

Culturally and Linguistically Diverse Women in the Australian Capital Territory

*Enablers and Barriers to Achieving Social
Connectedness*

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About Women's Centre for Health Matters Inc.

Women's Centre for Health Matters Inc. (WCHM) is a not for profit incorporated association that works with women in the ACT and surrounding region, with a focus on women who experience disadvantage. WCHM uses health promotion, community development, and capacity building to provide information and skills that empower women to enhance their own health and wellbeing. WCHM undertakes research and advocacy to influence systems' change with the aim to improve women's health and wellbeing outcomes.

WCHM is funded by ACT Health. The findings and recommendations of this report are those of WCHM and not necessarily those of ACT Health.

About Multicultural Women's Advocacy Inc.

Multicultural Women's Advocacy Inc (MWA) is the peak body representing a united voice for women from culturally and linguistically diverse (CALD) backgrounds living in the ACT and its surrounding region. It serves to advocate, exchange information, and cooperate with other community groups and government agencies to address issues of access and equity in order to improve the status of CALD women in the ACT community and to enable them to reach their full potential.

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Executive Summary

This report is intended to serve as a sister report to *Marginalised and Isolated Women in the Australian Capital Territory (2008)* and *Social Determinants of Women's Health in the Australian Capital Territory (2008)*. Accordingly, this report recognises Maslen's statements that certain groups within society are more at risk of poor health and wellbeing as a consequence of social factors, and that women from culturally and linguistically diverse backgrounds (CALD) are one such group.

Despite evidence that health and wellbeing can be seen as gendered (for example, women's health may suffer as a result of gender roles, domestic violence and discrimination), there is very little documented knowledge in relation to women's health and wellbeing in the Australian Capital Territory (ACT), and even less on the marginalised sub-groups within. Consequently, this report aims to develop a profile of CALD women in the ACT, and to determine the factors that are contributing to their levels of social connectedness and wellbeing (or lack thereof). It is through this analysis that this report will develop a range of suggestions and recommendations. In addition to the limited existing literature on the topic, this report seeks to provide services in the ACT with an evidence base from which to work with women of CALD backgrounds, and potentially shape the development of appropriate social policy.

Section two of the report reviews the existing literature on the enablers and barriers to women from CALD backgrounds achieving social connectedness, and the associated impacts on their health and wellbeing. Research from Canada, the United States of America (USA) and the United Kingdom (UK) is discussed, before addressing national studies. Finally, previous research undertaken in the ACT is examined. The studies reviewed did identify some of the determining factors in social connectedness and the social determinants of health for CALD women, including: the lack of understanding around culturally appropriate support in Western nations; the importance of social networks; barriers to accessing services such as language, insufficient childcare, problems navigating systems, immigration status, transport, discrimination and changes to family dynamics; the impact of trauma; challenges for health promotion; domestic violence; the financial situation of many CALD women; the experience of becoming refugees; and the impact of acculturation. These factors are common themes in the current qualitative data elicited in the research process.

Section three of this report describes the research design. It notes that it is a qualitative study, and explains the way in which participants were recruited. The demographic details of participants are also examined. The range of services involved in the research process is outlined briefly, before going on to describe the methods of the research, and of data analysis. Finally, the ethics of the research were considered.

Section four outlines the results of this research. Thematic analysis of the qualitative data indicated fifteen themes. These themes are immigration and emerging communities; language concerns; domestic violence; drugs and/or alcohol; legal issues; isolation; the need for cultural sensitivity; children and child protection; loss of qualifications and careers; discrimination and racism; limited transport; unfamiliarity with available services; mental health; trauma; and the elements that enhance social connectedness. The information provided by participants is broken down into these themes and described under each sub-heading.

Section five compares the results of the research with those of international, national and local studies discussed in section two. Further correlation between the results of this research and those of others on a more thematic basis is provided. Section six of the report makes concluding remarks.

This report makes a number of recommendations. These recommendations were developed in consultation with the women who participated in the study, ACT Government and community service providers, Multicultural Women's Advocacy (MWA), WCHM Board of Directors and WCHM staff.

Recommendations

In order to support ACT women of CALD backgrounds who are isolated and marginalised, a number of steps need to be taken to improve social connectedness. It is recommended that:

1. Women's Centre for Health Matters Inc.
 - a) Launch the report and its major findings by convening a forum that invites multiple Government and non-government agency representatives. A key outcome of the forum will be a preliminary document that outlines potential solutions to the issues raised within the report; and
 - b) Foster the formation of an inter-agency collaborative group of key stakeholders relating to identified gaps with the twin aims of raising awareness to effect change in addressing areas of unmet need across service sectors and to influence improvement of support services for women of culturally and linguistically diverse backgrounds in the ACT.
2. Women's Centre for Health Matters Inc. in collaboration with other agencies undertake additional research to:
 - a) Enhance the report's findings relating to country of birth of women within the ACT. The report's findings represented women of 14 different countries of birth with some groups comprising very small numbers. Whilst these results support the findings of this report it is understood that the inclusion of survey data from ACT women from other countries of birth categories as collected by the Australian Bureau of Statistics will provide an enhanced comprehensive and current representation of CALD women within the ACT. Such research could be conducted through a collaborative arrangement with the Multicultural Women's Advocacy Incorporated; and
 - b) Investigate established local, national and international evidence-based cultural awareness training programs that have a particular emphasis on meeting other areas of unmet needs, for example, the Beyond Blue national depression initiative model that encompasses diversity, multiculturalism and mental health. The review would focus on identifying the key components (e.g. access and equity), outcomes and critical success factors of such programs and recommending a preferred model or models that could be implemented within ACT health and wellbeing service sectors across professional groups.

1 Introduction

Australia has long held the belief that it is an egalitarian nation. Indeed, one of our primary values is the idea of getting a 'fair go'. Although many social researchers have voiced their opinions that this is not the case, the accuracy of these beliefs is rarely contested among the majority of the Australian population. Despite a somewhat questionable history in which Indigenous Australians were deprived of citizenship, a 'white Australia' was promoted through restrictive immigration policies, and women were forced to fight for their entitlement to vote, most Australians would claim that they live in a fair and just society.¹ This in itself raises some concern as to how ingrained social inequality has become.

The choices we make, especially in relation to areas of health, are a consequence of our social circumstances. While we often might blame health concerns on lifestyle or genetic predisposition, we largely ignore the overwhelming social inequalities that affect the distribution of ill-health.² Research has consistently demonstrated that socio-economic status is strongly correlated with health outcomes. Furthermore, health can be seen as following a social gradient (not confined to economic grounds). That is, the higher an individual's social position, the better the health they experience.³ The existence of a social gradient suggests that the circumstances in which individuals live and work can play an important role in determining health outcomes.

Social inequalities can have a significant negative effect on the health and wellbeing of individuals, groups and communities. These inequalities can be seen as social determinants of health, and are made up of a range of factors which can influence health and wellbeing. The social determinants of health include, but are not limited to "housing; income and its distribution; food; security; education and literacy; unemployment and employment security; early life development; Indigenous status; social safety nets; social exclusion; and access to quality health care services".⁴

The social determinants model of health is aligned with the World Health Organisation (WHO) definition of health; that is, that good health involves more than the lack of disease or sickness, but incorporates "a state of complete physical, mental and social wellbeing".⁵ While the social determinants model of health does not deny the existence of biomedical influences on health and wellbeing, it does argue that social factors can determine the development of the biomedical influences themselves. Therefore, broad social inequality can result in disadvantaged groups becoming more at risk of poor health and wellbeing.

The recognition that certain groups within society are more at risk of poor health and wellbeing as a consequence of social factors is a vital step in eliminating this inequality. Previous research commissioned by WCHM identified women who are socio-economically disadvantaged, women with mental health issues, and women from CALD backgrounds as being particularly at risk of poorer health outcomes in the

¹ Sarah Maslen, *Marginalised and Isolated Women in the Australian Capital Territory*, (Canberra: Women's Centre for Health Matters, 2008), 7.

² Alastair Greig, Frank Lewins and Kevin White, *Inequality in Australia* (Cambridge: Cambridge University Press, 2003).

³ Michael Marmot and Richard G. Wilkinson, eds., *Social Determinants of Health*, 2nd Edition (Oxford and New York: Oxford University Press, 2006).

⁴ See Sarah Maslen, *Social Determinants of Women's Health in the Australian Capital Territory*, 3.

⁵ World Health Organisation, *Constitution of the World Health Organisation*, 45th Edition (Geneva: World Health Organisation, 2006), 1.

ACT.⁶ The concept of 'CALD' itself is something of a loaded term. Whilst it is regrettable that such a label should exist, it is nonetheless helpful in defining a group who are undeniably disadvantaged, for the intention of targeting research. Having said that, the definition of CALD women for the purposes of this report will be limited to those women who were born in a country other than Australia, and who may speak a language other than English at home. These women may have migrated to Australia, or they might be refugees or asylum seekers, and all "are at risk of marginalisation and isolation socially, culturally, politically and economically."⁷ This is compounded by numerous gaps in relevant service provision in the ACT. These gaps will be identified later in the report.

Maslen's research also acknowledges that, despite evidence that health and wellbeing can be seen as gendered (for example, women's health may suffer as a result of gender roles, domestic violence and discrimination), there is very little documented knowledge in relation to women's health and wellbeing in the ACT, and even less on the marginalised sub-groups within. Consequently, this report aims to develop a profile of CALD women in the ACT, ascertaining the factors that are influencing their social connectedness and wellbeing (or lack thereof), and making recommendations accordingly. In addition to the limited existing literature on the topic, this report seeks to provide services in the ACT with an evidence base from which to work with women of CALD backgrounds, and potentially shape the development of appropriate social policy.

⁶ Sarah Maslen, *Social Determinants of Women's Health in the Australian Capital Territory* (Canberra: Women's Centre for Health Matters, 2008).

⁷ Sarah Maslen, *Marginalised and Isolated Women in the Australian Capital Territory*, (Canberra: Women's Centre for Health Matters, 2008), 22.

2 Literature Review

There is a growing body of international literature on the experience of migrants and refugees in their host countries. While there remains a need for further gender specific research, researchers are largely in agreement that it is imperative for people of CALD backgrounds to establish sound social networks as part of settling into a new country.

A recent Canadian article highlights the gap in Western nations' conceptions of social support. It contends that the Western nations that generally accept larger numbers of legal immigrants – such as Canada, the United States of America (USA) and Australia – lack an understanding of culturally appropriate support options. The importance of social support is often overlooked by governments. The experience of new arrivals can easily become one of social isolation given that “social networks may be deficient and social relations may either be disrupted or devalued in the host country.”⁸ It is important to remember that, while immigrants generally have some time to prepare for the transition to their host country, and may have financial resources behind them, refugees have no such luxury. These individuals are escaping war or persecution and the vast majority do not possess adequate finances or personal identification documents.⁹ Consequently, refugees often experience difficulty in their pursuit of education and employment even in their host country, compounding their isolation and marginalisation.

The article went on to identify a range of issues that were presenting challenges among their research sample of Somali and Chinese individuals. These included language problems, employment, navigation of systems, changes to family dynamics, insufficient childcare, immigration status, expectations not matching reality and discrimination.¹⁰ Of particular significance was the fact that participants highlighted the difficulties associated with learning English as an adult because of time constraints, responsibilities and age (although the same group recognised its importance). The issue of their qualifications not being recognised in their host country was also a huge barrier to gaining employment.¹¹ These challenges were sometimes able to be avoided by engaging in social networks, in an attempt to emulate the highly supportive social environment that so many immigrants and refugees had experienced in their home countries. For newcomers however, weak or non-existent social networks made this a challenge in itself. It is hardly surprising then, that most new arrivals in the study preferred to seek support from organisations where they were served in their own language, and favoured workers of their own ethnic background. The use of translation services tended to discourage access to services by newly arrived women.¹² The social isolation and marginalisation which are inherent in the challenges outlined above will often lead to poorer health and wellbeing.

The health needs of individuals from CALD backgrounds are often not well understood among Western nations, largely because surveys used in health

⁸ Miriam Stewart, Joan Anderson, Morton Beiser, Edward Mwakarimba, Anne Neufeld, Laura Simich and Denise Spitzer, “Multicultural meanings of social support among immigrants and refugees,” *International Migration* 46, no. 3 (2008), 126.

⁹ Miriam Stewart et al, “Multicultural meanings of social support among immigrants and refugees,” *International Migration* 46, no. 3 (2008).

¹⁰ Ibid.

¹¹ Ibid.

¹² Ibid.

research are not culturally and linguistically appropriate.¹³ Despite the stress of adapting and integrating into a new country, and the impact of acculturation among CALD women, health promotion still does not generally (successfully) target this population. A Canadian study noted that most information regarding health was written in English or French, with only minimal information provided in other languages. Furthermore, the provision of only written information presumes that women from CALD backgrounds are literate in their own languages, when this may not be the case.¹⁴

While this Canadian study is now ten years old, the issue of health promotion for women of CALD backgrounds remains pertinent. It found that there was considerable difference between those women who had a good understanding of English, and those who did not. Those who could speak English tended to avail themselves of written health information, whilst those who spoke only their native language were forced to rely on family or friends for information.¹⁵ Naturally, concerns arise regarding confidentiality of personal information, and the lack of health care and information available to women who feel their health is too personal to discuss with others. Domestic violence is one example of the issues that women often keep to themselves.

