education?
    - ☐ Primary Secondary
    - ☐ Vocational
    - ☐ Bachelor degree
    - ☐ Master Degree
    - ☐ Other
    - ☐ Prefer not to say

## B. COVID-19 Vaccination – Confidence and barriers in navigating health care system

**Instructions**

*This section contains questions exploring migrant and refugee women's confidence and barriers to navigating the health care system, in particular when accessing COVID-19 vaccination, boosters and COVID-19 vaccination for children.*

14. Have you received two doses of COVID-19 vaccine?
    ☐ Yes ☐ No ☐ Prefer not to say

15. Have you received a COVID-19 vaccine booster(s)?
    ☐ Yes ☐ No ☐ Prefer not to say
    (*Proceed to question No 17 if the participant is comfortable to share the reason why they have received or not received COVID-19 vaccination/boosters. If the participant does not want to disclose that, please proceed to question 18)*

16. Could you please tell us why have you received or have not received the COVID-19 vaccine/boosters?

_____

_____

17. How did you obtain health information about the COVID-19 pandemic and COVID-19 vaccination (*including a booster and COVID-19 vaccination for children*)?
    - ☐ From electronic sources of information (e.g Website, online news, social media, podcasts, television, radio broadcast, etc)
    - ☐ From health care service providers (e.g GP Clinic, dentists, hospitals, pharmacists and allied services)
    - ☐ From community health centre
    - ☐ From community members
    - ☐ Bilingual health education session
    - ☐ Other (Please specify)

18. How easy it was for you to get information about the COVID-19 vaccination in your language?
    - ☐ Very easy
    - ☐ Easy
    - ☐ Neither easy nor difficult
    - ☐ Difficult
    - ☐ Very difficult

19. Could you tell us more about why it was easy or difficult?

_____

_____

_____

20. How well do you think the Victorian Govt has communicated the information on the COVID-19 vaccination in your language and community?
    - ☐ Very Good
    - ☐ Good  Neutral
    - ☐ Poor
    - ☐ Very Poor

21. Could you tell us more about why it was good or poor?

_____

_____

22. Could you tell us your experience in accessing health care services to get the COVID-19 vaccination, or COVID-19 vaccination booster? (Prompt: *Did you find it challenging, did you experience hurdles or barriers? How did you overcome that?*)

_____

_____

23. If you have children, could you tell us your experience in accessing health care services to get COVID-19 vaccination? (Prompt: *Did you find it challenging, did you experience hurdles or barriers? How did you overcome that?*)

_____

_____

## C. Confidence and barriers in navigating health care services

**Instructions**

*This section contains questions exploring migrant and refugee women's experiences in navigating health care services for the provision of primary health, preventative health, sexual and reproductive health and mental.*

24. Which primary health care services do you access in the last year? (*Please tick all that apply*)
    - ☐ GP Clinic
    - ☐ Pharmacist
    - ☐ Dentist
    - ☐ Local Community health Centre
    - ☐ Nurse-on-call
    - ☐ Emergency unit
    - ☐ Other (Please specify)

25. How was your experience in accessing primary health care services? (*Prompt: Positive/negative? Did you have barriers or hurdles? Could you access interpreting service?)*

_____

_____

26. Have you accessed any preventative health care services during pandemic COVID-19?
    - ☐ Cervical cancer screening
    - ☐ Mammography screening
    - ☐ Diabetes screening
    - ☐ Bone density screening
    - ☐ Sexually transmitted disease screening
    - ☐ Other – Please specify
    - ☐ None of the above (Please continue to question no. 27)

27. What was the reason you did not access preventative health care services?

28. How was your experience in accessing preventative health care? (*Prompt: Positive/ negative? Did you have barriers or hurdles, did you find it easy and culturally appropriate to you?*

29. Have you needed to access mental health care services (Such as psychotherapy, counselling, mental health helplines, etc?
    - ☐ Yes – If yes continue to the next questions
    - ☐ No – If no continue to question 31

30. How was your experience in accessing mental health care services? (*Prompt: Positive/negative? Were you provided with appropriate service to your need? Could you access it for free?*)

