October 2018

Submission to the Consultation on the National Women's Health Strategy 2020-2030

Migrant and Refugee Women's Health Partnership and Harmony Alliance: Migrant and Refugee Women for Change welcome the opportunity to make a joint submission to the consultation on the draft National Women's Health Strategy 2020-2030. A dedicated focus on women's health is a significant step towards improving Australia's population health and wellbeing.

Migrant and Refugee Women's Health Partnership
The Partnership is a national initiative bringing together health and community sectors to address systemic barriers to access to health care for migrants and refugees, acknowledging and responding to the unique challenges faced by women within this cohort.

Harmony Alliance: Migrant and Refugee Women for Change
The Harmony Alliance is one of six National Women's Alliances funded by the Australian Government to promote the views of all Australian women, to ensure their voices are heard in decision-making processes. Its purpose is to provide a national inclusive and informed voice on the multiplicity of issues impacting on experiences and outcomes of migrant and refugee women, and to support women to directly engage in driving positive change.

Strategy context and background

- Recommendation 1: Recognise specific health access and experience issues facing women from migrant and refugee backgrounds under Women's health at a glance and Priority populations

Conditions surrounding migration and resettlement may exacerbate health inequities and expose women and their families to increased health risks and poorer health outcomes. Australian Bureau of Statistics estimates that there are over 3 million overseas-born women in Australia, and about 460,000 of them reported that they do not speak English well or at all.[1]

Women of migrant and refugee background are at increased risk of poor health across pregnancy (e.g. perinatal mortality, pre-term birth and low birth weight),[2] mental health (e.g. anxiety, depression and post-traumatic stress disorder)[3] and reproductive health.[4]

Factors contributing to health disparities are multi-faceted but may include specific risks related to prior environments (e.g. infectious diseases and anaemia), or specific population based risks (e.g. thalaessamia, diabetes mellitus, previous FGM).[5,6,7] Many factors, however, relate to broader issues such as access to care,[8] interactions with the health system and health literacy.[9]

Challenges accessing care include socioeconomic factors, such as visa class, finance, transport as well as language.[10] Many have lower levels of health literacy, lack familiarity with preventative health care, and have differing personal concepts of health and illness,[11] and therefore are more likely to access acute and emergency care.

Resettlement is an overwhelming process that involves issues that lead to many migrant and refugee women failing to prioritise their own health. Adaptation to a new culture and language barriers often result in social isolation and exclusion, all of which exacerbate psychosocial risk and vulnerability.[12] Women seeking asylum and those from refugee or refugee-like backgrounds, in particular, are at increased risk of poorer health and wellbeing due to both pre-migration experiences, including exposure to trauma, and post-resettlement experiences.

- Recommendation 2: Include 'women affected by gender-based violence' as a cohort under Priority populations

While noting that the health of women affected by violence is addressed specifically under Priority 4 – Conditions where women are overrepresented, in view of the impact of violence on women's physical and mental health, the strategy should provide specific focus on

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[1] Australian Bureau of Statistics. Census of Population and Housing. ABS; 2016.
[2] Higginbottom M, Morgan M, Alexandre M, et al. Immigrant women's experiences of maternity-care services in Canada: A systematic review using a narrative synthesis. Systematic Reviews. 2015;4:13/2-13/30.
[3] Kirkmayer L, Narasiah L, Munoz M, et al. Common mental health problems in immigrants and refugees: General approach in primary care. CMAJ. 2011;183(12):E959-67.
[4] Keygnaert I, Guieu A, Ooms G, et al. Sexual and Reproductive health of migrants: Does the EU care? Health Policy. 2014;114(2-3):215-25.
[5] Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. CMAJ. 2011;183(12):E824-E925.
[6] Correa-Velez I, Ryan J. Developing a best practice model of refugee maternity care. Women and Birth. 2012;25(1):13-22.
[7] Almeida LM, Caldas J, Ayres-de-Campos D, et al. Maternal healthcare in migrants: A systematic review. Maternal and child health journal. 2013;17(8):1346-54.
[8] Higginbottom M, Morgan M, Alexandre M, et al. Immigrant women's experiences of maternity-care services in Canada: A systematic review using a narrative synthesis. Systematic Reviews. 2015;4:13/2-13/30.
[9] Mladovsky P, Rechel B, Ingleby D, et al. Responding to diversity: an exploratory study of migrant health policies in Europe. Health Policy. 2012;105(1):1-9.
[10] Correa-Velez I, Ryan J. Developing a best practice model of refugee maternity care. Women and Birth. 2012;25(1):13-22.
[11] Almeida LM, Caldas J, Ayres-de-Campos D, et al. Maternal healthcare in migrants: A systematic review. Maternal and child health journal. 2013;17(8):1346-54.
[12] Ibid.

women affected by gender-based violence. The magnitude of the impact of gender-based violence on women's health and wellbeing is such that it warrants a much stronger focus under the women's health strategy. There is a role for the strategy in facilitating the integration and coordination, insofar as women's health is concerned, of various government strategies aimed at addressing family and domestic violence.