Research suggests that violence occurs within one quarter of all marriages.¹⁶ In reality, the occurrence of domestic violence may be much more common. The culture of silence associated with such violence means that the estimation of frequency is very conservative, and that the rates of domestic violence in some communities are largely unavailable. Immigrant and refugee populations are a particularly neglected group in terms of statistical representation of domestic violence. This is partially due to the “tendency to stereotype domestic violence in some ethnic groups as an inherent part of their cultural repertoire...[and that] domestic violence is higher among immigrants because they import it with them.”¹⁷ Not only are such views inaccurate, they also serve to perpetuate non-response to domestic violence among CALD populations, and are thus responsible for the ongoing trauma of already vulnerable women. These women’s experiences are compounded by “...limited host language skills, lack of access to dignified jobs, uncertain legal statuses and [potentially traumatic] experiences in their home countries, and thus their alternatives to living with their abusers is very limited.”¹⁸ This is exemplified in the experiences of so-called ‘mail-order brides.’ To make matters even more difficult, the social and emotional consequences of leaving one’s abusive partner can be significant in some cultural communities. If a woman chooses to leave her partner because of violence, “she runs the risk of being ostracised by her family [and/or community] because she left and thus could not possibly be a ‘good wife,’ and she feels profoundly guilty.”¹⁹ The same factors noted above again impact on women in these situations, and – not surprisingly – social isolation becomes the natural consequence.

Research on women from a Russian background also highlighted the experience of migrant and refugee women in violent relationships. The research was focused on Russian women who were living in New York, and its findings were largely consistent with those reported above. Furthermore, it pointed out that some cultural

¹³ U.K. Choudhry, “Health promotion among immigrant women in Canada,” *Journal of Nursing Scholarship* 30, no. 3 (1998).

¹⁴ *Ibid.*

¹⁵ *Ibid.*

¹⁶ Cecilia Menjivar and Olivia Salcido, “Immigrant women and domestic violence: Common experiences in different countries,” *Gender and Society* 16, no. 6 (2002).

¹⁷ *Ibid.*, 901.

¹⁸ *Ibid.*, 901-902.

¹⁹ *Ibid.*, 905.

communities (such as Russian) might not know about the available domestic violence services simply because no such support existed in their country of origin.²⁰ The research also

identified a wide range of needs that they [the Russian women participants] have at all stages of relationships ranging from information that would help them live independently, with assistance with legal issues, and with basic social and health services...women also had critical material needs including food, childcare, housing and transportation.²¹

While it is imperative for women experiencing domestic violence to have these needs met, this is also vital when looking at women from CALD backgrounds on a more general level.

Individuals are generally able to have their needs met through an extensive network of friends, family and service providers. This network is often referred to as 'social capital.' Unfortunately, women from CALD backgrounds rarely have established networks, particularly if they are refugees, and thus they can have significant difficulty in accessing resources from formal institutions.²²

Refugees, having generally been forced into migration through traumatic circumstances, often experience threats to their identity. These individuals have had very little or no control over the changes in their lives, and subsequently suffer post traumatic stress disorder (PTSD) and associated anxiety and depression.²³ The loss of control over their lives often means that refugees arrive in their host countries knowing very few people, and with extremely limited resources. The social isolation that is inherent in so many refugee experiences creates real problems in being able to connect with services, particularly when the individual does not speak the language. While once cultural and religious communities were encouraged and were a key factor in developing vital social capital among newer arrivals, world events have caused some change. Once seen as contributing positively to social integration, these groups are often now portrayed as threatening the solidarity and social cohesion of the mainstream population. Indeed, "in the wake of the 9/11 terrorist attacks...migration is increasingly framed in relation to terrorism, crime, unemployment and religious fundamentalism, rather than offering new opportunities."²⁴ While the study that states this was conducted in Britain, it is reasonable to suggest that these perceptions are also prevalent in other Western countries – including Australia.

The Australian Government accepts approximately 14, 000 humanitarian and refugee entrants each year.²⁵ One group of refugees that can be particularly vulnerable are asylum seekers. Colloquially (and disparagingly) known as 'boat people' and 'queue jumpers,' asylum seekers are often faced with discrimination and a range of practical

²⁰ Marie Crandall, Kirsten Senturia, Marianne Sullivan and Sharyne Shiu-Thornton, "No way out"; Russian women's experiences with domestic violence," *Journal of Interpersonal Violence* 20, no. 8 (2005).

²¹ Ibid, 949.

²² Pauline Hope Cheong, Rosalind Edwards, Harry Goulbourne and John Solomos, "Immigration, Social Cohesion and Social Capital: A Critical Review," *Critical Social Policy* 27, no. 1 (2007).

²³ Lada Timotijevic and Glynis M. Breakwell, "Migration and Threat to Identity," *Journal of Community and Applied Social Psychology* 10 (2000).

²⁴ Pauline Hope Cheong et al, "Immigration, Social Cohesion and Social Capital: A Critical Review," *Critical Social Policy* 27, no. 1 (2007), 34.

²⁵ Refugee Council of Australia, *Who bears the cost of Australia's Special Humanitarian Program? Research into the impact of travel costs on new Special Humanitarian entrants and their proposers* (Melbourne: Refugee Council of Australia, 2008).

problems in Australia. First and foremost are concerns regarding the legal status of asylum seekers. While some arrive on visitor or student visas, others enter illegally. Either way, they face a long and uncertain process in applying for refugee status on the basis of fear of persecution in their own country.²⁶ Add to this the mandatory detention that so many asylum seekers experience, and the situation can become quite traumatising for people who have already gone through so much. Even if refugee status is granted, individuals still encounter many hurdles. Healthcare is a vital support which often brings problems for refugees. Centrelink payments are low and limit the ability for individuals to pay for dental care or medications (neither of which are covered by Medicare). Furthermore, "fear, isolation, unfamiliarity with the health system and poor English language skills may also contribute to their disadvantage in terms of healthcare access."²⁷

A later study of healthcare delivery focused on the experience of Afghan refugees and found that many factors compounded the effect on the health and wellbeing of the group which included gender, age, marital status, housing, economic status, changed traditional roles, generational conflict, personal levels of resilience, the availability of social support, cultural clashes, and problems with settlement support services.²⁸ All of these factors, in addition to refugees' isolation from family and friends, the loss of any sense of belonging and even the loss of their professional identities, contribute to the frequent rates of anxiety and depression. Despite the obvious need for healthcare (whether physical or emotional), Afghan refugees reported a range of barriers in accessing services. They explained that many services and procedures were incompatible with Islamic religious beliefs. They had also encountered discrimination by service providers and were often excluded on the basis of their language (minimal written information is available in Dari, and there is a lack of interpreters). Consequently, Afghan refugees felt insecure in accessing services without family support, and struggled to negotiate Australia's healthcare system.²⁹ While accessing healthcare can be very challenging, any doctors' consultations that do eventuate can also present some concerns.

Refugees, particularly women, have a range of health and wellbeing needs that are very specific to their individual experience. Firstly, while they were living in their home country or in refugee camps, significant levels of violence and poverty may have been commonplace, and the most basic of human needs (such as food, clean water and adequate shelter) extremely limited. Education, employment and resettlement opportunities were even less available.³⁰ Furthermore, when individuals are accepted as refugees into a new country, they generally experience a great deal of stress throughout the resettlement process. Housing, transport, limited finances, limited English skills and efforts to negotiate government departments can result in severe pressure on refugees who are just trying to cope with such a huge transition. Another element of the refugee experience that is often neglected is the impact of grief.

Thus, "grief is experienced because of the loss of or traumatic separation from their loved ones, whose whereabouts are often unknown...As a result the memories of past trauma are kept alive."³¹ Consequently, it is important for people who work with

²⁶ Mitchell Smith, "Asylum Seekers in Australia," *Medical Journal of Australia* 175, no. 12 (2001).

²⁷ *Ibid.*, 3.

²⁸ Akram Omeri, Christopher Lennings and Lynnette Raymond, "Beyond Asylum: Implications for Nursing and Health Care Delivery for Afghan Refugees in Australia," *Journal of Transcultural Nursing* 17, no. 1 (2006).

²⁹ *Ibid.*

³⁰ Daniela Costa, "Health Care of Refugee Women," *Australian Family Physician* 36, no. 3 (2007).

³¹ *Ibid.*, 152.

refugees to keep in mind the grief and loss, not only of people, but also of culture. On a physical level, doctors need to keep in mind that many women are unfamiliar with their anatomy, and may have never experienced a physical examination of any kind, much less a breast or internal examination.³² Thus, women can be embarrassed or frightened during such examinations. Doctors should therefore engage a qualified female interpreter and provide an adequate allocation of time. The interpreter's role is essentially that of the woman's 'voice,' and is bound by the same rules of confidentiality as the doctor. The interpreter should not be regarded as the focus by the doctor; rather, the interaction between doctor and patient should be maintained.³³ Unfortunately, this is not always the case.

The barriers that women face in accessing medical care translate to lower than average rates of preventative health behaviours. Higher incidence of cervical cancer among certain country-of-birth groups has produced interest in the participation of cervical screening among women of CALD backgrounds. Research conducted in Australia suggested that Pap test rates were lowest among women who were born in Vietnam, women living in areas with a large migrant population and women who had the lowest socio-economic status.³⁴ A study regarding breast screening among the Thai population within Australia found similarly low rates of preventative health behaviours. The study cited limited English skills and a lack of knowledge regarding the available services.³⁵ Further research indicates that this can be countered by the "...provision of culturally appropriate services, increased education through ethno-specific media and targeted health promotion activities enhance... screening participation in women from ethnically diverse backgrounds."³⁶ However, it must be noted that health professionals should be sensitive to women's beliefs regarding risk factors for ill health. This was demonstrated in a study on traditional Chinese beliefs in relation to breast cancer screening. Migrant Chinese women are 50 per cent less likely to undertake breast screening than their Australian-born counterparts, largely as a result of their belief that poor health and death are predestined, and that they are therefore beyond individual control.³⁷ Furthermore, despite this belief in predestination, certain behaviours were believed to be bad luck. For example, discussing topics such as cancer were seen as taboo because "negative thinking brings negative outcomes."³⁸ Thus, certain cultural barriers must be broken down before targeted health promotion is engaged. Strong social support networks are an important factor in gradually engaging women from CALD backgrounds to participate in preventative screening practices.

Social support networks are vital in helping to prevent disease, facilitating recovery and adapting to ongoing illnesses. Indeed, a woman's role within her social network can affect her coping processes.³⁹ Additionally, participation in family and social groups can have a more broad effect on wellbeing, with improved mental health

³² Ibid.

³³ Ibid.

³⁴ Richard Taylor, Hassan Mamoon, Stephen Morrell and Gerard Wain, "Cervical Screening in Migrants to Australia," *Australian and New Zealand Journal of Public Health* 25, no. 1 (2001).

³⁵ Sansnee Jirojwong and Robert MacLennan, "Health beliefs, perceived self-efficacy, and breast self-examination among Thai migrants in Brisbane," *Journal of Advanced Nursing* 41, no. 3 (2003).

³⁶ Richard Taylor et al, "Cervical Screening in Migrants to Australia," *Australian and New Zealand Journal of Public Health* 25, no. 1 (2001), 56.

³⁷ Cannas Kwok and Gerard Sullivan, "Influence of traditional Chinese beliefs on cancer screening behaviour among Chinese-Australian women," *Journal of Advanced Nursing* 54, no. 6 (2006).

³⁸ Ibid, 695.

³⁹ Renata Kokanovic and Lenore Manderson, "Social support and self-management of type 2 diabetes among immigrant Australian women," *Chronic Illness* 2, no. 4 (2006).

outcomes among those with "...positive relationships that enhance self-acceptance, personal growth, trust, safety and reciprocity."⁴⁰ Social networks are necessary for survival in countries such as Australia, where government responsibilities to refugees are often associated with time limits. Once this time is up, individuals can only rely on the social capital and networks that they have established within this short timeframe. Unfortunately for refugees, strong histories of war and trauma within certain ethnic groups have meant that it can be difficult to forge new and trusting relationships. Somali refugees in Melbourne, for example, reported that poor financial positions have led to lower levels of reciprocity and the informal redistribution of resources that had characterised their lives in Somalia. They felt that inadequate finances limited the development and maintenance of social networks.⁴¹

The financial situation of refugee and humanitarian entrants to Australia is generally very precarious. While the refugee visa is fully funded, for the Special Humanitarian Program (SHP) new entrants and their proposers must be able to cover most of the costs involved in travel and resettlement. As one might imagine, the cost of travel can be exceptionally high, and – given that the vast majority of proposers are former refugee or SHP entrants themselves – there is often obligation to support family members who were left behind.⁴² Consequently, many refugee or SHP entrants have not been in Australia for a long enough period to have saved the amount of money necessary to resettle others, and ultimately take on loans to do so. Furthermore, when SHP entrants arrive, they are often required to take on these debts. This can make them particularly vulnerable to exploitation, as most new entrants are simply so grateful to their proposers, they would not contemplate questioning the amount of debt.⁴³ While the International Organisation for Migration (IOM) does provide loans of up to \$4, 000 for low income earners, the fact that a 35 per cent deposit is required and also that travel costs often exceeded the amount provided, has meant that it has not been accessed by as many as might otherwise. Instead, many proposers take on more informal loans (appealing because of low or no paperwork, no deposit and often no eligibility criteria) which frequently have exorbitant interest rates and very limited timeframes to pay the money back.⁴⁴ Such limitations can lead to immense hardship for new SHP entrants taking on large debts with exploitative conditions. The Refugee Council of Australia found that these new arrivals – understandably – expressed reluctance to visit general practitioners (GP) or buy medications simply because they could not afford to do so.⁴⁵ Taking such health risks has very damaging implications, particularly for pregnant women, young children and the elderly. New arrivals who have experienced sexual assault (which is most of the women) are also put at serious risk if they are not able to access medical care.