31. What are the main barriers for you in accessing health care services in Victoria? (*Tick all that apply*)
    - ☐ Language
    - ☐ Transport to get to the services
    - ☐ Cost
    - ☐ Unaware where to go
    - ☐ Distrust of the health care system
    - ☐ Other – please specify

32. Tell us more about your experience on those barriers in accessing health care services in Victoria?

33. How confident are you in accessing health care services in Victoria?
    - ☐ Extremely confident
    - ☐ Very Confident
    - ☐ Somewhat Confident
    - ☐ Not so confident
    - ☐ Not confident at all

34. What is the reason you are **confident or not confident** in accessing health care services in Victoria?

_____

_____

35. Have you ever attended any community health education conducted in your preferred language? (*Prompts: Positive/ negative? Did you have increased knowledge of the health issues? Did you get more confident?)*

_____

_____

36. How could the Victorian Government improve the accessibility of healthcare services for migrant and refugee women? (Tick all that apply)
    - ☐ Ensure interpreters are available in all health care service settings.
    - ☐ Ensure health information are available in multiple languages other than English.
    - ☐ Put equitable investment towards in-language community health education.
    - ☐ Empower the workforce of community multilingual health educators with training opportunities.
    - ☐ Other (Please specify)

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# Appendix 2 – Health Education Evaluation Form

*Note: This evaluation form is focused on evaluating the effectiveness of in-language health education sessions about COVID-19 vaccines/COVID-19 booster shots. It is important to complete the form accurately as the data will be used for formulating progress reports. Please note the data will be de-identified and not linked to any participant's name.*

## Suggested steps for filling out this form:

1. Pre-health education session: fill in 'General Information', 'Mandatory Data Collection' and 'Demographic Data'.
2. Directly after the session: record 'Women's Issues and Experiences' and 'Impact of Health Education Session' or have a colleague take notes here while you deliver the health education session.
3. After the session: undertake your 'Post Session Reflection'.
4. 2-4 weeks after the session: fill out 'Follow up on Vaccine Uptake'.

| General Information | |
|---|---|
| Health Educator Name | |
| Organisation | |
| Name of the group | |
| Contact person | |
| Contact email and phone | |
| Local Government Area (LGA) | |
| Session date and time | |
| Session language | |
| Cultural/ethnic group | |
| Topics/modules covered | |
| No. of participants | |

## Mandatory Data Collection

1. How many participants have had their COVID-19 vaccine/COVID-19 vaccine booster? (*Insert number*) .....

2. How many participants are NOT confident to get a COVID-19 vaccine/COVID-19 vaccine booster? (*Insert number*) .....

## Demographic Data

1. How many women in the health education session are
   (note the number for each category).
   Under 20 years old ..... 21-30 years old ..... 31-40 years old ..... 41-50 years old .....
   51-60 years old ..... 61+ years old .....

2. How many years have the women been in Australia?
   *(note the number of women for each category).*
   1 year or less ..... 1-5 years ..... 6-10 years ..... 15-20 years ..... More than 20 years .....

3. What is the cultural/ethnic background of the women, what language(s) do they speak?

| Information about the women | | |
|---|---|---|
| Cultural/ethnic background | Language(s) | Number of women |
| *Chinese* | *Simplified Chinese* | |
| Vietnamese | Vietnamese | |
| | Karen | |
| | Arabic | |

## Women's Issues and Experiences

It is important for us to know about new issues for migrant and refugee women in Australia so we can develop new programs and sessions. To assist, please listen carefully to the issues women raise in the sessions and document what they have discussed as accurately as you can.

| Women's issues and experiences | |
|---|---|
| Topics/Modules (please specify). | Specific issues or experiences discussed about this topic. |
| *E.g. COVID-19 vaccines and booster shots* | *E.g. The women were very interactive and asked a lot of questions, they were worried about their fertility with regards to COVID-19 vaccinations, they wanted to know more about boosters and vaccines for their children.* |
| | |
| | |

## Impact of the Health Education Session

1. How many of the participants reported that their knowledge about COVID-19 vaccines/ COVID-19 vaccine boosters improved after attending this session? (*Insert number*) .....

