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Family and Community Development Committee

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Family and Community Development Committee
Inquiry into Perinatal Services
via eSubmission

12 October 2017

## Submission to the Family and Community Development Committee – Inquiry into Perinatal Services

Dear Sir/Madam

Thank you for the opportunity to make this submission.

### About Multicultural Centre for Women's Health

This submission has been developed by the Multicultural Centre for Women's Health (MCWH), the national voice for immigrant and refugee[1] women's health and wellbeing.

MCWH is a Victorian women's health service established in 1978 that works both nationally and across Victoria to promote the health and wellbeing of immigrant and refugee women through advocacy, social action, multilingual education, research and capacity building. MCWH is partially funded through the Victorian Department of Health and Human Services as a part of the Victorian Women's Health Program.

MCWH works across Victoria to provide research, expert advice, and professional development to key stakeholders on improving the health and wellbeing of immigrant and refugee women. It does this through research and publication, participation in advisory groups and committees, written submissions, training and seminar programs, and presentations of our work.

MCWH also works directly with women in the community providing capacity building and multilingual education on women's health and wellbeing, across a wide range of issues and topics, through the use of trained, community-based, bilingual health educators (see MCWH Annual Report 2016).

[1] The term 'immigrant and refugee' refers to people who have migrated from overseas, and their children. It includes people who are a part of both newly emerging and longer established communities, and who arrive in Australia on either temporary or permanent visas.

Given MCWH's role as a national, community based organisation committed to the achievement of health and wellbeing for and by immigrant and refugee women, this submission focusses on the health, care and wellbeing of mothers and babies in Victoria from immigrant and refugee backgrounds.

In 2013, 31.6% of mothers who gave birth in Australia were overseas born women (women born in Africa, the Middle East and Asia together accounted for 19.6% of all mothers). However, most of the perinatal health research and data, particularly in relation to perinatal depression, focuses on the mainstream population. The perinatal support needs of immigrant and refugee women and their preferred support interventions have received little attention.

Specifically, this submission highlights the following research findings (see attached MCWH Sexual and Reproductive Health Data Report 2016) in response to the terms of reference:

## (1) the availability, quality and safety of health services delivering services to women and their babies during the perinatal period

Maternal country of birth can be an important risk factor for perinatal outcomes. Available research shows that immigrant and refugee women are at a greater risk of suffering poorer maternal and child health outcomes.

The recent cases of Victorian women Akon Goude, Sofina Nikat and Umal Abdurahman have also highlighted the critical need for equitable support of immigrant refugee women during the perinatal period.

## (2) the impact that the loss of Commonwealth funding (in particular, the National Perinatal Depression Initiative) will have on Victorian hospitals and medical facilities as well as on the health and wellbeing of Victorian families

Reduced funding would impact negatively on immigrant and refugee women.

A comparative study of the post-childbirth experiences of Australian born and immigrant mothers from non-English speaking backgrounds found that compared with Australian born women, immigrant mothers less proficient in English had a higher prevalence of depression (28.8% vs 15%) and were more likely to report wanting more practical (65.2% vs 55.4%) and emotional (65.2% vs 44.1%) support. They were also more likely to have no 'time out' from baby care (47% vs 28%) and to report feeling lonely and isolated (39% vs 17%). The Mothers in a New Country study of Vietnamese, Turkish and Filipino women's experiences of maternity care and physical and psychological health found the issues most commonly identified by women as contributing to depression were:

- isolation (including homesickness)
- lack of support and marital issues
- physical ill-health and exhaustion
- family-related issues and
- baby-related issues.

Significant associations with depression were seen on at least two of the above measures for mothers who: were under 25 years; had a shorter residence in Australia; spoke little or no English; migrated for marriage; had no relatives in Melbourne. Similar themes and issues were also identified among immigrant Afghan mothers in a further study of immigrant Afghan women's emotional well-being after birth. This study also found that some women were reluctant to discuss their emotional

difficulties with health professionals and did not expect that health professionals could necessarily provide assistance.

### (3) the adequacy of the number, location, distribution, quality and safety of health services capable of dealing with high risk and premature births in Victoria; and (4) the quality, safety and effectiveness of current methods to reduce the incidence of maternal and infant mortality and premature births

The Australian perinatal mortality rate in 2013 was ten per 1000 births. In Victoria, the perinatal mortality rate in 2013 (9.9 per 1000 births) was lower than the rate for 2009 (10.7 per 1,000 births). Despite this, perinatal mortality rates remain high for specific migrant groups including babies of women born in North Africa, the Middle East or southern and central Asia (the risk of perinatal death is one and half times higher) (CCOPMM 2016). Australian state-based studies have also shown that:

- Compared with other refugee groups, women from West African humanitarian source countries were found to have the highest stillbirth incidence (4.4% compared to 1.2% and 1.6% from other regions) (Gibson-Helm et al 2014).
- South Asian born women were more than twice as likely to have a late pregnancy antepartum (i.e. not long before birth) stillbirth than either Australian-born or South-East Asian born women (Drysdale et al 2012).
- Lebanese born women had the highest rates of stillbirth (7.2 per 1000 births) compared with low risk women born in Australia and other women born overseas (Dahlen et al 2013).
- According to a Victorian population based study women born in East African countries experienced increased perinatal deaths and other adverse perinatal outcomes compared with Australian-born women. Women from Eritrea and Sudan are particularly at increased risk of adverse outcomes (Belihu et al 2016).

Several studies also suggest that immigrant and refugee women may be at greater risk of adverse perinatal outcomes:

- Compared to African migrant women without a refugee background, African women of refugee background appear to be at greater risk of specific adverse pregnancy outcomes (Gibson-Helm et al 2014).
- Compared to low risk women born in Australia and women from New Zealand, England, China, Vietnam, Lebanon and Philippines (the most common migrant groups at the time of the study), Indian women were found to have the lowest normal birth rate and high rates of low birth weight babies (Dahlen et al 2013).

Antenatal care is associated with better maternal health, fewer interventions in late pregnancy and positive child health outcomes. The World Health Organization recommends receiving antenatal care at least four times during pregnancy and the Australian Antenatal Guidelines recommend that the first antenatal visit occur within the first ten weeks of pregnancy.

Women born overseas who gave birth in Australia in 2013 were found to have attended their first antenatal visit at later gestational ages than Australian born mothers. This finding suggests that immigrant women need to be linked to appropriate health supports and have access to perinatal education

### (5) access to and provision of an appropriately qualified workforce

A systematic and comparative review of studies in five countries (including Australia) of immigrant and non-immigrant's women's experiences of maternity care has shown that all women – both

immigrant and non-immigrant – want maternity care that is safe, high-quality, attentive and individualised, with adequate information and support (Small et al 2014). However, the same study has also shown that:

- immigrant women were less positive about their care than non-immigrant women.
- communication problems and lack of familiarity with care systems impacted negatively on immigrant women's experiences.
- immigrant women reported problems with discrimination or prejudice. (Yelland et al 2015)

Other Australian studies (Hennegan et al 2015; Yelland et al 2015; Lansakara et al 2010; Bandyopahyay et al 2010) have also shown that compared with Australian-born mothers, immigrant mothers were:

- less likely to rate overall postnatal physical health positively
- more likely to report relationship problems and to report lower emotional satisfaction with their relationship with the partner
- less likely to be asked about relationship problems by maternal and child health nurses
- less likely to be asked about feeling low or depressed by GPs
- more likely to say that health professionals did not always remember them between visits, or make an effort to get to know the issues that were important to them
- less likely to feel involved in decisions
- less likely to understand their options of care
- more likely to have no 'time out' from baby care
- more likely to report feeling lonely and isolated
- more likely to report wanting practical and emotional support

Another systematic review of studies that focused on the views and experiences of immigrant and refugee women in accessing sexual and reproductive health care in Australia (Mengesha et al 2016) similarly found that interactions with health care professionals were critical to immigrant and refugee women's access to healthcare.

Access to and provision of an appropriately qualified workforce relies on workers being trained to deliver culturally appropriate care that meets the specific needs of immigrant and refugee women.

### (6) disparity in outcomes between rural and regional and metropolitan locations

Immigrant and refugee women in rural and regional areas face multiple disadvantages accessing a range of health services compared to their metropolitan counterparts. Women in rural areas are less likely to obtain health care from medical specialists and more likely to rely on hospital care ('Women's Health in Rural Australia', National Rural Health Alliance 2012). However, for immigrant women, access to mainstream services do not always provide the culturally appropriate care women need.

While the majority of immigrants and refugees live in metropolitan regions of Victoria, the population of new migrants living in rural areas of Victoria is growing, and in many areas, exceeding the population growth of the general population. In the 5 years between 2006 and 2011, the average increase across Victorian rural regions of people who migrated from a non-English speaking country was 18.6%, compared with general population growth of 5.5%. At the 2011 census, the total of immigrants and refugees from non-English speaking countries living in rural and regional Victoria was 77,851, making up 5.4% of the general rural and regional populations ('Population Diversity in Victoria: 2011 Census Local Government Areas', OMAC, 2013)

(7) identification of best practice.

MCWH works within an intersectional feminist framework, which recognises that immigrant and refugee women experience multiple and interlocking forms of oppression and discrimination. An intersectional approach recognises that gender alone is not a sufficient lens through which to view women's health and access to services.

MCWH has published research and best practice guides, which draw on an intersectional framework and recommend culturally responsive health service delivery, such as provision of interpreters, bilingual health professionals and female health professionals.