The Office for the United Nations High Commissioner for Refugees (UNHCR) estimates that approximately "...80% of all refugee women experience rape and sexual abuse."⁴⁶ Rape and sexual abuse are heinous acts in themselves; however in the context of many cultures and religions, they can become so much more than a

⁴⁰ Celia McMichael and Lenore Manderson, "Somali women and wellbeing: Social networks and social capital among immigrant women in Australia," *Human Organisation* 63, no. 1 (2004), 89.

⁴¹ *Ibid.*

⁴² Refugee Council of Australia, *Who bears the cost of Australia's Special Humanitarian Program? Research into the impact of travel costs on new Special Humanitarian entrants and their proposers* (Melbourne: Refugee Council of Australia, 2008).

⁴³ *Ibid.*

⁴⁴ *Ibid.*

⁴⁵ *Ibid.*

⁴⁶ Julie Savage and Rise Becker, *Refugee women, sexual assault and communities* (Sydney: STARTTS, 2003), 1.

crime committed against an individual. Rape and sexual abuse can deeply isolate women, in spite of the fact that no woman willingly submits to these acts of violence. They are

an attack not only on the core of the individual, but also upon the culture at the level of its deepest beliefs...It attacks not only the woman's sense of self, but also her relationships with her partner, her children, her extended family and her community due to deeply held beliefs and feelings around issues of sexuality that are embedded in religious and community attitudes.⁴⁷

By no means should this be taken to mean that sexual violence is any less traumatic for the woman herself. Indeed, it impacts on almost every aspect of her life. It is, however, important to understand the possible effect on her family and community, and therefore why many women choose not to disclose their experiences. Refugee and migrant women often encounter difficulties in addressing the emotional consequences of sexual violence because of the wider context of war, death and other forms of violence.⁴⁸ This personal trauma, while completely valid, is often still considered secondary to the effective disintegration of the woman's country and society.

The vast majority of refugees and humanitarian entrants to Australia are torture and trauma survivors who have come from countries where gross violations of human rights are occurring.⁴⁹ Individuals working with these communities in Australia need to be aware that this is the case, and should try to stay informed as to the history and politics of various international conflicts. It should also be noted that up to 80 per cent of refugees world wide are women and children, and disturbingly, only three per cent of the world's refugees will ever be resettled.⁵⁰ The three per cent who are resettled generally experience poor health and wellbeing as a result of long term famine, disease and limited medical facilities. Women in particular frequently have poor health outcomes as a result of these factors. Lack of preventative healthcare leads to higher than average rates of cervical cancer and sexually transmitted diseases. The experience of childbirth among women who have been sexually assaulted can be especially traumatic as it has the potential to trigger memories that have long been suppressed. If women have undergone female genital mutilation, this trauma may be compounded.⁵¹ Domestic violence is an additional issue which can emerge when men who might have been tortured begin to act out their experience of abuse on their wives.⁵² This kind of violence is a way of exerting power over someone – generally a woman – in order to feel dominant and in control. Again, this should not be taken as excusing the responsibility of violent men, but rather as something support workers (such as community workers, social workers and psychologists) should be aware of. Women may not be comfortable reporting violence, not only because of the cultural implications, but also because they may fear government authorities such as the police. This fear is generally well founded as the social and political instability that many refugees are escaping is characterised by corrupt officials.

Research suggests that refugees, having been through a great deal of trauma and ultimately experiencing a certain level of acculturation in their host country, are vulnerable to fall into alcohol and/or substance misuse. It has been claimed that "the stress of adjusting, particularly when both internal and external coping resources are

⁴⁷ Ibid, 2.

⁴⁸ Ibid.

⁴⁹ Robyn Bowles, *Social work with refugee survivors of trauma and torture* (Sydney: STARTTS, year unknown).

⁵⁰ Ibid.

⁵¹ Ibid.

⁵² Ibid.

scarce, contributes to the development of substance use problems.⁵³ Adding to the vulnerability of refugees, evidence suggests that the experience of PTSD is associated with the development of substance abuse.⁵⁴ Interestingly, both PTSD and substance abuse disorders can eventuate after a time lag of five to ten years following the traumatic event. The latter tends to occur only after fundamental survival requirements have been dealt with, and acculturation becomes overpowering.⁵⁵ This suggests that the use of drugs and/or alcohol by refugees is very much a self medicating strategy. It can be shaming for individuals to speak about such personal issues as substance misuse, and the situation becomes even more difficult when interpreters need to be brought in. Many refugee communities in different parts of Australia are quite small, and it can be therefore difficult to retain anonymity on the part of the refugee. Furthermore, there are often concerns regarding the maintenance of confidentiality by the interpreter. This can result in reluctance to disclose relevant information, and may impede on the social connection.

The WCHM has commissioned several research projects over the last twelve months in relation to women's isolation and marginalisation, and the effect that these factors might have on women's health and wellbeing in the ACT when addressed from a social determinants of health perspective. One of these reports points out that despite the appearance of equality in the ACT, poverty and marginalisation remains invisible to the majority. It states that,

...while the ACT does experience the highest average income, lowest unemployment rate, and highest secondary education rate of all Australian states and territories, these figures hide an underclass of ACT residents who are extremely marginalised and isolated.⁵⁶

It is worth noting that social determinants of health research suggests that due to the comparatively high standard of living among the majority of the population, those who are socio-economically disadvantaged will experience even more health inequality than they otherwise might.⁵⁷ Having said this, recent statistics demonstrate that women who were born overseas are more likely to have a lower income than their Australian-born counterparts. Indeed, almost half of women in the lowest income quintile for the ACT in 2004-05 were women born overseas.⁵⁸ Related to this, and no less disturbing, is the fact that women born overseas and women who spoke a language other than English at home, were one and a half, and two and a half times more likely (respectively) to report fair or poor health status than ACT women on average.⁵⁹ This evidence overwhelmingly suggests that women from CALD backgrounds are certainly one of the most isolated and marginalised groups in the ACT, and their health and wellbeing is suffering as a consequence.

Seen but not heard, produced by Cheryl Bateman in association with Sexual Health and Family Planning ACT (SHFPACT), is one of very few research reports on women of CALD backgrounds in the ACT. It focuses on the experience of Muslim women from differing cultural backgrounds in relation to sexual and reproductive health. The

⁵³ Helen Sowe, *Are refugees at increased risk of substance misuse?* (Sydney: Drug and Alcohol Multicultural Education Centre, 2005), 2.

⁵⁴ *Ibid.*

⁵⁵ *Ibid.*

⁵⁶ Sarah Maslen, *Marginalised and Isolated Women in the Australian Capital Territory* (Canberra: Women's Centre for Health Matters, 2008), 7.

⁵⁷ Sarah Maslen, *Social Determinants of Women's Health in the Australian Capital Territory* (Canberra: Women's Centre for Health Matters, 2008).

⁵⁸ *Ibid.*

⁵⁹ *Ibid.*

report notes that “the predominant message was that *cultural difference was the biggest barrier to accessing services* (emphasis author’s own).”⁶⁰ It went on to identify a range of ‘needs’ which had been devised among the Muslim women involved in the research. These included: cultural sensitivity and respect; the improvement of interpreting and translating services; making a wider pool of interpreters available in order to limit concerns around confidentiality; extending bulk billing; having more time in medical consultations; recognition of the genuine preference for female practitioners; and the education of healthcare providers in Islam.⁶¹

Research commissioned by the WCHM in 2008 also noted a number of gaps were impacting on the social connectedness and wellbeing of women from CALD backgrounds in the ACT, and that this was having a profound influence in isolating these women. This research was consistent with that conducted through SHFPACT; however, rather than being limited to sexual and reproductive health, this report took a wider perspective of health and wellbeing. The gaps identified included

...inadequate services for women with unresolved immigration status through breakdown of sponsorship (usually through the woman experiencing domestic violence); lack of affordable legal services for culturally and linguistically diverse women; inadequate support services (including life skills support) for refugee women; isolation due to lack of English language; limited access to English language programs (particularly for mothers with young children); shortage of affordable and reliable translator services for women; difficulties in providing healthcare; lack of culturally specific service provision; [and] lack of collaboration across services to support women with complex issues.⁶²

In recognising so many barriers for ACT women of CALD backgrounds to achieve good health and wellbeing, the WCHM commissioned this research report to make the first step in raising awareness of the identified issues.

⁶⁰ Cheryl Bateman, *Seen, but not heard! Understanding Islamic women’s perceptions of sexual and reproductive health: Identifying barriers to access in order to improve service provision in the ACT*, (Canberra: Sexual Health and Family Planning ACT, 2003), iv.

⁶¹ Ibid.

⁶² Sarah Maslen, *Marginalised and Isolated Women in the Australian Capital Territory*, (Canberra: Women’s Centre for Health Matters, 2008), 35-36.

3 Research Design

This research utilised a qualitative approach. Qualitative research is frequently used in social inquiry, primarily because of the richness of data that can be gathered. While studies conducting qualitative research tend to involve smaller sample sizes than in quantitative, this is overcome by the detail that can be present in responses. Furthermore, the use of questionnaires with common scales of measurement (such as the Likert scale) has proven ineffective within certain cultural groups. For example, a study involving Thai women in Brisbane noted that there had been limited comprehension of the Likert scale which had been used.⁶³ Anecdotal evidence among peers and professionals working with marginalised groups of women supported this conclusion, and encouraged the utilisation of (solely) qualitative research methods.

3.1 Sampling

Given that the research objectives aimed to reach some of the most marginalised and isolated groups of women in the ACT, the sample of participants would not have been representative if it was expected that CALD women would initiate contact to participate. In an effort to disseminate the research questions to as many isolated CALD women (living in the ACT) as possible, a snowball sampling method was employed. That is, personal contacts, those of colleagues and the ACT Women's Services sector have been engaged to get in touch with their own CALD networks regarding this research, and each of those people did the same (and so on). Many studies have found this method to be effective in reaching and recruiting CALD groups.⁶⁴ The success of this method may be due, at least in part, to the element of trust inherent in hearing about the research from someone who is known to the individual. It is therefore easier to trust and build a rapport with the participant.

The technique proved successful in recruiting participants from a range of ages and backgrounds. A total of 21 women from CALD backgrounds were interviewed, in addition to five workers from the community sector and ACT Government. Seven women from the ACT women's sector formed the reference group. A total of 33 participants were engaged. The five workers who participated included two women from ACT Health, two men from Woden Community Service (WCS) and one man from the Sudanese Community Association. The women involved in the reference group (n=7) represented Heira House, Young Women's Christian Association (YWCA), Doris Women's Refuge, Beryl Women Inc, Women's Information and Referral Centre (WIRC), Women's Information Resources and Education on Drugs and Dependency (WIREDDD), Multicultural Women's Advocacy (MWA) and WCHM. All seven women identified as being from a CALD background.

For the purposes of describing the remainder of the sample, only the 21 women from CALD backgrounds (excluding the women from the reference group) were included in the following statistics. The countries of birth reported included: India; Tonga; Germany; Afghanistan; Italy; Bangladesh; Malaysia; Belgium; Burma (Mon); Somalia; Greece; Poland; Indonesia; and Croatia. The Mon women (who requested to be identified as such, rather than Burmese) were part of a focus group, and therefore formed the largest percentage of the sample (28.6%). Indian and Malaysian women

⁶³ Sansnee Jirojwong and Robert MacLennan, 'Health beliefs, perceived self-efficacy and breast self-examination among Thai migrants in Brisbane,' *Journal of Advanced Nursing* 41, no. 3 (2002).

⁶⁴ Ibid.

represented 9.5 per cent each in the sample, with the remaining nationalities being denoted by one woman each (4.8%).

Statistics from the Australian Bureau of Statistics (ABS) indicate that in 2006, there were 163,923 women in the ACT (just over half the population). A total of 73 per cent of these women reported being born in Australia. Five per cent of the women in the ACT declined to state their country of birth, leaving 22 per cent of women in the ACT who reported a different country of birth.⁶⁵ While an exhaustive list of the countries of birth represented in the ACT was not able to be located, the ABS does list the 35 most common countries of birth reported in the 2006 Census of Population and Housing. Of the 14 countries listed above, eight are among the 35 most common countries of birth for women in the ACT. This indicates that the research sample is relatively representative of CALD women in the ACT – whether they were born in one of the eight ‘common countries of birth,’ or one of the six that were not listed.