Policy principles and Strategy objectives

- Recommendation 3: Include a focus on social determinants of health as one of the policy principles for the Strategy

Building on the National Women's Health Policy 2010, which highlights the social determinants of health in view of their impact on women's lives and wellbeing, the Strategy should provide a great focus on addressing those determinants that generate social stratification in the society and determine differences in exposure and vulnerability to health-compromising conditions

- Recommendation 4: Recognise the need for, and invest in, tailored and culturally responsive approaches to health literacy, as well as health system literacy, and health promotion, with a view to reaching women from migrant and refugee backgrounds

We welcome the focus on prevention and the role that health literacy plays in the prevention strategies. Along with the health system response, health literacy should be a strategy under each of the priorities.

Based on the Partnership's and the Harmony Alliance's consultations with stakeholders nationally, health system literacy is equally important in health promotion. Australia's health system is complex, increasingly individualised and siloed, and relies on individual advocacy.

Strategies to facilitate health literacy and health system literacy, health promotion and disease prevention should factor in the diversity of ethnic communities and the complexity in their health experience, adopting a lens that would make it applicable for different community groups. This includes the delivery in a culturally specific way, in language, and led by community and women.

Strategies should not focus only on recently arrived women, but be inclusive of women from migrant and refugee backgrounds who have been in Australia even for extended periods of time.

There is structured provision of information to newly arrived refugees and some migrant women within settlement support programs, however, this is usually provided only initially in the short term. There are also significant gaps for women who do not have access to such programs.

It is also important to include women born in Australia to parents from migrant and refugee backgrounds—despite being born in Australia, a part of this cohort may experience health literacy gaps due to strong cultural and religious considerations.

It is critical not to 'reinvent the wheel', with a significant amount of resources and tools available already, and instead focus on improving access to, and facilitate distribution of, existing relevant information. Despite the abundance of information resources, women struggle to assess and understand what resources can be trusted as authoritative. A strategic approach should therefore seek to consolidate the fragmented resources and information.

Further, consideration should be given to tailoring the information to communities, including translation into other languages and oral, rather than written, presentation of information, where appropriate. The use of technology is an important mechanism for such communication and outreach and can facilitate the creation of easily accessible health and health literacy information. Tools should be co-designed with migrant and refugee women to ensure they are person-centred, easy to navigate, and responsive to users.

We further welcome the object to underpin service access improvement with investment in skilled workforce.

It is vital that health providers are equipped with the personal and professional tools to provide person-centred and culturally responsive care that recognises the heterogeneity of individuals within cultures. Our colleges, societies and health care settings need to support these endeavours by providing culturally responsive care, with systems that support the engagement of interpreters, and facilitate training and skills development for all health staff.

Health practitioners should have the skills to work with women from refugee and migrant backgrounds, being aware of culture, community, past experiences and their influence on women's expectations for care, health beliefs and behaviours.[10] It is particularly important for health practitioners to be aware of the need to provide trauma-informed care, incorporating such factors as patient-centred communication and care, safe clinical environments and knowing when to refer for trauma screening.

Focus should be on supporting the capacity of health practitioners to communicate with migrant and refugee women. Language and communication barriers include the communication capacity of both the woman and the health practitioner and are among the most serious obstacles to safe and quality care.[13,14] Engaging interpreters meets the communication needs of both parties, and is a vital part of ensuring optimal health care for women who are not fluent in English.

Engaging interpreters and not relying on ad hoc facilitators of interpretation (such as family members or friends) is recognised as best practice, and has been found to: decrease communication errors; improve the delivery of person-centred care; reduce unnecessary tests and treatments; improve clinical outcomes; raise the quality of care to the same level as that for patients without language barriers; and improve patient satisfaction.[15]

Further, women with low English proficiency or health literacy may lack the confidence necessary to be active participants in the process and to provide the practitioner with relevant information. Individual experiences can impact on women's knowledge of the healthcare system and capacity to navigate it. This may include poor understanding of their rights as consumers in the healthcare system. Women may also lack confidence in the healthcare system and need to be assured of the confidentiality between themselves, health practitioners and, if required, interpreters. Women from migrant and refugee backgrounds

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[13] Flores G. The Impact of Medical Interpreter Services on the Quality of Health Care: A Systematic Review. *Medical Care Research and Review.* 2005; 62(3): 255-299.
[14] Rowse J, Anderson K, Phillips C, Chan B. *Critical case analysis of adverse events associated with failure to use interpretersfor non-English speaking patients.*: Australian National University Medical School; 2017.
[15] Karliner LS, Jacobs EA, Chen AH, Mutha S. Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency? A Systematic Review of the Literature. *Health Services Research.* 2007;42(2):727.

may be more likely to feel comfortable around female health practitioners and interpreters,[16] particularly when disclosing women's health issues.