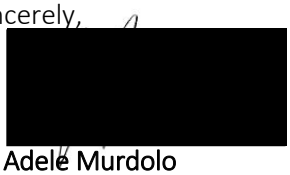
The development and

In summary, MCWH recommends that the Inquiry be attentive to the need for:

- more culturally appropriate and equitable perinatal health services for immigrant and refugee women
- the development of models of maternal health surveillance and primary care support that meet the specific needs of immigrant and refugee women
- bilingual support and education, particularly for newly-arrived women
- the development of an appropriately qualified workforce trained to deliver culturally responsive care
- further research that is inclusive of or focusses on immigrant and refugee women's perinatal health needs
- the collection, measurement and monitoring of robust data across core areas relating to immigrant and refugee women's perinatal health, care and wellbeing

I am grateful for the opportunity to make this submission. Should you require further information please do not hesitate to contact me.

Sincerely,



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Attachments (pdf):

- MCWH Sexual and Reproductive Health Report (2016)
- MCWH Common Threads Best Practice Guide (2012)

# Sexual and Reproductive Health Data Report

June 2016

MULTICULTURAL WOMEN'S HEALTH AUSTRALIA

The MWHA Program aims to improve the capacity of immigrant and refugee women to make informed choices about reproductive health through research, health promotion and advocacy.

## Introduction

This national data report summarises the latest available data across a range of areas that impact on the sexual and reproductive health (SRH) of immigrant and refugee women.

The data in this report has been obtained from a variety of sources ranging from national, population-based studies to small community-based studies. As a national report, ideally all data reported would be population-based. However, where national, disaggregated data sets are not available, state and territory based research has been used. Where Australian data or research is not available, international research is used. Community-based-studies have also been included to highlight the issues relating to immigrant and refugee women's health.

Available research shows that immigrant and refugee women are:

- at a greater risk of suffering poorer maternal and child health outcomes.
- less likely than Australian-born women to have adequate information and familiarity with modern contraceptive methods.
- at greater risk of contracting a sexually transmitted condition (such as HIV and hepatitis B), especially immigrant women who are from countries where the condition has a high prevalence.
- less likely to use health and social/support services. (It is important to note that low access to prevention programs leads to higher representation among crisis and acute service-users).
- less likely to have access to evidence-based and culturally relevant information which will enable them to make decisions about their health.
- well-placed to improve sexual and reproductive health through preventative health education;
- more likely to establish and/or improve health literacy more effectively through small group, same-sex education delivered by trained bilingual educators in the preferred language of the group.

## Sexual and Reproductive Health Data and Research

Significant data gaps exist in Australia in relation to SRH. In 2002 the Australian Institute of Health and Welfare created 44 Reproductive Health Indicators, but found that almost half (21 indicators or 48%) lacked adequate national, state and territory based data. While comprehensive data on fertility rates are available, other indicators such as maternal morbidity, infertility and family planning generally reflect a lack of standardised definitions and data collection tools (Ford et al 2003). For example, there are significant gaps in our knowledge of reproductive health because no data is routinely collected on:

- Abortion: it is currently not possible in Australia to reliably estimate the rate of surgical and medical abortions. Information is also lacking on the extent of induced abortions among population sub-groups; socio-demographic characteristics of women having abortions; measures of out-of-state procedures (i.e. when the state or territory where the procedure was carried out is not the woman's usual state or territory of residence); and reasons for abortion.

- Contraceptive use: understanding of trends and patterns of contraceptive use is fragmented and limited. There is also a lack of social, geographic and demographic data on contraceptive users.

- Unplanned pregnancy: There are currently no processes in place to collect data on unplanned pregnancy, including socio-demographic information and decision-making information.

In 2002 the Australian Institute of Health and Welfare created 44 Reproductive Health Indicators, but found that almost half (21 indicators or 48%) lacked adequate national, state and territory based data.

Moreover, the current evidence base is significantly lacking in specific data about immigrant and refugee women. If data collection does include immigrant and refugee groups, classifications used to measure ethnicity are often ambiguous, potentially misleading or inconsistent across studies and can include region of birth, country of birth and/or language spoken. The lack of available evidence-based information places immigrant and refugee women's sexual and reproductive health at greater risk.

There remains a paucity of SRH surveillance and monitoring data (SHFPA 2013) and this report strongly recommends:

- development of a national conceptual and information framework for reproductive health;

- more accessible data;

- comprehensive and cohesive coordination and analysis of collected data; and

- data disaggregated by gender, sex, ability, ethnicity, place of birth and visa status.

# Contraceptive Use

In 2015, 64% of married or in-union women of reproductive age worldwide were using some form of contraception (UN 2015). The rate of contraceptive use around the world may serve as an indicator of the likelihood that a newly-arrived woman will be familiar with a range of available contraceptive methods on arrival in Australia.

The rate of contraceptive use in Australia is nearly 70% (UN 2015) for women of reproductive age. By contrast, the rate is significantly lower in the countries of origin of immigrant women who have the highest birth rates* in Australia (see also 'Fertility').

| Contraceptive use in country of origin (%) | | |
|---|---|---|
| Country of birth of mother | Any method | Modern methods |
| Australia | 68.4 | 65.4 |
| Samoa* | 31.6 | 30.6 |
| North Africa and Middle East, including Egypt, Sudan | 52.7 | 47.7 |
| Iraq | 54.8 | 37.5 |
| Lebanon* | 63 | 40.4 |
| Syria* | 57.7 | 41.2 |
| SE Asia including Philippines and Vietnam | 64.1 | 56.5 |
| Laos* | 53.6 | 46.2 |
| Southern Asia including Afghanistan, India, Nepal, Pakistan | 58.6 | 50.3 |
| Afghanistan | 29.3 | 24.1 |
| India | 59.8 | 52.4 |
| Pakistan* | 38.5 | 27.9 |
| Sub Saharan Africa, including Eritrea, Ethiopia, Somalia and South Sudan | 28.4 | 23.6 |
| South Sudan | 6.8 | 2.6 |

## Contraceptive Management

According to Australian research:

- Patient factors such as age, ethnicity, Indigenous status and holding a Commonwealth Health Care Card were significantly associated with lower rates of contraceptive consultations (Mazza et al 2012).

- Inadequate access to information was the overwhelming issue cited by African and Middle Eastern immigrant and refugee women regarding knowledge about both the range and side effects of contraceptives (Allotey et al 2004).

- Use of the contraceptive pill was found to be lower among women from non-English speaking backgrounds (Yusuf and Siedlecky 2007).

# Family Violence and Sexual & Reproductive Coercion

The relationship between family violence and poor reproductive health outcomes is well established in international literature.

The World Health Organization (2010) reports that intimate partner violence (IPV) may lead to a host of negative sexual and reproductive health consequences for women, including unintended and unwanted pregnancy, abortion and unsafe abortion, and pregnancy complications.

International research (PPFA 2012) highlights the link between violence and reproductive health in the following ways:

- IPV is associated with poor sexual and reproductive health outcomes compared to non-abused women. This includes being at a greater risk of unintended pregnancy, repeat abortions, second-trimester abortions, and sexually transmitted infections.

- Reproductive coercion may be one mechanism that helps to explain the known association between IPV and unintended pregnancy.

- Unplanned pregnancies increase women's risk for violence and violence increases women's risk for unplanned pregnancies. Women who experience IPV are more likely to be in relationships with a partner who controls their contraceptive methods.

- There is a strong association between IPV and involvement in three or more abortions.

- Women in abusive relationships are more likely to be coerced into risky behaviours such as inconsistent condom use, which puts them at greater risk of sexually transmitted infections. Additionally, women exposed to IPV are less likely to disclose an STI to a partner due to fear. Studies show that young women who are exposed to IPV are more likely to have partners say that the STI was not from them or accuse them of cheating.

Research conducted in Australia into the impact of domestic violence on women's reproductive health and access to options and services (Cheung et al 2014; Children by Choice 2014) shows:

- Domestic violence impacts on women's reproductive autonomy.

- Unplanned, unintended or unwanted pregnancy is more common among women who identify as experiencing domestic or family violence.

- There is an increased risk of intimate partner violence and/or controlling behaviours towards women during pregnancy.

- For women who choose to terminate a coerced pregnancy, there are many barriers to current abortion provision in Queensland, which are compounded for women experiencing domestic violence.

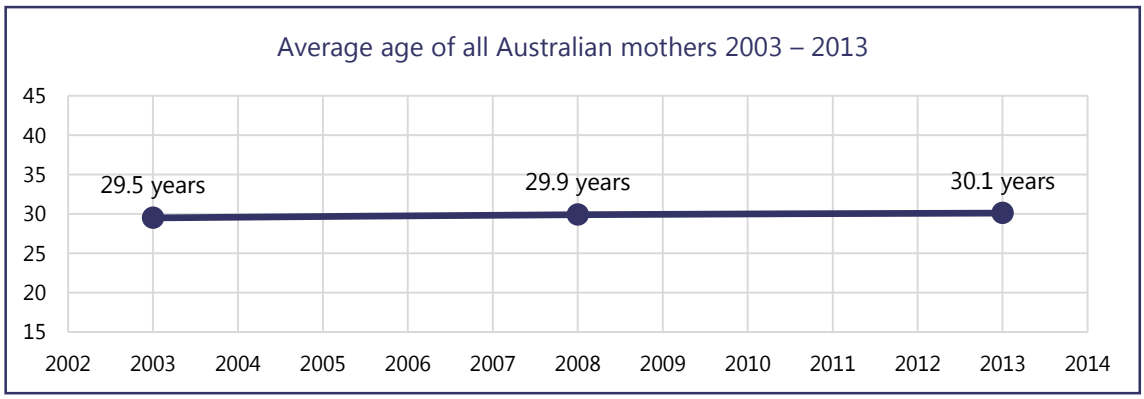
# Fertility

According to 2014 data (ABS Births Australia), the fertility rate for Australian-born mothers is 1.93 births per woman.