Among the 21 women, 18 different languages were reported as being the first language spoken. Several women, such as the Indian and Mon participants, noted speaking two languages relevant to their culture (such as Urdu and Hindi for the Indian women, and Mon, Burmese and/or Thai for the Mon women). Five of the Mon women in the focus group could not speak English and required a translator; this means that 23.8 per cent of the sample was able to speak adequate English for the purposes of an interview.

The sample represented a wide range of ages, with participants reporting years of birth between 1933 and 1987 – a 54 year age range. It should be noted, however, that a minimum of 28.6 per cent of the group were born between 1952 and 1959. Five (23.8 per cent) of the 21 participants did not answer this question. The remaining ten reported their birth years in the 1930s, 1940s, 1960s, 1970s and 1980s and thus represented a broad age range.

The lengths of time spent in Australia, and in Canberra also varied dramatically. They ranged from less than one year to 59 years, and less than one year to 43 years respectively. Interestingly, 47.6 per cent of the sample came directly to Canberra upon their arrival in Australia. Ten women arrived in Australia and moved to Canberra at a later stage (an average of 11.5 years after arriving in Australia). One woman did not wish to comment.

3.2 Methods

The research was conducted in three ways. Focus groups were undertaken among ACT community sector workers of CALD backgrounds, and also with close-knit populations such as the Mon community. In the latter situation, a focus group was particularly useful in terms of translation and interpretation requirements. Rather than attempt to conduct focus groups for the entire sample, feedback from colleagues and other professionals suggested that the potential participants who were most isolated and marginalised might be left out, and even if those women were able to come along, they might not have felt comfortable speaking in a group of strangers.

Consequently, an invitation for written participation was developed (Appendix A). The invitation was in a letter format, and outlined the project before inviting the reader to write an account of their personal experiences of social inclusion (or isolation). It included several suggested topics, but did not limit women’s responses to those alone. The invitation acknowledged that women may prefer to write in their own language, and indicated that this was welcomed and written responses would be

⁶⁵ Australian Bureau of Statistics. ‘Country of Birth of Person by Sex, Canberra.’ *2006 Census of Population and Housing*, 2006.

translated at a later date. It also requested some basic demographic information including first language, whether an interpreter was needed, country of origin, year of birth, length of time spent in Australia, and the length of time spent in Canberra. The letter was piloted among an initial reference group to ensure that it was clear and easy to understand. Recognising that not all women in the target group might be literate (in either English or their native language), the invitation also provided an alternative to written participation. Women were invited to discuss their experiences in person with the researcher if they did not feel comfortable or able to write about them.

A semi-structured interview guide containing five open-ended questions was devised in order for the researcher to conduct interviews in person (with the assistance of an interpreter where necessary). The researcher prompted participants in situations of confusion or miscommunication in order to obtain the most accurate and informative response. The interview guide, like the invitation, was piloted among the participants of the initial reference group in order to eliminate questions that were unclear. Again, the same demographic information was requested during these interviews. Notes were taken by the researcher throughout the interviews, with the permission of the participant.

When the information gathering phase of the research was completed, the researcher went through each response and reduced the data into themes for further analysis.

3.3 Data analysis

Thematic analysis was used in order to examine the data, and establish the meanings that participants placed on their experiences. In order to do this, three stages of data analysis were used. Firstly, the data was reduced and categorised into themes using a coding method. Secondly, the data was organised into a table of themes. Finally the data was interpreted.

3.4 Ethical considerations

This research took into account several ethical considerations in order to adhere to both WCHM ethical standards, and the Australian Association of Social Workers Code of Ethics.

Each participant was given a letter of invitation outlining the study and ensuring confidentiality of responses, and it was made clear to potential participants that they did not have to participate. The letter also provided contact details for the WCHM in the situation that a participant had any additional questions or concerns. Furthermore, translated copies of the invitation were made available where needed to ensure that women were able to give their informed consent to participate in the research.

Careful consideration was given to ensuring that the research would not cause any harm to the participants. The consent form noted that women were able to withdraw from the study at any time and, as explained above, provided women with contact details for WCHM, should they have felt the need to for contact.

4 Results

Thematic analysis of the qualitative data elicited a number of recurrent topics, each of which will be examined in this section. These themes include: immigration and emerging communities; language concerns; domestic violence; drugs and/or alcohol; legal issues; isolation; need for cultural sensitivity; children and child protection; loss of qualifications and careers; discrimination and racism; limited transport; unfamiliarity with available services; mental health issues; trauma; and the elements that enhance social connectedness.

4.1 Immigration and emerging communities

Concerns about immigration were consistent among participants, particularly newer arrivals. One young woman reported travelling from her home country on a fiancée visa only to experience domestic violence after she was married. When her relationship broke down she discovered that her husband's family had not notified the Department of Immigration and Citizenship (DIAC) of her marriage, and she now endures uncertainty as to whether she may stay. The young woman described herself as being in "immigration limbo" and felt that her circumstances caused her anxiety and depression. She noted that it was always in the back of her mind.

Another young woman experienced a similar situation. This woman had also been in a violent and controlling relationship, and again, her partner and his parents conspired to have her deported by not passing on letters and phone messages from DIAC about her permanent visa. It was only by luck that she had been taken to DIAC while visiting extended family. Neither women, both Muslim, chose to return to their country of birth because of the shame that their divorces would bring to the family.

Many women, including the two noted above, did not originally want to come to Australia. They had their lives all planned out, only to have those plans thwarted by (international) arranged marriages or the outbreak of war. One woman stated that she and her family decided to migrate to Australia from Croatia due to the political climate at the time. They waited three years for a visa, and were eventually admitted on refugee visas. Another woman wrote that she was forced to leave Poland because of the political instability, and eventually migrated to Australia.

Others, of course, come to Australia with their eyes wide open. One woman reported that she migrated with her grandmother more than fifty years ago in order to be with her husband and she remains very happy in Australia. Two other women spoke of their individual experiences coming to Australia on student visas as nurses. Both reported their stories of migration as positive, although also acknowledging that their ability to speak English had been of vital importance. Both women, despite working on opposite sides of the country, were encouraged by their employers to obtain permanent residency on the basis of the shortage of nurses in Australia at the time.

Another woman who also reported migrating on a student visa, initially described her experience as "more positive than most." As her story unfolded however, the concern that DIAC had caused her became apparent. As she was on a student visa, the woman had to renew her visa every year that she was studying. She stated that the staff at the DIAC had not been particularly kind in their interactions with her. The woman applied for and obtained a job in the public service while she was studying, but DIAC denied her application to remain in Australia, despite the knowledge that she was employable. As the woman was still studying at the time, she simply remained in the country on a student visa. When she finished her study she applied once again to remain in Australia. She was told that she would have to be deported and apply again from wherever she went. After working internationally for some time,

the woman applied for residency on the basis of her skills and was finally granted her visa. While she still describes her experience as a positive one, the woman acknowledged that the uncertainty surrounding her immigration status had impacted on the wellbeing of herself, her daughters, and her marriage.

The stressful nature of the immigration process was highlighted by many women. All participants representing women's accommodation services agreed that the uncertainty around immigration proceedings often results in depression and fear among the women involved. Domestic violence accommodation services in particular, engaged in immigration "battles" on a regular basis, and noted that this takes its toll on both the woman and the worker.

The general consensus among the women who participated was summed up concisely by one woman who stated simply that "migration is a very hard thing to do." It can become even more difficult when women arrive as refugees. A DIAC employee pointed out that the Australian government has slightly increased the number of humanitarian entrants accepted in 2008 – 09, however settlement funding for services such as those provided by organisations such as Centacare, Centrelink, St Vincent de Paul and Companion House (cultural awareness training, English classes, employment assistance), is inadequate. This person also believed that the global refugee situation was likely to escalate, given current world political and economic tensions and that settlement issues for countries absorbing even greater numbers of refugees and humanitarian settlers would likely continue and be costly.

A range of groups were identified by workers in the community sector as the 'emerging communities' in the ACT. These included Sudanese, Burmese, Afghani and Iraqi. The domestic violence accommodations services also identified Russian, Vietnamese, Filipino and older Ukrainian women as cultural groups that had accessed their services recently. Representatives from ACT Health also noted that the emerging cultural groups for older people can be seen in the establishment of Italian, Greek and Croatian aged care facilities.

4.2 Language concerns

English language skills were consistently acknowledged to be a huge advantage in settling in Australia for CALD women. Unfortunately, many women had struggled with the language and it was considered one of the biggest barriers in achieving social connectedness. In addition, accessing translation services was a significant difficulty, and often resulted in women not being able to access adequate health care and support services.

Although women knew of the Translating and Interpreting Service (TIS), they expressed reluctance to use interpreters for various reasons, and also difficulty in accessing the service at times when it was needed. The main reason reported for reluctance in accessing TIS was that the cultural groups are so small in Canberra that the woman might know her interpreter, which elicits concerns regarding confidentiality and also the impartiality of the interpreter. One woman stated that she never used TIS because "information always managed to leak out" in spite of confidentiality agreements. When TIS was required, women were sometimes unable to organise it. Several workers in the community sector related stories of reception staff in medical clinics telling patients to bring in a friend or family member to interpret rather than booking an interpreter as requested. Aside from the huge ethical issues involved in this with regard to the woman's confidentiality, it also often "places an unfair burden on the child" when they inevitably must step up to translate. This was a common circumstance. It was also raised that women were having interactions with police without an interpreter present, which "is a breach of their rights."

A worker from a domestic violence accommodation service noted an example in which a woman of CALD background had incurred a huge debt at Centrelink because she ticked the wrong box on a form. The woman had limited English skills, and had not been offered an interpreter or a linguistically appropriate form. Many women agreed that government departments should be obligated to offer interpreting services, and look into having forms in a range of languages.

One circumstance in which translation was not made available by the police was in a situation of domestic violence. The young woman reported that she had only recently arrived in Australia and spoke no English. She presented to the police on three occasions and on two of those an interpreter was not arranged. She stated that her mother-in-law, one of the perpetrators of the violence, volunteered to 'interpret' for her. Naturally the police were not given accurate information and the young woman said that she was portrayed as "crazy." Workers in the community sector stressed that police are often neglecting to use interpreters when working with CALD women, meaning that they are not getting the facts that they need, particularly in relation to domestic violence. Furthermore, it was noted that often the perpetrators are being listened to over the women, because they may speak better English.

In another example, the absence of suitable translation services, a woman did not receive adequate care in a case of domestic violence. In the absence of an accredited interpreter, the mother-in-law of a young woman stepped in to translate in a consultation with a woman's doctor. The woman was experiencing domestic violence, and the mother-in-law was one of the perpetrators. The young woman stated that she was prescribed a heavy dose of anti-depressants in response to what her mother-in-law had told the doctor (supposedly on her behalf). She was convinced to take a medication that she had no information about, and no idea why she was taking it.

Although most women stated that in their experience the 500 hours provided by the government was not enough to learn English, they had been successful in negotiating more hours from Centrelink. Younger women were generally able to access English as a Second Language (ESL) classes at school. The women involved in the Mon focus group said that home tutoring was available through Canberra Institute of Technology (CIT) and Migrant and Refugee Settlement Services (MARRS, formally Multicultural Resource Centre [MRC]) did after-school tutoring for young people. Having said this, only one of the six women was able to speak English despite the length of time that some had already spent in Australia. Other women pointed out that there are no gender-specific language classes, and this may account for some women not attending.

The same women also felt that language-specific counselling would be ideal for many women; however they were unsure how this might happen logistically. This would be a useful service, as the Mon women described how difficult it can be to explain their symptoms or feelings when they are unwell as a consequence of the language barrier. One woman noted that it could be very upsetting and stressful when these people were not available to translate, and that it had the potential to place significant strain on their relationships.

Even when women learned to speak English, it was often reported that it could be very difficult to find work. One woman (who spoke excellent English in the opinion of the researcher) reported that she was often told that her English was not good enough, and that she was too difficult to understand because of her accent. Another woman agreed with these criticisms and added that these judgments have an enormous impact on self esteem. So many things seemed out of reach, and it wasn't limited to employment. Shopping for new clothes was complicated because "you can't ask for what you want...and the sizes are all different." Even something as

simple as asking someone for directions could elicit shame and embarrassment if the person you asked was unkind. It was agreed among all participants that lack of English language skills, plus lack of confidence in them, greatly increases social isolation.

ACT Health participants concurred that lack of English increased social isolation, and, with their own older clients in mind, noted that the situation can also be reversed. As women from CALD backgrounds age, their social networks become smaller (whether as a result of health, mobility or the deaths of their friends) and they have less opportunity to practice their English. Others might revert back to their native language with the onset of dementia. One woman noticed this phenomenon when her grandmother reverted to her first language as her Alzheimer's progressed. Another woman acknowledged how hard it must have been for her parents when they migrated to Australia shortly after World War II. There were no ESL classes then and the existing culture of assimilation meant that she and her sister were pressured to "speak English" so they did not want to speak their native language with their parents at home.

This kind of situation often led to divisions in families as children and parents bickered over language usage and cultural maintenance. Parents often felt quite isolated in their new country. The woman felt that her mother learned more English than her father did because her mother's job as a seamstress in Melbourne meant that she was forced to speak English with others as many of her co-workers were also migrant women. English was the only language they had in common. Her father's job did not demand much English usage so he did not learn much and consequently never became a fluent English speaker.