Culturally responsive practice needs to be embedded in health practitioner education, training and professional development to ensure improved individual client health and well-being outcomes.[17]

Comments on specific priority areas

Priority area 1 – Mental health and wellbeing

We strong support the focus on mental health and wellbeing. Adaptation to a new culture and language barriers often result in social isolation and exclusion, all of which exacerbate psychosocial risk and vulnerability. Women seeking asylum and those from refugee or refugee-like backgrounds, in particular, are at increased risk of poorer health and wellbeing due to both pre-migration experiences, including exposure to trauma, and post-settlement experiences. In particular, the mental health needs and the complexity of emotional issues experienced by migrant and refugee women are often overlooked in the process of settlement.

A recent longitudinal study on the settlement of refugees indicates that Women were also more likely to have a high risk of mental health problems.[18] Women were significantly more likely than men to report poorer levels of health, which is different from the trend in the general Australian population, and were also more likely to experience symptoms of PTSD.

Priority area 3 - Sexual and reproductive health

We welcome the inclusion of an action to address late presentation to antenatal care for women from migrant and refugee backgrounds, and support further strategies to promote earlier uptake of antenatal care among migrant and refugee women. Health promotion and antenatal screening may be less effective in reaching migrant and refugee women, as opposed to Australia-born women, resulting in inequalities in maternal and perinatal health outcomes. For example, in 2013, women born overseas in predominantly non-English speaking countries were 10 per cent less likely to attend antenatal care early in pregnancy than women born in Australia. However, they were almost equally as likely as other mothers to attend seven or more antenatal visits throughout the course of the whole pregnancy (86% of mothers born in other countries compared with 87% of Australian-born mothers).[19]

Consideration should also be given to the importance of antenatal care for engaging with migrant and refugee women to identify health and mental health problems and make a substantial intervention on health promotion and prevention, as well as for gender-based violence screening purposes. It should be noted that pregnancy is often the first time a newly arrived woman interacts with health services therefore the information needs are quite high. In addition, there are many cultural issues that surround birth, and relevant clinicians need to be able to understand and factor those in the provision of care.

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[16] Yelland J, Riggs E, Szwarc J, et al. Compromised communication: A qualitative study exploring Afghan families and health professionals' experience of interpreting support in Australian maternity care. BMJ Quality& Safety. 2016;25:E1.

[17] Tawara D, Goode M, Dunne C, et al. The Evidence Base for Cultural and Linguistic Competency in Health Care. National Centre for Cultural Competence. Centre for Child and Human development, Georgetown University; 2006.

[18] DSS, Building a New Life in Australia (BNLA) the longitudinal study of humanitarian migrants, findings from the first three waves, follows 1,509 humanitarian migrating units who arrived in Australia or had their permanent visas granted in the six months between May and December 2013.
Wave 1 Oct. 2013- March 2014 / wave 2 Oct. 2014- March 2015 / Oct. 2015- March 2016

[19] Australian Institute of Health and Welfare, *Australia's Health 2016* (2016)

Priority area 4 - Conditions where women are overrepresented

- Recommendation 5: Recognise the impact of gender-based violence on women's health and wellbeing

Family, intimate partner and sexual violence are among the forms of gender-based violence. Importantly, other forms of gender-based violence that have significant impact on women's health and wellbeing include violence perpetrated by non-intimate partners, such as child-on-parent abuse, elder abuse, perpetrated by in-laws and other relatives, and perpetrated by non-family relations. Non-physical violence, including emotional abuse, must also be clearly recognised. Further, complex forms of violence, including dowry abuse, forced marriage and female genital mutilation (FGM) should be treated first and foremost as forms of gender-based violence.

While research is not yet sufficient to ascertain whether incidence of violence is any more or less prevalent for women from migrant and refugee backgrounds than across the rest of Australian society, women from these cohorts are less likely to seek assistance in situations of violence due to compounding barriers and require tailored solutions.

This recommendation is informed, in particular, by the findings of the Harmony Alliance's consultation to inform the development of the Fourth Action Plan of the National Plan to Reduce Violence against Women and their Children 2010-2022.

Investing in research

- Recommendation 6: Ensure adequate disaggregation of existing and future data and research to develop better understanding of health access, experiences and outcomes of women from migrant and refugee backgrounds.

For more information or to discuss the contents of this submission further, please contact:

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