2. Why are participants more confident to get a COVID-19 vaccine/COVID-19 vaccine booster or have their children/family vaccinated? (*Select all that apply*)
   - ☐ Participants became aware of the health benefits associated with getting a COVID-19 vaccine/COVID-19 vaccine booster.
   - ☐ Participants became aware of the health benefits associated with getting a COVID-19 vaccine/COVID-19 vaccine booster for themselves or their family/children.
   - ☐ Participants received in-language health information which made understanding information relating to the COVID-19 vaccine/COVID-19 vaccine booster easier to understand.
   - ☐ Participants became aware of where to access information about COVID-19 vaccines/ COVID-19 vaccine boosters.
   - ☐ Participants became aware of where to get a COVID-19 vaccine/COVID-19 vaccine booster.
   - ☐ Participants became aware of the importance of showing evidence of COVID-19 vaccination via the government issued certificates.
   - ☐ Other – Please *describe*

3. Did participants prefer receiving the session in-language? ☐ Yes ☐ No

*Describe why or why not:*

| |
|---|
| |

Please write down some quotes and/or stories from the women with regards to their confidence and the effectiveness of the session (please see the example below):

| |
|---|
| *E.g.: Confidence and effectiveness* Did the women's confidence to take action with regards to their health increase post session? If so, how? What might they do/change post session? What did the women say they had learnt? How did having an in-language health education session have an impact on their understanding of the issue? |
| *E.g. Quote 1: "I learnt about COVID-19 vaccine boosters in my language and I will take up an appointment soon as I am planning to travel to China by year end"*<br>*E.g. Quote 2: "I learnt about COVID-19 vaccines for my children and the importance of getting my daughter vaccinated knowing that she is weak makes her prone to catch infection and getting vaccinated will protect her"*<br><br>*E.g. Story 1: One woman talked about not knowing much about the booster shots and did not know how to access information in her language on the topic. Now she is more confident to take action and get a COVID-19 booster after receiving an in-language health education session.*<br>*E.g Story 2: Participants felt more confident to take booster shot and get their children vaccinated after the session and felt more confident to do RAT Tests more correctly to get accurate results after the session.* |
| *Confidence and effectiveness* Did the women's confidence to take action with regards to their health increase post session? If so, how? What might they do/change post session? What did the women say they had learnt? How did having an in-language health education session have an impact on their understanding of the issue? |
| Quotes and/or stories: |

## Follow up on vaccine uptake

This section is to be filled in two to four weeks after the health education session. Please attempt this section if you recorded that there were participants who attended the session who had not received a COVID-19 vaccine/COVID-19 booster.

1. How many participant(s) got a COVID-19 vaccination/COVID-19 booster shot after a health education session?

2. Did the health education session influence the participant's decision to get a COVID-19 vaccination/COVID-19 booster shot? (Insert number of participants next to each category, e.g.
   - ☐ Yes, a lot
   - ☐ Yes
   - ☐ Somewhat
   - ☐ No
   - ☐ Not at all

3. Did the health education session influence the participant's decision have their child/children vaccinated? (Insert number of participants next to each category)
   - ☐ Yes, a lot
   - ☐ Yes
   - ☐ Somewhat
   - ☐ No
   - ☐ Not at all

4. If possible, can you note the main ways the health education session helped to establish more confidence in the participants with regards to getting a COVID-19 vaccination, booster shot and/or a COVIDI-19 vaccination for their children.

## Post Session Reflection:

| How did the session go? | |
|---|---|
| | Please tick all that apply: |
| There was a lot of positive interaction between the women. | |
| Women asked me a lot of questions. | |
| There was not much interaction between the women – they were mostly quiet and listening. Please explain in the comments box below. | |
| Some women were disengaged. Please explain in comments box below. | |
| One or two of the women took up a lot of time in the session. Please explain in comments box below. | |
| | |

| How did you go? | |
|---|---|
| | Comments: |
| Did you have any difficulties completing this evaluation? (Please circle) Yes / No<br><br>If yes, what difficulties did you have? | |
| Did you have any difficulties making the presentation? (Please circle) Yes / No<br><br>If yes, what difficulties did you have? | |
| Can you think of any way the session could be improved to make it better for the women in this group? | |


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