Services such as Heira House and Doris Women's Refuge have noticed a major difference since the cost of interpreters was not included in Supported Accommodation Assistance Program (SAAP) funding agreements. It was noted that some community organisations engage workers from other organisations in the sector to interpret. This is not part of the job description of these workers, the organisations are not funded for it, and the workers are not trained for it. They also felt that it could compromise boundaries in the community sector, however sometimes they had no choice. A worker from another women's service said that they used TIS frequently, but agreed that the money would be much better spent on improving women's services.

4.3 Domestic violence

Representatives from Heira House and Doris Women's Refuge in the initial focus group reported that around 60 per cent of women accessing their services are from CALD backgrounds. That is, well over half of service users in *two* different refuges targeted to women escaping domestic violence, were migrants or refugees. Beryl Women Inc. also indicated high numbers in the 2007-08 reporting period, with 23 per cent of service users being of CALD backgrounds.

Some of the women who were interviewed had ended up at a domestic violence accommodation service under very similar circumstances, despite being from different cultural backgrounds. These women experienced verbal, emotional, physical and financial abuse by their husbands and in-laws. They were frequently threatened with divorce and deportation, and were completely dependent on their abusers for money. One of the women described a time when she was forced to ask first her husband for money to buy sanitary items, and then her father-in-law. This incident brought her a great deal of shame. These women (during individual interviews) likened their experiences to that of a "slave." They had to do all the housework and cooking, and one woman said that she was "sometimes not allowed to eat at all." The

women were not permitted to leave the house alone, even for English lessons, and neither could they call the police because of the total control their in-laws exerted. Their experiences of domestic violence were encapsulated in a simple statement made by one of the women: "It's not like being treated like a dog. It's so much worse than that. People love animals."

Another woman reported that her abusive husband would rarely let her go out, and that when he attended functions alone he would tell people that she was unwell. The women in her cultural community knew her as "sickly, unhealthy," and thought that she was simply not interested in mixing with them. These examples demonstrate just how isolating domestic violence can be, and how it can impact on women's health and wellbeing through their subsequent lack of social supports.

These situations of violence, and the (often) subsequent poor self-efficacy, caused women such desperation that they considered suicide. One woman reported trying to end her life by overdosing on her anti-depressant medication and throwing herself from the balcony. Her husband and his family brought her inside the house, but did not seek immediate medical attention. The woman had suffered a badly broken leg in addition to cuts and bruises. Neither her injuries, nor her overdose prompted her husband and his family to take her to the hospital until well into the following day.

Of course, not all experiences of domestic violence end in suicidal ideation. One woman spoke about it almost as though it had empowered her. She regarded the emotional abuse that she had endured with wry humour, and explained that she had shocked her husband by asking him to move out, and initiating their divorce – in spite of his belief that she would remain married to him because of her Muslim faith. She felt that he had married her, and then another Muslim woman, because he thought they would let him walk all over them, and he could do as he pleased. This was certainly not the case. The woman went on to say (hardly containing her amusement) that the Muslim woman he married after her had left him, and taken his child and his house! While this woman's story is something of a symbolic victory against her abuser, her health and wellbeing was negatively impacted on for some time.

Other women reported that different cultures responded to domestic violence in different ways. One woman noted that Tongan women will often minimise domestic violence particularly if it is verbal or emotional. Even physical violence will often be tolerated if it is not directed at the head or face. Touching someone above the neck is considered a taboo in the Tongan culture (except by a mother or aunt), and therefore violence towards the face is often a breaking point, at which time a woman is just as likely to hit her abuser back. Consequently, only around two per cent of Tongans accessing Domestic Violence Crisis Service (DVCS) do so voluntarily. The woman went on to say that she thought children were the most vulnerable among the Tongan community. Parents could be dealt with through a range of services, however children tended to fall through the gaps. Children might experience violence until they are adults, and all discipline (physical and verbal included) was seen as acceptable (see Section 4.9, Children and Child Protection). Another participant, working in the community sector, commented that although domestic violence was an issue, it sometimes took some time to re-educate people on what is acceptable in a foreign culture. It is the researchers understanding that this education is provided at the time of arrival, and although it can be understood that such changes might take time, it should not be tolerated regardless.

Another element of domestic violence that is not often acknowledged is elder abuse. Although there has been some recent awareness of elder abuse, participants from ACT Health did not know of any CALD specific information or targeted campaigns. However it was agreed that there is certainly the potential for abuse when older women of CALD backgrounds are reliant on others for support or translation.

4.4 Drugs and/or alcohol issues

Drug and/or alcohol addiction was raised in several interviews. One woman explained that, in her community, youth groups often emerged out of the church as a response to drug/alcohol misuse. The groups do a range of activities, such as a radio show and community gatherings. This was seen as a proactive counter-measure to the number of young people from CALD backgrounds who were falling into patterns of drug and/or alcohol use.

Other women felt that more attention needed to be directed to newly arrived parents. She explained that it was easy for newly arrived refugees and migrants to become wrapped up in their own emotions, particularly if their children were teenagers, and somehow allow their children to “fall through the cracks.” One woman noted that, in her experience, Croatian parents were not likely to think of their children using drugs, because before the war (and consequent migration) drugs had never really been an issue in their society. The woman told of her friend (residing interstate) who recently experienced the death of her son as a result of his involvement in drugs. She had simply never known what to look for. Her friend’s tragic loss reminded the woman that more should be done to raise awareness about such issues among parents from CALD backgrounds.

Drug and alcohol use can be initiated as a response to a range of issues. One woman reported attempting suicide by overdose on two separate occasions as a result of feeling trapped in her situation of domestic violence. On both occasions she chose to use prescription drugs. These drugs became available to her when she was prescribed anti-depressants without understanding a word of what the doctor told her, or even what she was taking. She simply did what she was told by her abusive partner and his parents. The woman added that she has since been told by a doctor that the medication she had been given was far too strong for her, and not at all suitable for a young woman. By this time however, she had already been taking the drug for more than a year. A worker from WIREDD also reported encountering this concern among service users. She explained that it is common for women to be prescribed medications without knowing what they are, or what their side-effects might be. The worker raised her concern that women are becoming addicted to medications such as benzodiazepines without knowing that this is even a risk.

The women from the Mon focus group explained that they would never take any medication unless it was prescribed to them by a doctor. Consequently, these women experienced unnecessary pain because they did not trust medications such as paracetamol available over the counter.

A representative of WIREDD felt that women of CALD backgrounds often rely on their GP to cover everything, rather than find specialist service providers. Thus, when GPs are not well informed about either drug/alcohol issues or culturally sensitive practice, women of CALD backgrounds miss out on appropriate support. It was also pointed out that these women need the support of their GPs, as language barriers can prevent their access to detoxification and rehabilitation facilities. A situation was raised that occurred approximately seven years ago of a woman who was not given the opportunity to detox when she wanted to, simply because she spoke a language other than English.

4.5 Legal issues

One young woman shared that her in-laws had once wrongfully taken out an apprehended violence order (AVO) against her. The police simply went on the account of the in-laws (well respected, wealthy and fluent in English) because the

young woman could not speak English to explain the truth. Again, this raises the issue of the neglect of services to access interpreters.

Domestic violence compounded by a lack of English skills is a common and dangerous mix. Participants in the study described circumstances in which they had expensive jewels and clothing with great sentimental and cultural value stolen from them by their abusers. Women were not able to retrieve these items, even when some other possessions were returned with the help of police. The perpetrators simply denied that they had taken the items of value, and it seems that there was no further investigation into the matter. Women felt that because their mothers-in-law were wealthy, well-respected and spoke English fluently, the police were more likely to believe their version of events, and thus they never received their belongings back.

Domestic violence accommodation services reported that they frequently need workers to seek lawyers who will work pro bono because, at times, Legal Aid doesn't take on the cases of CALD women. Services explained that this was very time consuming because it can be difficult to find legal professionals in the ACT who are trained to work in a culturally appropriate manner. At present, many do not recognise the emotional and cultural implications involved for women in cases such as divorce.

Other cultural groups had identified legal issues, and have sought to find solutions to these concerns as a community. A member of the Sudanese Community Association of the ACT (referred to as the Sudanese Community) shared the responses of the community to some legal concerns that were raised in a recent meeting. The Sudanese Community decided that a community conflict mediation and resolution committee would be set up to handle conflict within the community so that it might be resolved without the involvement of police. The committee would also be able to advise the police on how to deal with Sudanese young people.

4.6 Isolation

Workers in the community sector noted that women from CALD backgrounds tend to have smaller support networks available to them. A representative of a women's accommodation service recalled a woman describing "the telly [as her] best friend." The high cost involved in private rental can also present an obstacle for engagement into activities that promote social inclusion. One woman noted "the first six months in Canberra were the hardest. I had to start my life all over again and make new friends."

Isolation is generally increased by domestic violence. One woman explained that for the first five months of her time in Australia she knew no-one other than her abusive partner and his family. Since leaving her husband she has discovered freedom; "now I have a life and friends." She is also able to contact her family via international phone calls at times. Despite now having some independence, the woman voiced that she often feels extremely isolated. Whilst residing at an accommodation service, she has formed a trusting relationship with a worker, but she added that she has no friends that she feels she could share her secrets with.

Another young woman shared a similar story, in which her husband and his family deliberately isolated her from her wider cultural community. Although the woman actually had family in Canberra (an auntie and cousins), her husband and in-laws did not allow her to see them. Eventually they moved interstate, making the young woman even more isolated. Her in-laws would tell their cultural community that she had mental health problems and that was why she always remained at home. This woman has returned to Canberra since leaving her husband, however feels isolated here in spite of her auntie's presence. She intends to eventually sponsor her younger brother so that he might migrate to Australia.

Of course, the isolation inherent in domestic violence is not limited to young women. An older European woman also experienced the kind of 'power over' that characterises domestic violence by her husband. This woman was essentially under house arrest.

Sometimes cultural factors can influence isolation. One woman explained that "if you're Tongan and you don't belong to a church you tend to become very [culturally] isolated." Yet another woman noted that women from some cultural backgrounds could become socially isolated if they did not feel comfortable mixing with people who they perceived to be of a higher status. Workers from the ACT community sector commented that they had noticed a trend among some communities, such as the Sudanese, of the man doing everything for his wife. He would even do the groceries. Consequently, the women in these relationships could become very isolated. Work opportunities for these women were seen as being quite limited because of low levels of English language skills and the reluctance of the men to have their wives mixing with other men in the workplace. It could also be difficult for women to access healthcare services because their husbands/fathers might not want them to see a male doctor, nurse, dentist or other health professional. It was also reported that, for some cultures, social isolation could cause a breakdown in the decision making process, as in many cultures decisions are made with the help and support of family and friends.

Some women reported they had never asked about counselling despite having experienced overwhelming grief and loss. One woman just wanted to get through it by herself, stating that "it's so much more complicated than I could ever explain." The woman went on to say that the injustices that she had witnessed were devastating, and even now when she hears about bombings in Serbia (a neighbouring country to where she grew up) on the news it is incredibly emotive. "It's hard, but that is life," she said.

A common complaint among the participants was that people don't have time for each other anymore. Visits always had to be planned in advance if they were to happen at all, and this was a huge departure from the norms in many cultures. Indeed, several women commented that it could be very lonely without having any extended family nearby. Some were in a position to be able to travel internationally to visit family; however even then, this could be difficult with children in tow.

Another recurrent element when discussing social isolation was the times of day that some women were able to leave the house. Some women reported that they were not able to go out at night. As such, if accessing a service means that a woman will not be home before dark, she will often go without the service.

An additional participant described her isolation upon moving to Australia. She stressed that even her ability to speak the language did not change the fact that she did not know a single person in the country except for her husband and their two babies. The woman described just wanting "a hug from a friend." She missed being able to walk down the street and run into someone she knew.

An example was noted by a service provider in the community sector of a CALD woman who had been living here for a few years with her husband and had never gone out for a coffee. The worker recalled what a big deal it was for the woman to have a coffee in a café with a friend. Similarly, a worker in the initial focus group shared the story of a woman who had not been to any other place other than her local supermarket in the five years she had been living in Canberra.

Although examples of isolation such as those noted above were common, some women also reported that they did not feel that this was the case. Some women stated that they did not have time to feel lonely between work, cleaning and

shopping. It was noted however, that new mums could become quite isolated from mainstream society without the ability to work or attend language classes. A concern was also raised that women frequently avoided going to a doctor when they were sick because of the expense involved.

Older women voiced that they often faced isolation if they could not drive or speak the language. Many women have spent their time in Australia looking after their husband and children, and have therefore had limited exposure to English. Consequently, women reported feeling at a loss if their children moved out and/or they lost their husband. Some social groups had been established in an effort to counter this isolation, and it was also mentioned that cultural regional clubs could also be a good support. Representatives of ACT Health agreed with the assessment that older women from CALD backgrounds were at increased risk of social isolation if they became widowed.

In order to reduce social isolation of women from CALD backgrounds, several participants suggested the real need for childcare and adequate transport be addressed. Without these provisions women could not move forward. It was also suggested that there need to be more services designed to encourage women's involvement. Although CIT courses were recognised, the long waiting lists were a deterrent for many. One woman felt that encouraging other women to volunteer for community radio improved their social connectedness. Although cultural organisations were raised by several women as being a good support, some were not so suitable. Some women noted that such clubs largely involve older people, and thus lose some of their appeal for younger generations.