Among overseas-born women, rates vary widely, with the highest rate at four (for mothers born in Lebanon), more than double the Australian rate. However, the age-specific fertility rate for some overseas-born women aged 15-19 years, is between three to four times higher than that of the Australian rate for the same age category.

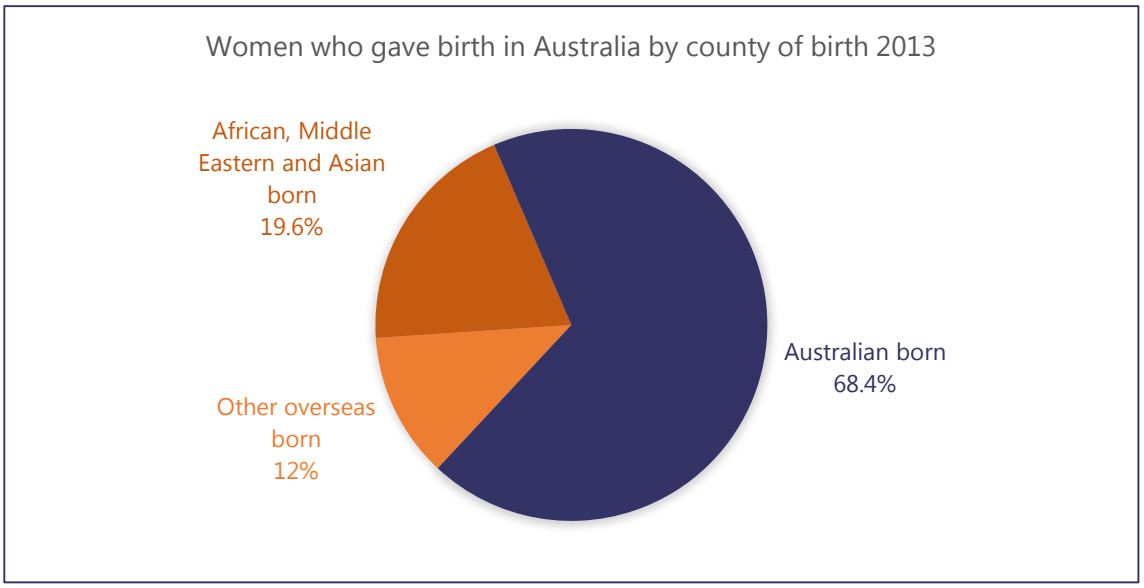
| Australian fertility rates 2014 (of mothers giving birth in Australia) | | |
|---|---|---|
| Country of birth of mother (selected) | Total rate | Age-specific rate: (15-19 years) |
| Australia | 1.8 | 15.4 |
| Samoa | 3.2 | 30.2 |
| North Africa and Middle East, including Egypt, Iran, Iraq, Israel, Lebanon, Syria, Turkey and Other | 2.8 | 23.4 |
| Lebanon | 4.0 | 60.3 |
| Syria | 3.3 | 31.9 |
| SE Asia, including Burma (Republic of the Union of Myanmar), Cambodia, Indonesia, Laos, Malaysia, Philippines, Singapore, Thailand Viet Nam, and Other | 1.6 | 5.8 |
| Burma | 2.5 | 24.9 |
| Laos | 3.4 | 62.5 |
| Southern & Central Asia including India, Pakistan, Sri Lanka and Other | 2.0 | 5.4 |
| India | 2.0 | 2.5 |
| Pakistan | 3.02 | 9.6 |
| Sub Saharan Africa, including Kenya, Mauritius, South Africa, Zimbabwe and Other | 2.1 | 11.2 |
| Other (sub Saharan) | 3.3 | 26.1 |

(Source: AIHW 2015)



## Maternal country of birth

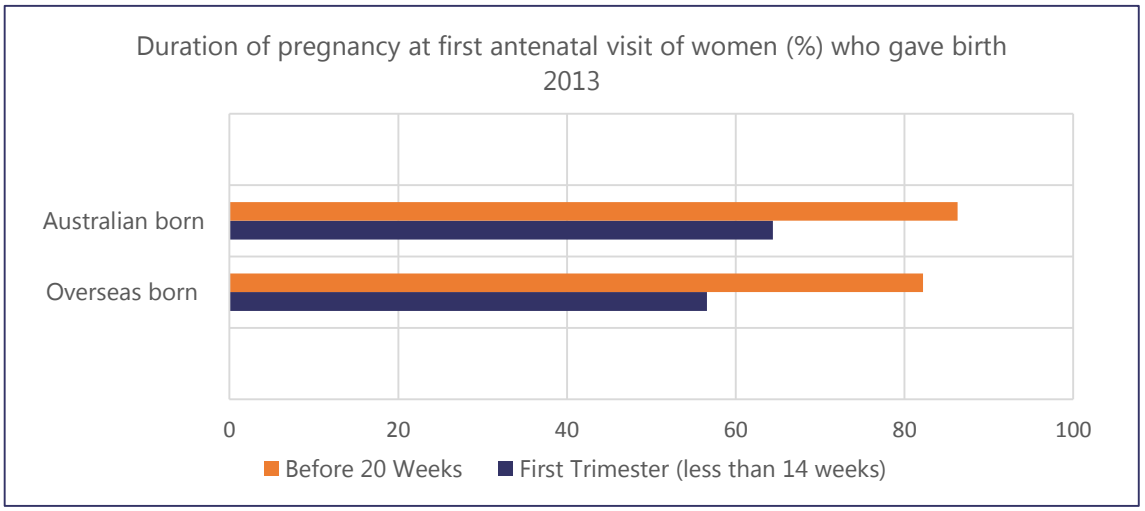
Maternal country of birth can be an important risk factor for obstetric and perinatal outcomes such as low birth weight and perinatal mortality. Among the 31.6% of overseas born women who gave birth in Australia in 2013, women born in Africa, the Middle East and Asia together accounted for 19.6% of all mothers (AIHW 2015).




(Source: AIHW 2015)

## First antenatal visit

Antenatal care is associated with better maternal health, fewer interventions in late pregnancy and positive child health outcomes. The World Health Organization recommends receiving antenatal care at least four times during pregnancy and the Australian Antenatal Guidelines recommend that the first antenatal visit occur within the first ten weeks of pregnancy. Women born overseas who gave birth in Australia in 2013 were found to have attended their first antenatal visit at later gestational ages than Australian born mothers.




(Source: AIHW 2015)

# Maternal Health and Pregnancy Outcomes

## Preeclampsia and eclampsia

Preeclampsia is a major pregnancy complication leading to substantial maternal morbidity and mortality. It is associated with various pregnancy complications including pre-term birth, fetal growth restriction, perinatal death and adult long-term health problems in offspring.

A cross-country comparative study of six industrialised countries (including Australia) shows that immigrants from Sub-Saharan Africa, Latin America and the Caribbean were at higher risk of preeclampsia (Urquia et al 2014).

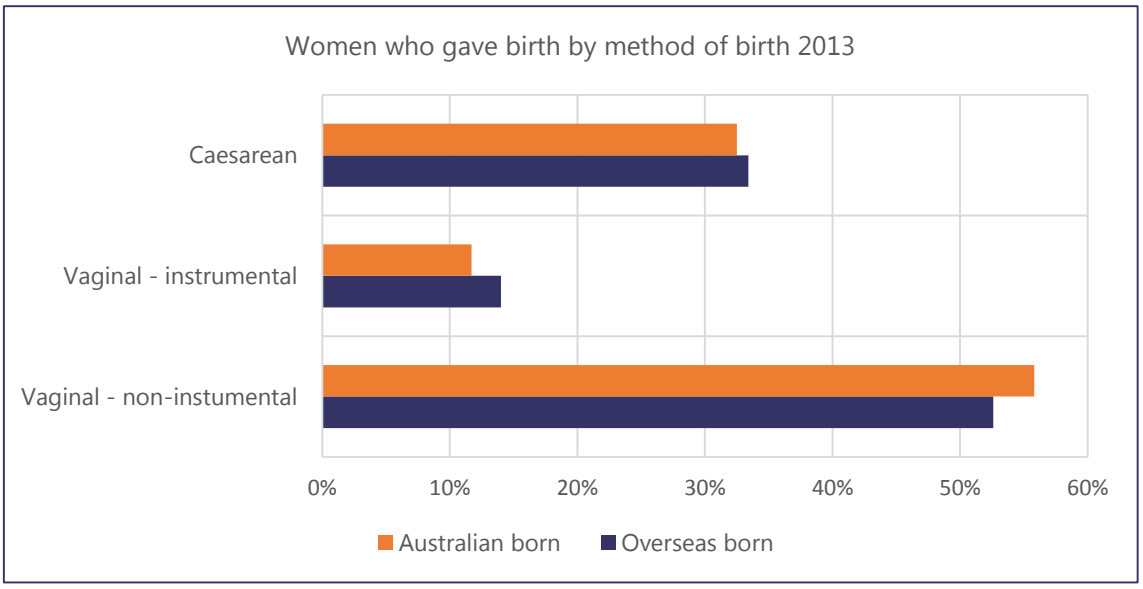
## Gestational Diabetes Mellitus (GDM)

In 2013, mothers born overseas reported higher proportions of pre-existing diabetes (1.2%) than mothers born in Australia (0.9%) (AIHW 2015). In addition, mothers born in high-diabetes-risk regions, such as Polynesia, Asia and the Middle East, were slightly more likely to have Type 2 diabetes, and three times as likely to have GDM, as mothers born in Australia (AIHW 2010).