4.7 The need for cultural sensitivity

The importance of recognising each woman's experience as unique, not simply generalising their circumstance according to cultural background, was strongly highlighted. It was felt that the community sector in the ACT should be moving away from the Western model of working with people, and adopt a more culturally appropriate form of support. It was stated that workers needed to be more tuned in and sensitive to cultural issues, and need to be well-informed and have a range of skills. In these respects, women reported that the ACT is lagging behind Sydney and Melbourne because there is less funding available for a full range of services.

Instances of workers in the community sector neglecting to disclose their own cultural background when working with service users of the same background, despite potentially knowing the people involved (given the small cultural groups in the ACT) were described. Several women supported the idea of a proper Islamic school in Canberra, because, in women's experience, the use of volunteers had not been effective. Women felt that volunteers had not taught Islam as they should, and promoted some more extreme aspects that they did not see as relevant to the Koran. The woman noted that these volunteers had been mixing cultural tradition with religion, and that was not the kind of Islam that she wanted her children exposed to. Yet another woman felt that there is a widespread misconception that because someone comes from a certain region they must follow the common religion, and it is important to remember that this is not necessarily the case.

Several women in domestic violence situations kept secrets from their families, as they didn't want to bring shame to them. One woman felt ashamed that her marriage had ended (due to violence) because her five sisters were all happy within their arranged marriages (common in Islam). Several women reported that separation and divorce are seen as very shaming in some cultures, and workers need to remain aware of this. One woman stated that "divorce is very bad," and that people would talk about her and her family and say "bad things." The extremity of these feelings of

shame and guilt was demonstrated when another woman said that she felt that she would be “dead” to her parents if she left her husband and returned to India. She repeatedly stated that she would “rather die than go home,” and that she would kill herself if Immigration tried to make her leave.

Although women consistently agreed that separation and divorce are very shaming, not all women felt that it would be the end of their world. One woman explained that her parents did not care that she was divorced and would subsequently have a “bad name.” They wanted her to move back to her home country anyway. Despite her parents’ plea, the woman made the decision to remain in Australia. She described her parents as being quite well educated and open minded about such issues.

Another Muslim woman spoke of her unhappiness in her marriage. While her circumstance did not involve domestic violence, she and her husband were “incompatible.” She did not want to separate from her husband because of her religious and cultural beliefs. The woman described her husband as a good man; however she constantly felt that, emotionally, she was a single mother to her two children. She added that she was often physically a single mother as well, because her husband frequently travelled for work. Immediately after making these statements, the woman quickly noted that to voice them was taboo. She felt that while it was okay to say these things to a researcher, the gravity of her feelings should not be underestimated. The woman explained that voicing her feelings to another Muslim woman could be incredibly powerful for both parties.

Women emphasised that not all women from CALD backgrounds are “door mats,” however some believed women must look after their house and husband, and that women should want to look after their husbands; not simply do it out of duty. Other women stressed that cultural dress such as the hijab are worn out of choice, not oppression, and that not all women wear a hijab unless they were at a place such as a mosque. Even then, this was a personal choice.

Women explained that it could be difficult to get other women of their culture engaged with services, particularly medical, which requires a great deal of advocacy. It was noted that many women might feel uncomfortable seeing “white” doctors because they have historically looked up to white people. For example, in Tongan culture “whites” were placed on a pedestal as they were perceived to have assisted in ending civil war. As a result of their reluctance to access medical services (including preventative), some cultural groups, such as Tongan, have quite high rates of preventable disease. Even second generation Tongan women in Australia often have aversions to accessing services. One woman indicated that there is one Tongan doctor (male) in Canberra and he is kept very busy. “There would be a huge demand for a female Tongan doctor,” she added. As is, there is a Tongan nurse with ACT Health who is constantly asked health questions because of the reluctance of her community to see a doctor. It was also reported that a common alternative was to visit doctors from other CALD backgrounds. It was agreed that there is a serious lack of culturally appropriate care in the ACT, however it was voiced that not all women want to see a doctor of the same cultural background as themselves. While it can certainly eliminate language concerns, it may mean that women are ashamed to disclose issues around domestic violence, addiction, mental health, rape or sexual assault.

As with Tongan women, the historical cultural context also influenced the way Malaysian women viewed the British (and other “white” people by extension). The British were seen as saviours by the Malaysian population from Japanese invasion, and were subsequently treated like royalty. This perception of debt to the British generated a move toward the teaching of English in schools and the adoption of Christianity. One woman felt that, as she grew up with these influences, she was well

equipped to migrate to Australia with competent English, and the ability to integrate into society. Coming from a culture where servitude was commonplace, the woman did acknowledge that there was some culture shock when she did not have a maid to cook for her as she had been accustomed in Malaysia. She also missed the company.

There are certain cultural quirks which can become common when working with new arrivals. Workers in the community sector noted that some cultures consistently struggled with appointment keeping. They raised the example of refugees of some cultures who had never encountered Western time keeping, and could sometimes take years to adapt.

One worker had heard about a Magic Man who told a man that he needed to put his wife to sleep and have her stay overnight in order to cure her. He could subsequently do whatever he wanted to the unconscious woman, under the guise of 'curing' her. Another worker had worked with a man who refused to treat his daughter's epilepsy as had been recommended by a doctor, and took her to someone in the Middle East to 'cure' her. One of the workers had noticed that there are regular advertisements in the Arabic newspaper (based in Sydney) for Magic Men who claimed to be able to cure anything. Another woman noted that deformities were traditionally considered to be curses in the Hindu religion.

It was suggested that there is some culture clash in that men in the family often take the lead role, and women can be left out. Children and men can be exposed to more opportunities to learn English through school and work, whereas if a woman must remain at home, her isolation is increased by limited English skills. It was also observed that women seem to be more at risk of acculturation than men. This may be a result of women having less opportunity to have their senses of cultural identity validated by others.

An Indonesian woman indicated that cultural differences even had an impact on her working life, as the Indonesian work ethic was different to that of Australia. In rural Indonesia people would wait to be told things and didn't want to overstep the mark in terms of personal initiative. She noted that big cities might have been different, however in her experience, personal initiative was not promoted as it is here.

Given the diverse nature of culture, one woman explained that it can be difficult to read people from other backgrounds, thus making it very challenging to know what might constitute symptoms of mental health concerns. Even when knowing a diagnosis, she would then be confused by the different reactions people had to it. She felt that Australians often seem to have a sort of 'head in the sand' approach, which she could not comprehend. She felt that this was an important cultural difference. Physical health problems can also be disregarded in certain cultures. One woman had worked with South East Asian women in relation to diabetes, and found that such illnesses were unfamiliar concepts, and therefore women generally did not want to know about them.

ACT Health works with aged care facilities in order to help prevent these cultural differences impacting on elderly people of CALD backgrounds. It was noted that even the décor can make a huge difference; for example, Muslim women frequenting public spaces which have crucifixes everywhere could be disconcerted by such displays. Another way in which ACT Health tries to advance culturally appropriate care is by encouraging the provision of multicultural food options and bilingual workers. They also promote workers linking clients in with their cultural communities if they are isolated, and intend that these interventions become ongoing rather than once off situations.

One woman felt that there are significant differences in the value of education and intellect between cultures. She explained that there is a huge emphasis on intelligence in Malaysia, whereas here in Australia, her daughter was bullied because she expressed her intelligence. Being a bright student in Australia is often equated with being a “nerd” or a “teacher’s pet,” and these students are often subsequently subjected to bullying. The woman went on to say that the effect of such bullying could be profound, and that her daughter still experiences a low self-esteem as a consequence.

It is certainly important to realise that the migrant experience is completely subjective. One woman told of her parents’ experience of living in Australia as refugees. She said that they were forced to embrace their new menial work in Australia, because going back to Russia was never an option for them. Stalin was still in power at the time, and they would have been shot as traitors because they had worked in Germany (despite the context of forced labour). More recently, one woman reported that she had come to Australia with the knowledge that she would have to settle in Australia, and would never be able to live in her home country of Croatia again. She explained that she would not put her family through all those processes of learning a new language, starting education and training all over again, and essentially starting their lives over.

A woman from DIAC felt that the Australian government is always looking to provide appropriate settlement services to new refugee and humanitarian arrivals and promotes, through education, two-way cultural awareness programs so that all Australians can learn about, and understand, each other. Updating settlement services will need to be ongoing, as it appears that new arrivals with special needs will continue to enter Australia in the coming years. Others felt that certain programs might be put in place to better enable women to achieve social inclusion. Workers from the community sector, for example, felt that perhaps migrant and refugee groups could have the same kind of special entrant access to universities and other tertiary institutions such as the CIT that are in place for our Indigenous counterparts.

Some women felt that a huge barrier in accessing services in the ACT was simply feeling as though they didn’t fit, and that no-one else was like them. It was noted that different rules of socialisation also played a role. For example, if they are not welcomed and recognised when they enter a service, they feel unwelcome, whereas Australians may carry on as usual on the assumption that generally all are welcome. Rather than address the confusion on each occasion, one woman explained that it is “sometimes...easier to just stay home.” On the other hand, some services were welcoming; however they had limited understanding of cultural sensitivity. The workers at the legal service, for example, were reported as being very nice, however they had assumed that women would understand legal jargon even if English was not their first language. This could potentially influence whether women of CALD backgrounds might access, or continue to access, a service such as this.

Another woman reported having a negative encounter with a staff member of a cultural organisation and had heard similar stories from others. People go to such organisations generally not really knowing what they’re looking for, and will be reluctant to go back if they have a negative response. Cultural services need to have a solid and cohesive team in place if they are to be confident in working with CALD groups. A number of women reported some CALD organisations to be quite mainstream, and felt that they needed to make their consultation more representative by including women’s voices rather than exclusively consulting male dominated communities.

Representatives from ACT Health suggested that a barrier in access to aged care services was that the fact that the whole concept of aged care was literally a foreign

concept to many women from CALD backgrounds. Thus, the sheer lack of knowledge regarding the available services was seen as a barrier. This was also seen to be a problem among groups of young people, such as the Sudanese, who often drop out of school because they are struggling with their education and don't know about the supports in place.

Mon women involved in the focus group expressed surprise at Australia's healthcare system. They explained that, although Burma is a poor country, doctors are always available, and "if you knock [on their door], they will answer." There is also no charge for prescriptions in Burma. Here you have to pay for the appointment, pay for the prescription, and then if it doesn't work, you have to go back and pay again. Both waiting times and the cost involved were seen as powerful barriers to accessing medical care.

A representative of the Sudanese community explained that the past experiences of refugees could significantly impact on their access to services, and also on how they could establish more independence. He stated that:

traditionally, it was seen as a humiliation to live on handouts unless things are really out of control as in famine or drought or war... To complicate this situation, in the past two decades over four million Sudanese people got displaced and for a long time lived on handouts from the UNHCR and World Food Program and other humanitarian organisations. Entire generation of people knew nothing other than living on handouts.

It was also noted that homesickness was an additional barrier to good health and wellbeing. The perception of stigma being attached to government support was also raised during the initial focus group, and it was subsequently suggested that the 'Welcome to Canberra' brochure needs to be developed with cultural sensitivity in mind. It was suggested that it should not only outline services, but provide more explanation as to why the services exist and are necessary.

A gap in service provision which was identified time and again was the limited services targeted to women who had been in Australia for some time.

The complex nature of support periods in residential services such as Heira House and Doris Women's Refuge was raised, especially when children are involved. It was reported that the scale of the work would sit comfortably with one full time worker to one CALD woman. Workers have to cover housing, immigration, legal, child protection, health (mental and physical) and any number of other issues that might arise. One woman stated "you become like a carer in the initial stages of the support period," because everything taken for granted (such as grocery shopping, negotiating public transport and going to the doctor) is an incredibly difficult task for women who have limited English skills. It was noted that if the workers didn't cover something, often nothing would happen due to inadequate knowledge, services and personal networks. Furthermore, women often require assessments of one kind or another (such as legal, psychiatric, social work) to accompany immigration applications. Workers agreed that these were near impossible to organise with culturally appropriate practitioners who can comply with immigration requirements. A service also has to pay for this, although they are not funded for it.

It was also suggested that services need to provide outreach for CALD women, as they often won't access services directly. Sometimes this is purely because they won't know about services (such as for domestic violence) because the concept might not even exist in their country of origin, and thus they don't know to look for them. CIT used to do an outreach program (similar to the co-morbidity bus tours run by the Youth Coalition) for members of CALD communities. Women agreed that it

would be great if a tour of this kind could be established for CALD women specifically.

4.8 Trauma

Women felt that those who have experienced trauma need to be given opportunities for self care and the chance to acknowledge their experiences regardless of the context. A representative of the Sudanese community in Canberra suggested that “people at the workplace have no understanding of the background of Sudanese people and what they went through during the war.” Similar stories of war and trauma were told by several other women. Women from the community sector agreed that there is generally a limited understanding of PTSD in women who escaping war-torn countries.