An Australian study of immigrant South Asian women who were recently diagnosed with GDM found that before diagnosis, women's knowledge and awareness of any diabetes was low. (Bandyopadhyay et al 2011).

A study comparing migrant women of refugee background from African countries with women who migrated for non-humanitarian reasons, found that mothers giving birth from humanitarian source countries in Middle and East Africa were more likely to experience GDM (Gibson-Helm 2014).

## Birth type, including caesarean section




(Source: AIHW 2015)

Of the mothers who gave birth in 2013, those born overseas were less likely to have a non-instrumental vaginal birth than mothers born in Australia (52.6% compared to 55.8%). Mothers born overseas were more likely to have instrumental vaginal births (14%) or a caesarean section (33.4%) compared with Australian born mothers (11. 7% and 32.5% respectively) (AIHW 2015).

A NSW population-based study found that compared with low risk women born in Australia and women born overseas, Indian-born women had the highest caesarean section (31%), instrumental birth rates (16%) and episiotomy rates (32%) (Dahlen et al 2013).

A 2016 study of caesarean rates for African immigrants in Australia found that both first-time mothers and mothers who had previously given birth from Eastern African countries (Eritrea, Ethiopia, Somalia and Sudan) had elevated odds of unplanned caesarean in labour. The study further found that the odds of any first-time caesarean (planned or unplanned) were elevated for first-time mothers from Eritrea, Ethiopia and Somalia, and were elevated for mothers who had previously given birth from Ethiopia and Somalia (Belihu et al 2016).

The caesarean rate recommended by The World Health Organisation is between 10-15%.

When medically justified, a caesarean section can prevent maternal and perinatal mortality and morbidity. However, there is no evidence showing the benefits of caesarean delivery for women or infants who do not require the procedure. As with any surgery, caesarean sections are associated with short and long term risk which can extend many years beyond the current delivery and affect the health of the woman, her child, and future pregnancies (WHO 2015).

## Stillbirth (perinatal or fetal deaths)

The Australian perinatal mortality rate in 2013 was ten per 1000 births.

In Victoria, the perinatal mortality rate in 2013 (9.9 per 1000 births) was lower than the rate for 2009 (10.7 per 1,000 births). Despite this, perinatal mortality rates remain high for specific migrant groups including babies of women born in North Africa, the Middle East or southern and central Asia (the risk of perinatal death is one and half times higher) (CCOPMM 2016).

Australian state-based studies have also shown that:

- Compared with other refugee groups, women from West African humanitarian source countries were found to have the highest stillbirth incidence (4.4% compared to 1.2% and 1.6% from other regions) (Gibson-Helm et al 2014).

- South Asian born women were more than twice as likely to have a late pregnancy antepartum (i.e. not long before birth) stillbirth than either Australian-born or South-East Asian born women (Drysdale et al 2012).

- Lebanese born women had the highest rates of stillbirth (7.2 per 1000 births) compared with low risk women born in Australia and other women born overseas (Dahlen et al 2013).

- According to a Victorian population based study women born in East African countries experienced increased perinatal deaths and other adverse perinatal outcomes compared with Australian-born women. Women from Eritrea and Sudan are particularly at increased risk of adverse outcomes (Belihu et al 2016).

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## Other Perinatal Outcomes

Several studies suggest that immigrant and refugee women may be at greater risk of adverse perinatal outcomes:

- Compared to African migrant women without a refugee background, African women of refugee background appear to be at greater risk of specific adverse pregnancy outcomes (Gibson-Helm et al 2014).

- Compared to low risk women born in Australia and women from New Zealand, England, China, Vietnam, Lebanon and Philippines (the most common migrant groups at the time of the study), Indian women were found to have the lowest normal birth rate and high rates of low birth weight babies (Dahlen et al 2013).

## Maternal death

- In 2008-2012, there were a total of 105 maternal deaths that occurred within 42 days of the end of pregnancy. The majority (64 or 71.5%) of women who died were born in Australia .Twenty-six (or 25% where country of birth was known) were women born overseas. Nine of the women not born in Australia (whose country of birth was known) were born in New Zealand and 12 were born in the Asia-Pacific region (AIHW 2015).

- It is important to note that information on ethnicity is not routinely collected in perinatal data collections and therefore, no information on whether women were recent immigrants or refugees was available.

- International research (Ronsmans and Graham 2006) suggests that inequalities in the risk of maternal death exist globally and developed health systems such as Australia's need to target

and tailor interventions towards the most vulnerable groups.

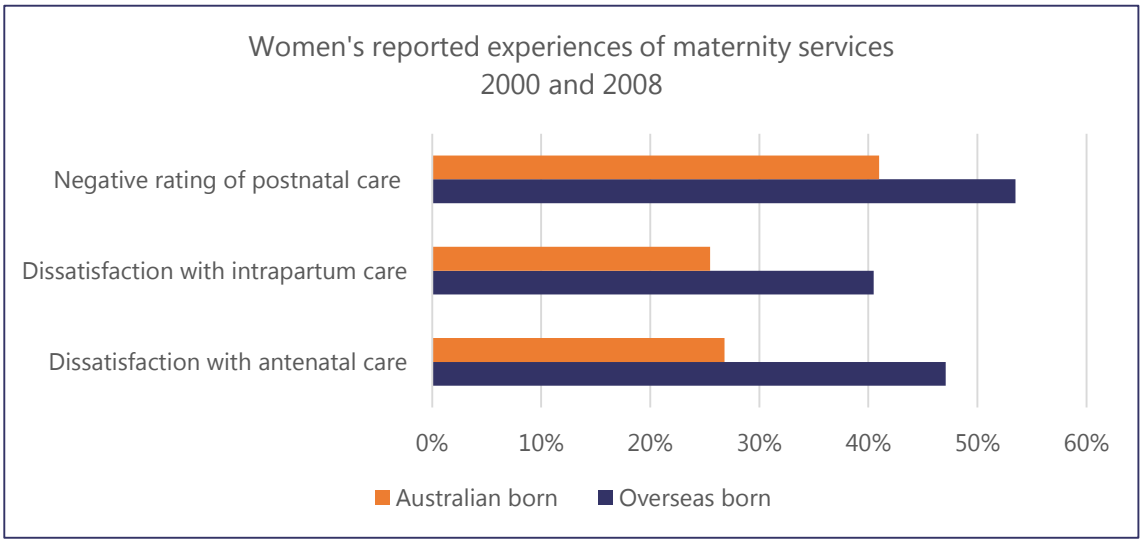
- Victoria's Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) has identified immigrants, refugees and asylum seekers as being at risk of maternal death:

> An emerging theme from the review of recent maternal deaths is the barriers to accessing care that recent immigrants, refugees and asylum seekers may face. As well as these challenges, these women may face social isolation and negative psychological impacts from experiencing pregnancy and motherhood in an unfamiliar environment. Information about these maternal factors is not comprehensively collected and further research is needed to fully understand this issue.
> (CCOPMM 2016)

## Maternity Care and Postnatal Experiences

A systematic and comparative review of studies in five countries (including Australia) of immigrant and non-immigrant's women's experiences of maternity care has shown that all women – both immigrant and non-immigrant – want maternity care that is safe, high-quality, attentive and individualised, with adequate information and support (Small et al 2014). However, the same study has also shown that:

- immigrant women were less positive about their care than non-immigrant women.
- communication problems and lack of familiarity with care systems impacted negatively on immigrant women's experiences.
- immigrant women reported problems with discrimination or prejudice.




(Yelland et al 2015)

Other Australian studies (Hennegan et al 2015; Yelland et al 2015; Lansakara et al 2010; Bandyopahyay et al 2010) have also shown that compared with Australian-born mothers, immigrant mothers were:

- less likely to rate overall postnatal physical health positively
- more likely to report relationship problems and to report lower emotional satisfaction with their relationship with the partner
- less likely to be asked about relationship problems by maternal and child health nurses
- less likely to be asked about feeling low or depressed by GPs
- more likely to say that health professionals did not always remember them between visits, make an effort to get to know the issues that were important to them
- less likely to feel involved in decisions
- less likely to understand their options of care
- more likely to have no 'time out' from baby care
- more likely to report feeling lonely and isolated
- more likely to report wanting practical and emotional support

In one study women also more frequently reported having distressing flashbacks and feeling depressed in the postnatal period (Hennegan et al 2015).

## Maternal Depression and Postnatal Depression

A comparative study of the post-childbirth experiences of Australian born and immigrant mothers from non-English speaking backgrounds found that compared with Australian born women, immigrant mothers less proficient in English had a higher prevalence of depression (28.8% vs 15%) and were more likely to report wanting more practical (65.2% vs 55.4%) and emotional (65.2% vs 44.1%) support. They were also more likely to have no 'time out' from baby care (47% vs 28%) and to report feeling lonely and isolated (39% vs 17%) (Bandyopadhyay et al 2010).

The Mothers in a New Country (MINC) study (Small et al 2003) of Vietnamese, Turkish and Filipino women's experiences of maternity care and physical and psychological health found the issues most commonly identified by women as contributing to depression were:

- isolation (including homesickness);
- lack of support and marital issues;
- physical ill-health and exhaustion;
- family related issues; and
- baby-related issues.

Significant associations with depression were seen on at least two of the above measures for mothers who: were under 25 years; had a shorter residence in Australia; spoke little or no English; migrated for marriage; had no relatives in Melbourne. Similar themes and issues were also identified among immigrant Afghan mothers in a further study of immigrant Afghan women's emotional well-being after birth (Shafiei et al 2015). This study also found that some women were reluctant to discuss their emotional difficulties with health professionals and did not expect that health professionals could necessarily provide assistance.

## Female Genital Mutilation/Cutting (FGM/C)

Due to lack of data, it is impossible to speculate on either the incidence or prevalence of FGM/C in Australia. In Australia, prevalence estimates are obtained from Demographic and Health Surveys and Multiple Indicator Cluster Surveys from African countries and extrapolated to the number of female migrants from FGM/C practising countries residing in Australia. This estimation is inadequate as prevalence depends on various other factors including ethnicity, socio-economic status and education.

There is no evidence to suggest that FGM/C is practised in Australia. However, research conducted by the University of Melbourne (Vaughan et al 2014a; Vaughan et al 2014b) indicates that the practice has declining support among communities in both rural areas and in the inner metropolitan areas of Victoria (MCWH 2016).

To ensure that women who have experienced FGM/C are properly supported and that the practice is not being continued in communities once they migrate to Australia, it is essential that effective and comprehensive health promotion programs and community education initiatives are in place (Chen and Quiazon 2014).

## HIV

The number of HIV infections newly diagnosed in Australia has remained stable for the past three years (1,081 cases in 2014; 1, 028 in 2013 and 1, 064 in 2012). Based on newly diagnosed cases, the main route of HIV transmission in Australia continues to be sexual contact between men, which accounted for 70% of the cases in 2014.

Among cases attributed to heterosexual sex, 23% were of people born in countries recognised by the UNAIDS as having a national HIV prevalence above 1%, and 16% of people with sexual partners of people born in these countries. In addition, the proportion with late diagnosis was highest in people born in South East Asia (42%) and sub-Saharan Africa (38%) (The Kirby Institute 2015).

# Hepatitis B

Hepatitis B leads to chronic liver conditions, including liver cancer. The estimated prevalence of chronic Hepatitis B infection among people born in Australia is 1%. Research has identified that:

- People from the Asia-Pacific (including Taiwan, Vietnam, China, and Cambodia), who represent 9.6% of the Australian population, accounted for an estimated 38% of those living with hepatitis B infection in 2013; and

- People from Sub-Saharan Africa, who represent 1.4% of the Australian population, accounted for an estimated 4% of those living with hepatitis B infection (The Kirby Institute 2015).

Primary prevention strategies to protect people from acquiring Hepatitis B infection include vaccination, use of clean needles and condom use. Testing and treatment are secondary prevention strategies.

Women should be targeted for education because Hepatitis B can be transmitted via sexual contact. Women are particularly vulnerable in this context due to violence and limited information about sexually transmitted infections.

# Experiences of accessing sexual and reproductive healthcare

A systematic review of studies that focused on the views and experiences of immigrant and refugee women in accessing sexual and reproductive health care in Australia (Mengesha et al 2016) found the following barriers and facilitators:

## Barriers

- Both spoken and written language, including issues relating to interpreters
- Health professionals' lack of knowledge regarding cultural norms
- Systemic barriers relating to the health care system and difficulty navigating the system
- Transport difficulties
- Cost of services

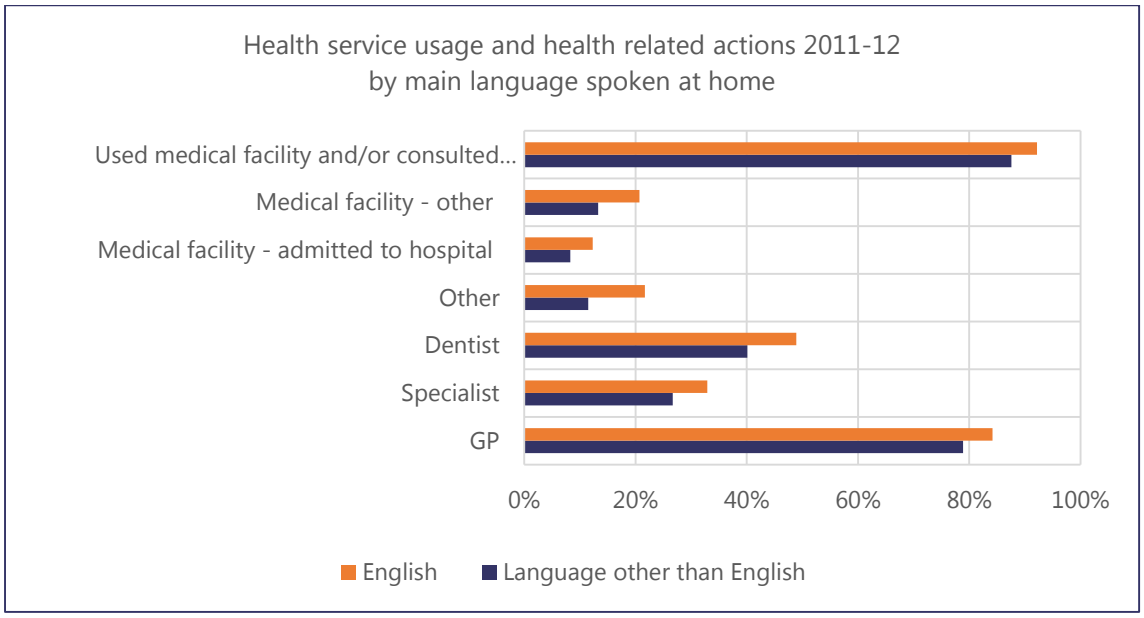
## Facilitators

- Provision of interpreters and bilingual health professionals
- Multilingual resources, including information on how to reach healthcare facilities
- Appointment reminding services
- Home visits
- Provision of female health professionals
- Health professionals using their time to listen to concerns, answer questions and explain treatment options

Overall, the study found that interactions with health care professionals were critical to immigrant and refugee women's access to healthcare.

## Health Service Usage

There is evidence to suggest that people who speak a language other than English at home participate less in health services than those who speak English (ABS 2013).

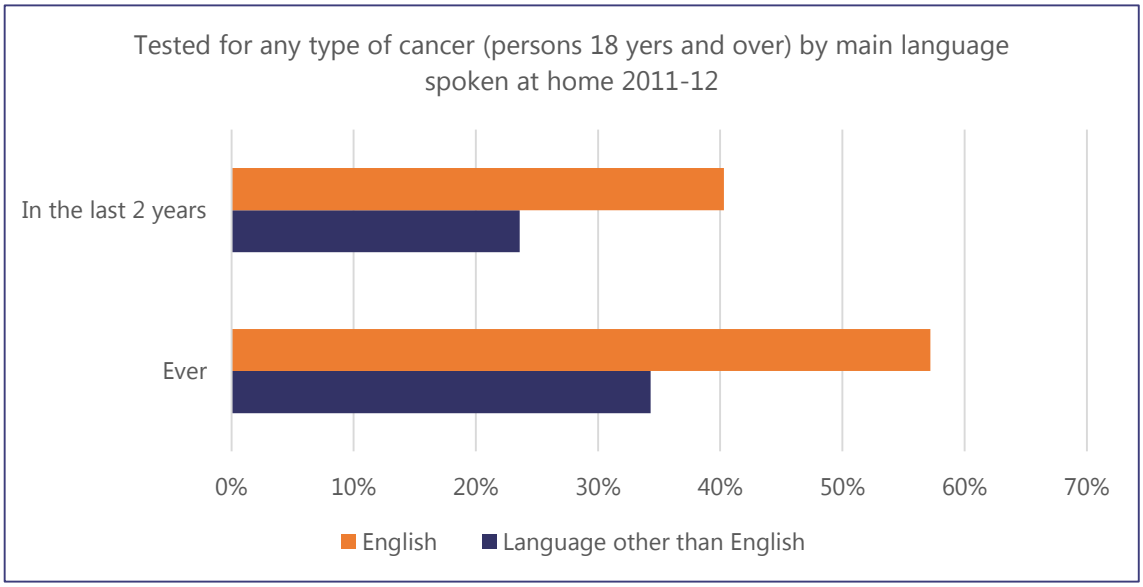



(ABS 2013)

## Cancer Screening, including cervical screening

Australia's cervical screening program currently recommends two-yearly screening for women aged 18-69 years.

Australian research shows that migrant women from Asian and Middle-eastern countries are less likely than Australian born women to participate in cervical screening at the recommended level (Aminisani et al 2012).




(ABS 2013)

## Breast Screening

In Australia, population-based breast cancer screening is available through BreastScreen Australia, which targets women aged 50–74 for two-yearly screening mammograms (women aged 40–49 and 75 years and over are also eligible).

In 2012-2013, participation of women who report that they speak a language other than English at home was 55.0% compared with the English-speaking rate of 48.8%. (AIHW BreastScreen Australia 2015).