Similarly, a woman of Russian background came to Australia with her family as a refugee when she was only two years old. Despite her young age, she recalled her parents’ stories of being “on the run...[as] political gypsies” in the two years following the end of World War II. If they had been “gathered up by ‘do-gooders’ and sent back to the Soviet Union...” they would have been at risk of persecution, exile to a gulag or extermination under the Stalinist regime. The woman wrote that her parents experienced:

forced removal from their homeland as teenagers, without the opportunity to say goodbye to family or friends; loss of their familiar shelter and culture; fragmentation of their established family units and family history; constant fear about what would happen to them in the German camps and in the future; knowledge that return to Russia after war’s end would mean certain death for them; knowledge that transplantation from all that was familiar to them in food, lifestyle, language, culture and faith would continue to be difficult but was essential if they and their twin daughters were to survive. They knew that they had to start a new life in a new place that would welcome them.

She spoke of how proud she is that her parents made the brave decision to start their lives over in Australia despite all of the traumatic experiences that they had already encountered.

When war threatened in Croatia, yet another woman and her family made the decision to get out. They waited for three years for a visa to migrate, and when the war broke out they were granted refugee status. The woman was forced to leave all of her extended family behind, dead or alive. She has not been back yet. Since leaving, her mother, brother and many other relatives have died. She plans to visit Croatia again soon, however it will largely be to visit the graves of family and friends. Every time this woman sees scenes of war in Europe on television, she is triggered once again into reactions of grief and loss.

4.9 Children and child protection

One woman gave a very positive report of her involvement with the child protection system. Her teenage daughter had recently started demonstrating behavioural difficulties, and was constantly getting into trouble with “the wrong crowd.” Care and Protection Services became involved and the woman reported a positive relationship. She felt that their intervention had been required, and they were helping get through to her daughter.

On the other hand, another woman gave an example of (what she saw to be) the failings of various child protection systems in the country. A 17 year old woman had been abused for years but her family moved around constantly and managed to avoid child protection authorities. When they were reported after moving to the ACT,

the young woman was overlooked because of her age. Now she is 19 and still living at home experiencing violence. She has to give her father all of her wages, and won't leave because her mother is also being abused. It was reported that children of some cultures are falling through the cracks, as there are no targeted resources for children in domestic violence as there are for adults.

One woman noted that, although her husband was infertile, he blamed her for their inability to conceive, and threatened that he would divorce her and find a new wife to give him children. As mentioned above, separation and divorce can be perceived as very shaming in some cultural groups, and this was therefore a powerful threat.

Some women felt very strongly that more attention needs to be paid to the parenting of new migrants, as it can be easy for parents to become absorbed with their own issues, particularly when their children are teenagers.

Women pointed out that there are often major shifts between first and second generation Australians, and there seems to be little recognition of this. Issues around sex education, dating, drug and alcohol use and parenting are often raised, and have little dedicated support. They also noted that childcare is a major concern for women of CALD backgrounds (in regard to both cost and availability) because they can't move forward without it.

4.10 Loss of qualifications and careers

Many women reported sadness over the loss of their qualifications and careers upon their move to Australia, whether they had come by choice or had been forced to leave their countries of birth. One woman said that both of her parents had worked, but in unskilled jobs despite their education and experience. Her father had been an accountant but became a railway porter. Her mother became a seamstress. Another woman reported that, in her experience, migrants from countries such as India, Bangladesh and parts of South East Asia tend to be well educated, but are often working well below their level of qualifications in Australia.

One participant shared that she had been a journalist before she came to Australia, however her "Australian English" was not good enough to be able to do the same thing here. Consequently, she went back to university to undertake postgraduate study. She felt that life was easier at university because there were many international students.

Another woman told of her grief for her once successful career in law. She regrets that her daughter was forced to change schools (and languages) in her final years of high school, and that her son had to start his tertiary qualifications all over again (despite having almost completed them in their home country). Although the woman considered going back to university to qualify for employment in the Australian legal system, she decided against it for two reasons: she would have felt out of place taking the same lectures as her daughter, and she wasn't sure that her English was good enough for academic writing. This was a painful decision to make for a very intelligent and ambitious woman.

It was reported that there is a preconception among many CALD groups that volunteer work is for people who "can't get a 'real' job." One woman, a volunteer for a community radio show, opposed such presumptions. She used the example of community radio in order to explain that volunteering can be a great opportunity to up-skill and gain more confidence, whether a person is in paid work or not.

A worker in the community sector observed that many women of CALD backgrounds have degrees in teaching and "other caring professions." He suggested that their skills could be highly transferrable to childcare if there was a suitable bridging course.

4.11 Discrimination and racism

Some women reported that since the London bombings, they have noticed a bit more of a push for assimilation at a governmental level. It has been reported that on the whole, discrimination in the ACT is not great because the population, including migrant communities, are well-educated and largely accepting of differences. It was noted that DIAC staff visit regional areas to listen to community issues and to report on them. Issues of discrimination are reported to the appropriate national and state bodies. It seems that some community groups do experience discrimination and racist attacks more than others do.

Sudanese refugees, in particular, were acknowledged to often face discrimination and/or racism because they are more easily identifiable than other groups. Some workers in the community sector observed that Iraqi women seemed to be able to get work more easily than African women, thus supporting the suggestion that racism and discrimination is often based on appearance in the ACT. Women agreed that discrimination and racism are very appearance based, however they felt that it occurs in Canberra a lot more than most people are aware. An example of this was provided by a worker from a women's accommodation service; a white woman arrived at the refuge with her young daughter, but turned and left immediately when she saw a Sudanese woman in the lounge room. To make matters worse, the white child was screaming in fear because she had never seen a black woman before (and also undoubtedly because of her mother's response). The Sudanese woman, while understanding (at least of the child's response), became quite depressed because she was constantly stared at or feared.

Another woman, a leader in the Muslim community, felt that racism and discrimination are still rife in the ACT, and that it "always hurts" because women need to be able to feel safe regardless of their cultural background. She acknowledged that racism is very covert in the ACT, however it does occur, and it does so on a range of levels from the personal to the organisational. Employment is often restricted because of cultural background, however this would never be verbalised as the reason. Indeed, other women agreed that there had been occasions when they had felt discriminated against, and these were often in job interview situations. Women felt that prospective employers should give people of CALD backgrounds more of a chance, looking beyond minor grammatical errors in resumes to the content and skills presented. It was indicated that prospective employers should acknowledge that interview situations could be more stressful when English was not one's first language.

One woman reported that she was normally quite oblivious, but she does notice the occasional stare, especially when using public transport. On the first occasion this woman was interviewed, she largely spoke about what her daughters had experienced within the ACT school system around 20 years ago. Upon enrollment, her eldest daughter was immediately placed two levels below the class she should have been in. Although she was a bright child, it took a great deal of argument to move her up even a single level. At another school a teacher told the same child that her mother should change her name, because she, the teacher, could never remember it. The principal at the same school had also taken issue with the fact that the girls had no last name. The girls had constantly worried about going to school, and the woman felt that this had left a profound impact on her daughters, particularly the eldest. The woman encouraged her daughters to engage in extra-curricular activities, however teachers at both high school and college accused her of repressing them. She was regarded as "a pushy Asian mother" if she showed an interest in her daughters' education, yet if she did not and one of them received a poor grade, the school would send a note criticising her lack of involvement. The woman simply wanted to know what her daughters were doing at school so that she

could help them, or at least monitor their progress. She is unsure whether the school system is still so discriminatory, as these incidents occurred some time ago.

The same woman emailed around two weeks after the initial interview with further details of discrimination and racism in her life. Despite her first response being that she had not experienced either personally, the email indicated that she had felt quite overwhelmed when speaking of her daughters' experiences and had been reluctant to discuss discrimination in the workplace as well. She wrote:

I myself have faced a lot of bullying and harassment in the work place, which was Commonwealth Public Service, for the last 14 years. As I understand and also as some of my friends (mainstream white people) observed, that this was mainly because of my weak position as a woman, as a person from non-English speaking background and perhaps (I am not sure of it) as a Muslim. My experience, however, is not unique. I think ANU [Australian National University] is the only place which was to a great extent tolerant of people from diverse background and recognised skill, and that's why the ANU is one of the world's first class.

The school system has failed my children (as I discussed with you with great details) and the work system has failed me. There is a lot to improve in Australian work environment, especially in terms of providing training and education to managers about recognising others. Having an equal employment opportunity (EEO) clause in the Australian Public Service (APS) code is not enough.

However, I must also mention that there have been some wonderful people at work who could see and appreciate me beyond my colour race and tongue. Because of them work place is still enjoyable.

Another woman who is educated, intelligent and multilingual, has worked in the community sector in a leadership role for many years. Although she has applied for many public service positions that she is more than qualified for, she is consistently overlooked in job interviews.

One participant shared the story of a woman who was given a job cleaning, but was dismissed a week later because "she didn't smile at the workers and the supervisors." When they finally asked why, she told them that she had nothing to smile about because of everything she had gone through before coming to Australia.

Contrary to these experiences, some women reported that they had never been discriminated against in the ACT. Again, the education of the majority of the population was attributed to this. Other women believed that, in general, they are treated fairly by white Australians, however added that they sometimes feel that they are treated as second class citizens by non-white Australians. One woman compared her experience in Canberra to that in an interstate city when she had observed a blatant show of racism that her sister had elicited. She had watched as jaws literally dropped when some locals had seen her sister in a hijab, and was glad that her sister had not noticed their shocked stares and the odd look of antipathy. The woman had never seen a reaction to a woman wearing the hijab like that in Canberra.

Some women suggested that groups for the mainstream population (such as parenting groups) could often be quite patronising to women of CALD backgrounds. A young woman who had arrived in Australia only very recently shared an experience relating to her baby son. Her baby became quite sick and she needed to take him to a doctor. As there was no doctor at Companion House at the time, the young woman went to a public medical centre. The doctor did not take them seriously; he didn't even touch the baby, let alone conduct a proper examination. The woman could only

put this down to their cultural background, given that her baby had genuinely been sick.

Another woman felt that she was often judged when she was with her husband who looked a bit older than her. The woman looked a great deal younger than her actual age and attributes this to her culture, however she did feel that she was often perceived to be a “mail-order bride” or that she had married her husband for money, simply because she looked so much younger than him. The woman never wore fancy clothes or makeup because she didn’t want to attract any attention to herself or be noticed. Often, she noticed, the most judgmental were older women, and she stressed that this kind of racism occurs in Canberra as well as other places. A colleague had once asked (solely based on the information that the woman was married to a white man and lived in Griffith) to see a photo of her “rich husband,” and on another occasion, questioned why she even worked. Despite these experiences, the woman felt that she did not experience a great deal of racism because of the social circles she maintained. She added that friends of the same culture had related experiences of being told to “go home” when in various public spaces around Canberra.

Some women raised their concern that telephone companies could be particularly discriminatory. One woman reported a very negative experience with a telephone company since coming to the ACT. She said that they had been charging her \$70 to \$80 every month without sending any bills. Because she did not receive a bill, she did not know to pay and was prone to having her line cut off. They would then charge her a reconnection fee, in addition to the \$70 to \$80 original bill, but refused to give her an itemised account that showed how her bill had been calculated. She couldn’t complain because of her poor English skills. A community development worker from Companion House agreed that new arrivals are at particular risk of exploitation in this respect. He said that there had also been cases of the same bill being paid several times, and not being recognised by the company as paid. Companion House could rarely follow up on these occurrences because of low staffing levels.

4.12 Limited transportation

Limited transport as a barrier to accessing services and social inclusion was a common theme, with the initial focus group and the majority of participants raising it as an issue. One participant explained that this was often because women did not have a driver’s license or if they did, they may have lacked access to a car. Another woman elaborated; “I found that Canberra was a place of widely spaced suburbs and it was nearly impossible to get around without a car, especially on weekends and at night.”

Representatives from ACT Health agreed, adding that it could especially be a problem for older women. Even if they have a car, they may not be able to drive anymore, or they may have always relied on their husbands to drive them places. They also noted that buses are quite expensive and sometimes older women of CALD backgrounds felt shy about asking for a ticket. They felt that the community bus was a great initiative, however that there were not enough buses.

4.13 Unfamiliarity with available services

Unfamiliarity and lack of information about services were also frequently raised. It was suggested that older migrants who have been in the country a few years and young women who are recent arrivals might be particularly unfamiliar with services. One woman felt that the solution to this could be providing brochures in a range of appropriate languages and placing these in ethno-specific locations (such as halal butchers, churches, Anglicare, ethnic newspapers and radio stations, and with

female community leaders). Supermarkets were also suggested as good locations for information relating to women of CALD backgrounds.

One woman reported that she had wanted to get her children into some extra-curricular activities; however she had to ask the school because she did not know what to try. The only one the school informed her of was Girl Guides, and neglected to mention any sporting clubs etc. Her daughters hated Girl Guides.

Schools were a point of contention among several of the women, who felt that they tend to ask a lot of parents (such as canteen duty), but don't give a lot back in return. Although some women admitted that it had been some time since their last interactions with the school system, at the time they had not been helpful in providing information about available services, and the women generally felt that they'd been kept in the dark about what their children were doing at school.

Another woman described her confusion and isolation in dealing with her partner's mental illness. She felt that the main issue in her situation was that she simply did not know that the services exist until someone told her. She noted that Australians tend to mind their own business unless they know you, so it could take some time before someone referred you to the appropriate service. One woman also said that the concept of support groups held strong connotations of being a "loser" and that you have no-one who loves you to support you.