# Health Education Preference

Research suggests that verbal, same-sex, group-based, peer education sessions are the preferred mode of health education for immigrant and refugee women:

- A UK based study (Greenhalgh 2009) of a peer model of health education found that positive outcomes can be achieved through group participation (in addition to knowledge acquisition), as participants are able to negotiate meanings and make information meaningful for themselves.

- A Victorian study (McMichael 2008) conducted with resettled youth with refugee backgrounds in relation to the promotion of sexual health, found that gender-matched educators were the preferred method for learning about sexual health issues.

- Research conducted in Perth, Western Australia (Lee et al 2013), into the topic preferences and means of access to health information among newly-arrived women, found that women's health ranked a top priority along with employment advice and mental health issues. Preferred methods for receiving information were interactive talks with written materials. In addition, it was found that non-threatening, participatory processes encouraged women to prioritise sensitive topics such as family violence and highlighted the need for such topics to be incorporated within general health information.

- An evaluation (Hurwurth et al 2003) of MCWH's group-based health education program found that the majority (70%) of immigrant and refugee women who participated in the study expressed a preference for verbal delivery of information. The top three features and benefits cited by participants were: 'are offered only to women'; are offered in a preferred language'; and 'enabled learning'.

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For more information contact info@mcwh.com.au, visit mcwh.com.au or (free) call 1800 656 421.

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BEST PRACTICE GUIDE

# COMMON THREADS, COMMON PRACTICE

WORKING WITH IMMIGRANT & REFUGEE WOMEN IN SEXUAL & REPRODUCTIVE HEALTH

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

BEST PRACTICE GUIDE

# COMMON THREADS, COMMON PRACTICE

## WORKING WITH IMMIGRANT & REFUGEE WOMEN IN SEXUAL & REPRODUCTIVE HEALTH

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## CONTENTS

# INTRODUCTION

Current evidence suggests that immigrant and refugee women have poorer health outcomes than Australian-born women, with a marked deterioration in their health status becoming evident within 3-5 years of settlement. With particular respect to sexual and reproductive health, immigrant and refugee women are at significant risk of adverse outcomes. They are less likely to have information about modern contraception methods, and less likely to commence timely antenatal care and/or access preventative services. Their poorer health outcomes are due to a range of factors, including barriers to accessing health services and the lack of culturally appropriate support.

While there is now a general acceptance of 'culture' and 'diversity' in health service delivery, there is still a lack of understanding of what is required to implement culturally appropriate and relevant services.

Immigrant and refugee women have the right to access culturally appropriate sexual and reproductive health services. A model of health that recognises the impact of

*'Immigrant and refugee women' refers to all women from immigrant communities, including asylum seekers and women from both emerging and established communities. Unless otherwise stated, 'immigrant and refugee women' and 'women' are used interchangeably in this guide.*

social, economic, cultural and political factors on health and wellbeing is the starting point for ensuring that women from these communities are receiving care that is both sensitive and responsive to their needs.

## WHO WE ARE

The Multicultural Centre for Women's Health (MCWH) is a national, community-based organisation committed to the achievement of health and wellbeing for and by immigrant and refugee women. Its mission is to promote the wellbeing of immigrant and refugee women across Australia through advocacy, social action, multilingual education, research and capacity building.

MCWH advocates for a model of care that situates immigrant and refugee women's health needs at the centre of policies and practices. This is only possible if core ideas around social justice and equity form the basis of the provision of health.

## AIM OF THIS GUIDE

To promote a gendered cross-cultural understanding and practice in the delivery of services for immigrant and refugee women based on best practice principles.

## BACKGROUND

Our research shows that there is a need for more information tailored to best practice for working with women from immigrant and refugee backgrounds in sexual and reproductive health. This guide is the product of an extensive literature review of immigrant and refugee women's sexual and reproductive health, as well as key stakeholder consultations and focus group discussions with immigrant and refugee women themselves. This guide is based on those findings and accompanies the project report, Common Threads: The sexual and reproductive health experiences of immigrant and refugee women living in Australia (Hach, 2012).

A cross-cultural training program has also been developed from the Common Threads study. The training aims to provide community and health workers with an understanding of how to embed best practice principles into their work with immigrant and refugee women.

## WHO CAN USE THIS GUIDE?

This guide is intended for health practitioners who work with immigrant and refugee women in sexual and reproductive health, community and clinical settings.

## ABOUT THIS GUIDE

This guide has two parts. Part 1 examines the limitations of current models of cultural competency and common misconceptions of the term 'culture'. Part 2 puts theory into practice, and outlines four best practice principles for working with immigrant and refugee women. Scenarios are based on both the findings from Common Threads and MCWH's 34 years of knowledge and experience working with immigrant and refugee women in health.

'Women have the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice… and the right of access to appropriate health-care services…'

Cairo Declaration's definition of reproductive health. United Nations, 1994

## WHAT INFORMS THIS BEST PRACTICE GUIDE?

This guide is informed by the principles of human rights, feminism and community development. Particularly drawing on the concepts of participation and inclusion, a rights-based approach provides the foundation for a feminist framework that emphasises non-discrimination and empowerment.

This framework provides a way of addressing inequity, injustice and disadvantages that impact on immigrant and refugee women's capacity to access sexual and reproductive health services.

## BEST PRACTICE PRINCIPLES

The following principles are at the core of what we mean by best practice when we engage with immigrant and refugee women. These principles are the backbone of the MCWH's successful health education sessions which have been conducted in industry and community settings for more than 30 years. Sessions are conducted using a participatory model that acknowledges and respects the knowledge that women already have about their health and their bodies.

- ✓ WOMEN'S EMPOWERMENT
- ✓ CULTURAL AND LINGUISTIC APPROPRIATENESS
- ✓ ACCESS AND EQUITY
- ✓ COLLABORATION

# PART 1

## BEING 'COMPETENT' IS NOT ENOUGH

What constitutes competent practice in relation to social and cultural diversity and how do you know when you have achieved cultural competency? With the growing number of people from diverse cultural and linguistic backgrounds in Australia, there is an increasing need to re-examine the approach that clinical health services take in delivering culturally appropriate services.

The challenges associated with working with women from immigrant and refugee communities have been widely documented. Services have responded in some way to these challenges, through what is generally referred to as culturally competent practice. However, there is still a lack of understanding of what is required in the implementation and delivery of culturally appropriate services.  Immigrant and refugee women in particular, bear the brunt of this failure.

## WHAT IS CULTURAL COMPETENCY?

There is no single universally accepted definition of cultural competency. Part of the difficulty in defining cultural competency is the fluidity of the components contained in the term. Culture, by its very definition is constantly changing and evolving. Mainstream cultural competency models tend to represent culture as a set of traits or characteristics that can be 'known' which often results in cultural stereotyping. While there is not one model of cultural competency, conceptions of cultural competency in the health sector share a number of common characteristics. They tend to:

- Take a skills development approach. This approach assumes that once a certain amount of knowledge or skill is acquired, an individual is 'culturally competent'. It also assumes that skills are observable and assessable.
- Assume that cultural competency can simply be reached with training and interaction with clients from other cultures rather than recognise that it is a dynamic, continuous process.
- Have a 'one size fits all' approach to culture, which does not leave room for dialogue, flexibility or mutual exchange.
- Take a gender neutral approach.
- Downplay the specific and often sensitive needs of women from immigrant and refugee backgrounds.
- Link cultural competency to linguistic competency. Organisations and individuals often describe themselves as culturally competent if they have policies concerning the use of multilingual resources or interpreters. While linguistic appropriateness is important, it is not the only component of cultural competency.

'The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.'

WHO, 2012

One of the problems with the cultural competency model is that it can take a 'one size fits all' approach to service delivery. Rather than take a perspective which acknowledges the social determinants of health, mainstream health initiatives continue to focus on individual risk factors related to physical health and do not consider how factors such as migration experience, education levels, income, and cultural norms impact health and wellbeing. Furthermore, the lack of a gendered perspective is particularly problematic when discussing immigrant and refugee women because gender and culture both have an impact on health outcomes.

Within this model, cultural incompetence is presumed to arise from a lack of exposure to and knowledge about the patient's culture, in addition to individual biases and prejudices.

An alternative approach is needed if immigrant and refugee women are to truly exercise their right to access culturally appropriate and relevant health care. What is needed is a gendered cross-cultural understanding of the needs of immigrant and refugee women. At a basic level, cross-cultural understanding can only be realised in practice if ideas about culture are redefined to encompass all the factors that make up immigrant and refugee women's complex and changing identities.

A complex understanding of culture is crucial to ensuring that women's diverse needs are accommodated. It is also important to understand that cross-cultural understanding is a continuous process of dialogue, reflection and mutual exchange.

## WHAT IS CULTURE?

Culture is a term that is used freely, without much thought as to where it comes from, and how it impacts on our lives. We assume that we are who we are because of our experiences and belief systems. However, if we give it deeper thought we realise how all-encompassing and important culture actually is.

Culture is often described as the lens through which we view the world, meaning that our culture influences our perceptions and interactions in everyday life. For many of us, culture might be the food we eat, the language we speak and the religion that we follow. For many others, culture might influence their whole way of life and underpin all their beliefs, attitudes, and customs. Culture impacts social relationships, family life, child rearing, health and wellbeing.

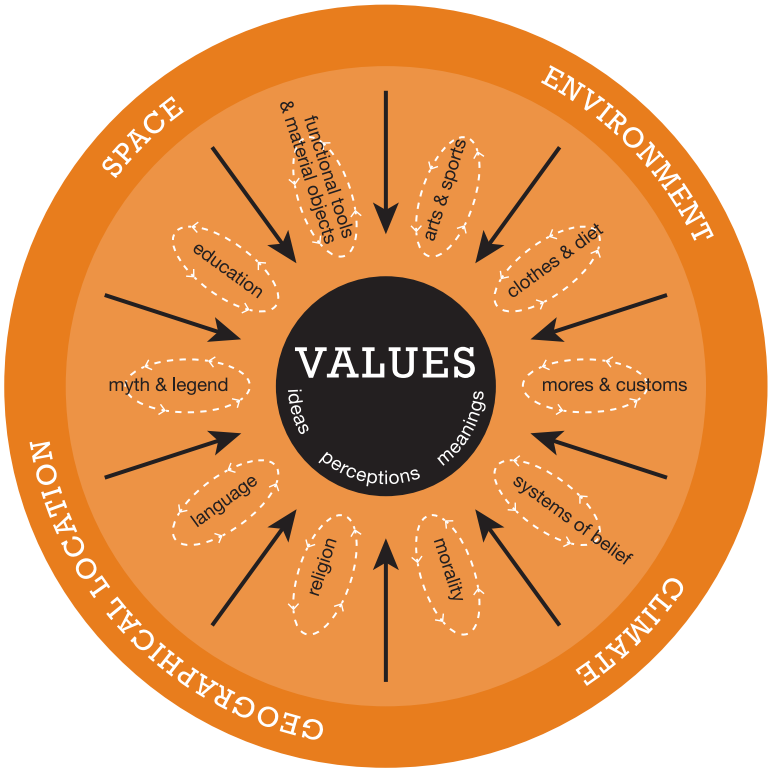
Individuals or groups may be influenced by the following:

- Cultural Identity
- Ethnic Identity
- Nationality
- Acculturation
- Class
- Education
- Language
- Literacy
- Perception of time
- Family configuration
- Social history
- Religion
- Spiritual views
- Gender
- Sexuality
- Political orientation

List adapted from the National Centre for Cultural Competence (cited in Ethnic Communitiesí Council of Victoria, 2006)

‘Culture is the distinctive way of life of the group, race, class, community or nation to which the individual belongs. It is the first and most important frame of reference from which one's own sense of identity evolves.’

O'Hagan, 2001



An understanding of the role of culture in people's lives is fundamental in terms of providing needs-based and person focused healthcare. Unfortunately, culture is frequently seen in narrow terms (usually as more or less equivalent to ethnicity and race) and this narrow definition is often what informs mainstream approaches to cultural diversity.

Culture and identity, two things that are inextricably linked, change and evolve. A static view of culture can perpetuate the belief that culture is primarily an 'ethnic' phenomenon rather than the notion that everyone has a culture. Groups that have more social power are generally seen as not having a culture and are excluded from the concept of cultural diversity.

Narrow definitions of culture can also lead to the stereotyping of particular cultural groups and the attitude that 'one approach fits all.' For example, representations of immigrant and refugee women are often limited in their diversity. The stereotype is that these women are all essentially married, heterosexual and always put their family's needs ahead of their own. Descriptions of immigrant and refugee women tend to focus on their disadvantages and problems, and to construct women as passive victims who are subject to the control of their husbands, their cultures and their religions. Culture is seen as the cause of immigrant and refugee women's problems and something that can't change or be challenged.

Immigrant and refugee women are not a homogenous group. There is as much difference within cultures as there is in between cultures. Stereotyping a group means that they are not seen as individuals with distinct, individual needs. Immigrant and refugee women have different life experiences and, as such, have different ideas about health and goals for treatment.

## CULTURE AND HEALTH

Culture and health are inseparable. Culture plays a part in the production, presentation and experience of illness and wellbeing. For example, how might culture and the migration experience impact on a refugee woman's sexual and reproductive health? Let's examine the scenario on page 12.

## SCENARIO 1

Aabida arrived in Australia with her husband 3 years ago after spending almost 5 years in a refugee camp. She never finished high school because of the war in her country.

She had her first child in her home country, and she is now pregnant with her second child. Her husband is supportive and tries to comfort her when she is upset, but Aabida is anxious because when she had her first child, her mother and aunts were there to help her and made sure she followed traditional birthing customs.

As her husband works long hours, she is wondering how she will manage looking after two children as well as doing all the housework by herself.

When she went to the hospital in Australia for a check-up, the nurse became angry with her for not presenting earlier. She didn't understand what she had done wrong, because women who gave birth in the camps rarely saw a doctor or nurse before they went into labour.

She thought she was doing the right thing and she even made her husband take a day off work when she knows how hard it is for him to do so, so he could attend the appointment with her. Aabida is worried that she has harmed her baby but she is scared to go back to the hospital.

## DISCUSSION

This scenario tells us that the migration experience can be a difficult and isolating one. Furthermore, health and a sense of wellbeing are inextricably tied to notions of family, kinship and cultural practices and traditions. As war broke out in her country, Aabida's education was interrupted so it is unlikely that she was ever taught about sexual and reproductive health. Everything she knows, she has learnt through her own personal experiences and from what others have told her in the refugee camp.

Aabida's story tells us that while cultural factors are important, health outcomes can be less about 'culture' (in its narrowest definition) and more about the political and socio-economic context in which a person lives. That is why a definition of culture must include not only ethnicity and race but also (at least) gender, age, income, education, and socio-economic status. Furthermore, as the scenario suggests, newly-arrived migrants are more likely to lack support networks and have competing priorities like gaining employment and learning English which often put sexual and reproductive health needs on the backburner.

## 8 THINGS TO KNOW ABOUT 'CULTURE'

1 Everyone has a culture.

2 Culture is individual. Individual assessments are necessary to identify relevant cultural factors within the context of each situation for each person.

3 An individual's culture is influenced by many factors, such as race, gender, religion, ethnicity, socio-economic status, sexual orientation and life experience. The extent to which particular factors influence a person will vary.

4 Culture is dynamic. It changes and evolves over time as individuals change over time.

5 Reactions to cultural differences are automatic, often subconscious and influence the dynamics of the health professional-client relationship.

6 A health professional is influenced by personal beliefs as well as by professional values.

7 The health professional/community worker is responsible for assessing and responding appropriately to the client's cultural expectations and needs.

8 There is as much difference within cultures as there are between cultures.

Adapted from College of Nurses of Ontario: Practice Guidelines, Culturally Sensitive Care, 2009. p. 3.

# PART 2

## FROM CULTURAL COMPETENCE TO A GENDERED CROSS-CULTURAL UNDERSTANDING AND PRACTICE

Being culturally competent (as it is widely understood) is not enough when it comes to working with immigrant and refugee women, particularly in terms of sexual and reproductive health. It is much more than just an awareness of cultural difference, and an understanding of cultural customs and traditions, although this is important. What is needed is cross-cultural understanding and an awareness of the relationship between gender and health.

Health professionals should understand how their own values and beliefs impact upon their interaction with clients, and how their cultural prejudices and assumptions might come across during care. By learning, implementing, and supporting the following best practice principles, quality of care can be strengthened for immigrant and refugee women.

You cannot fully comprehend the meanings of the cultural practices of another group. Every interaction with another person is cross- cultural. If you want to know more about women's beliefs and values, just ask. Cross cultural communication is about reciprocity and a willingness to engage in unfamiliar discussions.

## PRINCIPLE 1
### WOMEN'S EMPOWERMENT

Women's empowerment is a process rather than an outcome in which individual women who feel disempowered engage in dialogue with each other and come to understand the social sources of their powerlessness and see the possibility of acting collectively to change their social environment (MCWH, 2010). It implies that there are hierarchies of power that need to be recognised in the first instance.

Indicators:

- ✓ Health information is exchanged in a non-hierarchical manner and women feel safe to contribute their knowledge and experiences. Their choices are respected and considered within treatment options.
- ✓ The information shared increases women's knowledge about their sexual and reproductive health and builds their capacity for making informed choices.
- ✓ Encounters are non-discriminatory and non-judgemental, and conducted in a safe, non-threatening environment.
- ✓ The uniqueness of the experiences, needs and aspirations of each individual woman is respected and acknowledged.

## SCENARIO 2

Lita is a young woman from the Philippines who has come to Australia to study marketing and international relations. She has had an Australian boyfriend for a year but they recently broke up. She has never been to a GP in Australia before, but she has missed two periods and thinks that she might be pregnant.

While the GP conducts a test for pregnancy, she asks Lita how she feels about the idea of being pregnant. Lita explains that she has been raised in a strict Catholic family and that she would be afraid to tell them.

As a Catholic, she does not agree with abortion, but if she is pregnant she doesn't think she will be able to complete her studies and she has no idea how she could financially support the child. She is on a student visa now, so she is afraid that if she doesn't keep up with her studies, she will violate the terms of her visa.

The GP suggests that Lita might want to speak to a counsellor of a similar cultural background to help her decide what she wants to do, and calls the local community health centre to help her to find one. She also suggests that a community legal centre can give her good advice relating to her visa, and gives Lita their contact details.

She discusses each of Lita's options in relation to her pregnancy, including methods of abortion, and she provides Lita with written material about each of her options. She offers to send Lita the information in Tagalog, if she would like, and she reassures Lita that it is her choice to make about her body and her pregnancy, and that the GP will support her decision, regardless of her choice. The GP then arranges a follow up appointment for Lita to get her test results.

## DISCUSSION

The GP listened to Lita's story without making assumptions about her family background, cultural or religious beliefs. She was able to make Lita feel comfortable enough to talk about the personal concerns and questions she was facing and she responded to Lita's situation without judgment. The GP recognised and addressed the issues particular to Lita's situation, and was not afraid to seek external assistance and support for issues that were outside her expertise. She provided information about all of Lita's options both verbally and in writing, and provided her with culturally appropriate resources and support to build her capacity to make informed decisions. Finally, the GP reassured Lita that her health choices would be respected and that she would be supported in her decision.

# PRINCIPLE 2
## CULTURAL AND LINGUISTIC APPROPRIATENESS

Cross cultural understanding is about being responsive to immigrant and refugee women's cultural and linguistic needs. It is the recognition of women's complex and multiple identities along with the impact of added layers such as migration, settlement and socioeconomic context.

Indicators:

- ✓ A qualified interpreter is used when and wherever possible. The gender of the interpreter is considered.
- ✓ If the situation is not critical and the woman indicates she wants to learn more about her sexual and reproductive health, she is referred to a community health centre or organisation such as MCWH. (Sessions conducted by trained bilingual and bicultural health educators who share the same gender, cultural and linguistic background of participants are an appropriate and effective form of health promotion).

- ✓ Encounters are non-discriminatory and non-judgemental, and conducted in a safe, non-threatening environment.
- ✓ Multilingual health information is provided to women and is available in a number of different mediums such as written information, DVDs, CDs, posters, charts and 3D models.

## SCENARIO 3

Mariam is a recently arrived refugee woman from Sudan. She has developed a good relationship with the nurse in the local community health clinic.

On a visit, she asks the nurse how to arrange for female genital cutting for her daughter. The nurse, having educated herself about FGC, understands the cultural meaning and deeply ingrained nature of the practice in some communities. Although FGC is illegal in Australia and the nurse personally believes that it is wrong, she explains to Mariam in a non-judgemental manner, the potential risks and harm associated with the practice and the legal implications.

The nurse calls a FARREP (Family and Reproductive Rights Education Program) worker who she has worked with in the past, and asks for her advice about how to best handle the situation. She then explores the custom with Mariam and answers any questions that Mariam has.

The nurse also refers Mariam to the FARREP service as she knows that FARREP workers provide support to women and their families affected by FGC in a culturally sensitive and appropriate way. At the end of the discussion, the nurse provides Mariam with multilingual information about the sexual and reproductive health issues associated with FGC.

## DISCUSSION

Regardless of her personal feelings about female genital cutting (FGC), the nurse understood this custom as a culturally complex one that is often viewed by family members as an important cultural tradition and a social necessity. The nurse discussed FGC with Mariam in a non-judgemental manner, while still informing her of the illegality of the practice in Australia and of the potential risks and harms to her daughter's health.

By approaching Mariam's inquiry in this way, the nurse had a better chance of preventing a practice that carries considerable risk of harm. The nurse also consulted with FARREP and offered Miriam multilingual education, increasing cultural and linguistic appropriateness.

Some communities & cultures favour & rely upon oral forms of information sharing. Being aware of this enables you to provide information for your client in the most appropriate form.

## PRINCIPLE 3
### ACCESS AND EQUITY

Barriers to accessing sexual and reproductive health services are complex and real for immigrant and refugee women. Access and equity should be founded on social justice principles; immigrant and refugee women have the right to access affordable and culturally appropriate sexual and reproductive health care. While equality means that individuals receive the same services regardless of their level of need, equity implies that people's access to services is based on the need for those services. Specific structures and policies should be put in place in order for women to exercise their right to access affordable sexual and reproductive health services.

Indicators:

- ✓ Additional time and resources are available for immigrant and refugee women, including flexible, longer and multiple appointment times.
- ✓ Information and delivery is tailored to the specific and diverse needs of all immigrant and refugee women, including women with disabilities, same-sex attracted women, outworkers, shift-workers, mothers, carers, rural women, young women and newly-arrived women.
- ✓ Encounters are non-discriminatory and non-judgemental, and conducted in a safe, non-threatening environment.
- ✓ A qualified interpreter is used when and wherever possible. The gender of the interpreter is considered.
- ✓ Health providers or organisations have flexible hours. If this is not possible, they are able to refer women to organisations that provide sexual and reproductive health education and information in an outreach capacity. (For example, MCWH goes to workplaces, community settings, homes, educational institutions and other locations any day of the week and at any time of the day suitable to the particular group or individual).

'Access means that Australian government services should be available for culturally and linguistically diverse (CALD) clients and accessible by them. Equity means that these services and programs deliver outcomes for CALD Australians that are on par with those other Australians can expect to receive.'

DIAC, 2012

## SCENARIO 4

Linh is a newly arrived young Vietnamese woman. She has a job working night shift at the chicken processing plant.

She has lower abdominal pain every time she gets her period, but does not know why. Due to the nature and hours of her work, she cannot find the time to access mainstream services. She is also worried that she will lose her job if she takes time off work.

As the pain grows worse, she finally makes an appointment with a local GP, as she doesn't know where to find a Vietnamese speaking doctor. The GP she sees is male, and she is very embarrassed that she has to talk to him about these sensitive issues. Although she has requested an interpreter and one is provided, the interpreter is also male.

The GP ascertains that Linh has a very basic level of knowledge about women's health and her body and senses that she is very uncomfortable and distressed to be there. He provides her with the name of some medicine to take for her lower abdominal pain but also looks up other clinics in her area with Vietnamese-speaking female GPs.

Linh indicates via the interpreter that she wants to know about contraception options and the menstrual cycle. The GP understands the difficulties with Linh's work hours so he contacts a women's health organisation on her behalf and arranges for a Vietnamese Health Educator to visit her at home, at a time of her convenience. He also asks the organisation to send Linh information in Vietnamese.

The GP assures Linh that it is a free service.

## DISCUSSION

The GP's commitment to client-centred care prompted him to explore ways of meeting his client's needs within the limits of the clinical setting. The GP was sensitive to the fact that Linh was uncomfortable because the interpreter that was provided was male. By referring her to an organisation that provides bilingual health education by women at any time, the GP provided Linh with greater access to health information. He was aware of Linh's financial situation and also made sure she knew that the service was free. The GP also encouraged greater equity and access by providing Linh with the names of other GPs in the local area who speak Vietnamese and also by providing information in Linh's own language.

# PRINCIPLE 4
## COLLABORATION

Collaboration is needed between organisations that work with immigrant and refugee women and mainstream health providers in order to share information and best practice ideas.

Collaboration also ensures that women are well linked with their local ethno-specific/multicultural women's health and welfare services.

Indicators:

- ✓ Mainstream health providers collaborate with women's ethno-specific/multicultural health and welfare agencies and refer women to appropriate sexual and reproductive services.
- ✓ Mainstream health providers collaborate with women's ethno-specific/multicultural health and welfare agencies to promote appropriate services among immigrant and refugee women.
- ✓ Community health centres collaborate with information centres that specialise in offering multilingual information about women's sexual and reproductive health.

## SCENARIO 5

A Spanish speaking woman arrives at a local hospital with her 10 year old son. She is badly injured and appears very scared and shaken.

The woman speaks very little English. The child says he can interpret. A nurse sees the woman and decides not to use the son as an interpreter and instead calls for the hospital's Spanish interpreter. The woman tells the interpreter that she hurt herself in an accident. The nurse suspects a situation of intimate partner violence.

The nurse takes the son to the children's play area, where there are toys, magazines and a television.

After treating the woman for about half an hour, and with some gentle questioning via the interpreter, the woman reveals that her partner has been violent towards her, but that it was her fault, and she just wants to go home. The nurse listens without judgement and tells her about culturally specific organisations that work with women who experience violence. The nurse also prints off information in Spanish for the woman about where she can go for help. When the woman leaves the hospital, the nurse contacts the multicultural crisis support service, and notifies them of the incident.

## DISCUSSION

While it is often convenient to rely on children to interpret for their parents, the nurse in this scenario was sensitive to the needs of the mother and the child. The National Health and Medical Research Council's (NHMRC, 2004) advice for practitioners on communicating with clients is that qualified interpreters should be used when and wherever possible. This is backed up by other cultural diversity guidelines at both national and state levels. In this situation, a qualified adult interpreter was required to ensure a thorough and comprehensive assessment. The nurse also suspected that domestic violence was involved, and displayed cultural sensitivity by not forcing her own ideas onto the patient, instead referring her to a multicultural organisation that works with immigrant women. The nurse has educated herself about where to go for multilingual resources about women's issues, and is able to provide this information to the woman.

## THINGS TO THINK ABOUT – WORKING WITH IMMIGRANT AND REFUGEE WOMEN

- Everyone has a culture! Think about your own. What makes you, you? How might your culture influence your response to illness or the type of care you give your patients?
- You can never know enough. Seek to broaden your understanding about cultural ideas and concepts. Reflection and learning is an ongoing process.
- Be sensitive about issues of power, trust and respect.
- Cultural difference can sometimes mask other things such as socio-economic position, gender, class and age which might be more important to women.
- Make efforts to accommodate women's cultural values and beliefs in a way that does not compromise safety.
- Use open ended questions to understand women's beliefs and ideas.
- For example: What treatment do you expect? What fears do you have about your treatment? Do you observe any religious or traditional practices that will affect immediate care? Tell me about your migration experience.

## WANT TO KNOW MORE?

You can access more information on cross-cultural understanding on our website or contacting us on the phone numbers below.

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

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