Women reported that Centacare stops work with new arrivals after six months. Before the contract ends, Centacare workers ask the service user if there is anything else they need, presumably to set them up independent of intervention. One woman reported that she had requested a microwave and a computer, which was agreed to by the worker; however she had not heard from them since. Other than Companion House and the Mon organisation, the group of Mon women did not know of any other services that might be able to support them.

ACT Health also noted the lack of knowledge of services to be a huge barrier for older women of CALD backgrounds. Furthermore, they often felt that they could rely on family or their cultural community for support as they age, however if/when this support did not eventuate, women would reach crisis point and be forced to enter aged care facilities.

4.14 Mental health issues

Women reported a range of mental health concerns (whether their own or those of someone they knew) which included depression, anxiety, PTSD, bipolar disorder and dementia. Most women acknowledged that isolation had been a negative influence on their mental health, particularly among those with depression and/or anxiety. Having only recently moved with her partner to Australia from her country of origin, one woman had no idea where to go to access support for herself or her partner when he began demonstrating symptoms of a mental illness.

The diagnosis (or misdiagnosis as the case may be) of a mental illness left some women of CALD backgrounds vulnerable to exploitation. One woman reported that her in-laws had her taken to a psychiatric unit, saying to police that she was "crazy." Another woman was prescribed powerful anti-depressants on the whim of her mother-in-law, and had to take them without knowing anything about the drug.

It was noted that the onset of dementia can mean that women of CALD backgrounds gradually revert to their first language.

4.15 Elements that enhanced social connectedness

A Tongan woman said that belonging to a church promoted social inclusion in her culture. She added that after church all the women get together and have a chat. It is a good opportunity to be updated on the happenings within the community and occasionally to educate others on preventative health measures. Another woman identified her religion as Orthodox, and explained that it had a similarly positive effect of social networks.

Language classes were reported to be a good opportunity to pass on information. One woman said that when she was taking classes through the Adult Migrant English Program (AMEP), people would come in and give students information about the various services that they might need. She added that these presentations ranged from Governmental (Centrelink and Housing) to community (DVCS and Canberra Rape Crisis Centre [CRCC]). There was also someone translating in these sessions so that the information was not lost.

Cultural clubs were a popular avenue of socialisation. Although not suited to everyone, some women felt they greatly reduced their chances of social isolation. A few women were members of multicultural women's clubs, and felt that they were a key element of social inclusion. Another woman joined a Polish choir group and had similarly positive experiences.

Migrating to Australia as a student was seen as an advantage by several women. All reported that there were other people of CALD backgrounds in these learning environments with whom they could mix with on a social basis. One woman noted that "social networks are instrumental in helping individuals adapt to a new culture and new norms."

Women who had an income of some description and a good grasp of English also reported a smoother transition. One woman described her Australian friends as being "like extended family." Another felt that emotional and financial support from her mother around the time that she migrated had helped her through training to be a nurse. Many women noted that having phone contact with relatives whenever they could was also positive.

When every participant in the Mon focus group reported that they had come directly to Canberra (despite arriving at different times over many years), they were asked if this had been coincidental or planned. The women elaborated that their arrival in Canberra was at government direction because this is where the Mon organisation is located. This organisation has been a primary support for these women. The women went on to report that Companion House and Centacare were also positive in reducing isolation. Community development workers at Companion House, in particular, provided extra support for young families. Companion House also did "most health things" such as preventative health screening. The doctors there were helpful, and would refer on to GPs in the community. The informal network of the Mon women seemed very strong, as there were people coming in and out of the apartment on a frequent basis throughout the focus group. Furthermore, the women explained that they met every week, and during school holidays they would go on group day trips or holidays. All women agreed that there was always someone who they could call or visit if they needed to discuss anything.

ACT Health participants reported that some older CALD women felt that there was an element of comfort in being able to access service providers of the same cultural background. They often also felt more comfortable accessing a group if there was someone with them for support.

5 Discussion

The results of this research largely reflect the information presented in the literature review, suggesting that the findings of international and national studies can be generalised to the ACT to a certain extent. Some barriers to accessing services appear to be common, regardless of location, and yet the ACT Government has largely not acted on this information by introducing supports, or at minimum, has not provided the funding for community organisations to do so.

Concerns around immigration were consistently raised throughout focus groups and interviews. Women unanimously agreed that the process of immigration could cause a great deal of stress among women and workers alike. Research supports the notion that high levels of stress are experienced throughout the resettlement process.⁶⁶ The complexity of issues that refugees face is immense, and it therefore follows that support workers engaging with refugees also experience a certain level of vicarious stress. In addition to and because of settlement concerns, uncertainty and feelings of being “in limbo” frequently triggered women into depression and anxiety. Although the impact of this uncertainty on refugees’ mental health was not examined in the literature, further research indicates that “feelings of insecurity experienced by refugees amplify and extend the durations of their illnesses...[and are] major contributors to anxiety and depression.”⁶⁷ The already heavy workload of workers in women’s services increases exponentially when they must engage in immigration “battles.” This, it is important to note, is not their role. Indeed, when trying to link CALD women in with the necessary range of services, they are rarely successful and ultimately often do the work themselves. As noted in the literature review, when it comes to women of CALD backgrounds, many services neglect collaboration in spite of the complexities involved, and simply leave the work to the service with initial commitment.⁶⁸

Even those women who had been in Australia for some time reported that they could recall their experience regarding their immigration status, and the majority did not have positive stories to tell. In particular, it became clear how much women have to lose in relation to their immigration status when interviewing those who had been in domestic violence relationships. Women expressed their fear that their husbands would follow through with their threats to have them divorced and deported. They felt that they could not return to their countries of origin because their divorce would bring shame to them and their families. This information was consistent with that of an international study noted in the literature review; that is, women leaving violent partners are perceived to bring disgrace to themselves and their families, and are generally considered to be at fault for any violence that may have occurred.⁶⁹

Workers in the community sector noted that there seemed to be a pattern of arrival among certain populations; they felt that men often came out first as refugees, and then returned to their country of origin to find a bride to bring to Australia. Regardless of the accuracy of this perception, the lack of choice in the refugee experience remains. As explained in the literature review, refugees rarely have any time to prepare themselves for the transition to their host country, and generally are lacking

⁶⁶ Daniela Costa, “Health Care of Refugee Women,” *Australian Family Physician* 36, no. 3 (2007).

⁶⁷ Mark Harris and Barbara Telfer, “The health needs of asylum seekers living in the community,” *The Medical Journal of Australia* 175, no. 12 (2001).

⁶⁸ Sarah Maslen, *Marginalised and Isolated Women in the Australian Capital Territory*, (Canberra: Women’s Centre for Health Matters, 2008).

⁶⁹ Cecilia Menjivar and Olivia Salcido, “Immigrant women and domestic violence: Common experiences in different countries,” *Gender and Society* 16, no. 6 (2002).

in adequate finances and even personal identification documentation.⁷⁰ Even when women migrate to Australia to marry, they often have had little choice in the matter. Two young women in domestic violence situations had both originally been averse to the idea of coming to Australia, however were persuaded to do so by their families and future in-laws. The lack of control in the experience of these women, whether migrants or refugees, has the potential to impact on them profoundly.

The limited nature of their finances often adds feelings of lack of control experienced by many women of CALD backgrounds. Several women pointed out that more than half of their income from Centrelink is spent on rent in the private market. Many women expressed reluctance to visit GPs because of the expense involved, not only of the visit itself, but also in filling prescriptions. Research supported the notion of women (particularly new arrivals) avoiding medical attention as a result of the cost.⁷¹ The same report also highlighted the financial hardship that people experience when taking on exploitative loans to sponsor new SHP entrants.⁷² One young woman indicated that as soon as she is allocated a house (which could take over a year in itself), she will sponsor her younger brother to come out to Australia. The cost did not deter her; she felt that if she had the opportunity to help her brother come to Australia, she should take it, regardless of loan conditions. This is yet another example of times workers need to demonstrate some cultural sensitivity and work with the woman, rather than immediately disrespecting her decision.

Both the ACT Government and the workers in the community sector should endeavor to engage in training to teach culturally appropriate behaviours and the range of issues that women of CALD backgrounds may encounter. Knowing that the vast majority of refugees and humanitarian entrants into Australia are survivors of torture and trauma,⁷³ workers and politicians should try to stay more informed as to the history and politics of various international conflicts. As suggested by a public servant, refugee and humanitarian arrivals are likely to increase, so it is imperative that government and community work together to achieve acceptable settlement outcomes for this group, as quickly as possible. Companion House, a service invaluable to newly arrived refugees, is already stretched to the limit, and further influxes of refugees might be well beyond capacity. While the ACT Government recently made a commitment to increase MARSS funding by \$50,000 every year for four years, the service does not specialise in the kinds of issues faced by refugees such as loss, grief and profound trauma. This commitment by the government is really positive for the multicultural community in general, however more targeted funding will be required if we are to truly address the gaps in services.

Language was reported as a concern across the board. International, national and local research has all noted that language is a primary barrier in the access of services by CALD women. This was consistent with the results of the present research. Several participants also raised the difficulty which can be associated with learning a new language. While young children generally pick up languages very quickly, the same cannot be said for all adults. Research supports this notion, suggesting that time constraints, responsibilities and age influence women's ability to

⁷⁰ Miriam Stewart et al, "Multicultural meanings of social support among immigrants and refugees," *International Migration* 46, no.3 (2008).

⁷¹ Refugee Council of Australia, *Who bears the cost of Australia's Special Humanitarian Program? Research into the travel costs on new Special Humanitarian entrants and their proposers* (Melbourne: Refugee Council of Australia, 2008).

⁷² Ibid.

⁷³ Robyn Bowles, *Social work with refugee survivors of trauma and torture* (Sydney: STARTTS, year unknown).

learn new languages.⁷⁴ The Australian government provides 500 hours of language lessons for new arrivals. Although most women felt that this was not nearly enough, they largely agreed that they were able to obtain more hours by negotiating with Centrelink.

In spite of being in Australia for several years, most women in the Mon focus group were not able to speak English. This may raise some concern as to why the women, despite knowing that the services existed, were either not finding the lessons effective, or choosing not to participate, particularly because they felt that language was the biggest barrier they have in accessing services. This could potentially be a result of the lack of gender specific language classes, as some cultures frown upon women and men mixing socially. Although private tuition is available (despite a shortage of volunteers), this inherently perpetuates the social isolation that so many CALD women experience by not allowing them to meet a diverse group of women. Consequently, some women must engage in one-on-one lessons and be isolated from others in similar circumstances, or they may miss out on language classes altogether.

Women who are not able to speak English are generally forced to rely on family members or friends to interpret during appointments; this is often because interpreting and translating services are unavailable. The results of this research suggest that there are not enough interpreting and translating services in the ACT, and those that do exist are limited by cost or even language. This was supported by earlier research conducted by the WCHM, when a “shortage of affordable and reliable translator services for women” was identified as a gap in services which was impacting on the social connectedness and wellbeing of women of CALD backgrounds.⁷⁵ Alarmingly, of the 18 languages that were reported as being a woman’s first language in this study, only *one* of those was represented in the seven languages covered by interpreters at the Migrant Health Unit.

Unfortunately, even when the translating services are available, sometimes the organisation/department involved does not insist upon using them. As mentioned in section 4.3, two different women in relationships where there was domestic violence were not given an independent interpreter (instead one of the perpetrators ‘translated’) in legal and medical circumstances. These situations led to extreme vulnerability of women who were already at risk. Workers also reported that, even when requested, interpreters were not provided at medical appointments, and the receptionists would ask the patient to bring a family member along to translate. Again, several participants agreed that this places an unfair burden on children, and also raises important ethical issues regarding women’s confidentiality.

Results of this research also highlighted the language difficulties that are faced specifically by aging women of CALD backgrounds. Of particular importance is the possibility of language regression if women develop Alzheimer’s disease or dementia.⁷⁶ Several women reported that they had observed women gradually losing their English, and slipping back to their first language. Even when women do not experience dementia, the lack of opportunities to practice English can result in reverting to their first language. This occurrence of regression assumes that these women ever had the opportunity to learn English. ESL classes may not have existed when they first arrived, and they may have since relied on their partners or children.

⁷⁴ Miriam Stewart et al, “Multicultural meanings of social support among immigrants and refugees,” *International Migration* 46, no.3 (2008).

⁷⁵ Sarah Maslen, *Marginalised and Isolated Women in the Australian Capital Territory*, (Canberra: Women’s Centre for Health Matters, 2008), 35.

⁷⁶ Anonymous, “Ethno-specific homes to help dementia patients,” *Australian Nursing Journal* 12, no. 1 (2004).

As time passes their children may move on and many women may become widowed, thus leaving them isolated and unable to communicate. Paying bills and organising finances can be an arduous task for an elderly woman who does not speak English, and who has always relied on her partner to take care of such matters.

Many cultural groups have historically relied on their family's support as they age, and the shift to a far more individualist society as in Australia means that many elderly women from CALD backgrounds are left without support, and must transition into supported accommodation. Unfortunately, this isolation and vulnerability does not necessarily improve when they make this progression into aged care facilities. While government services can access TIS free of charge, many aged care services must pay. This cost is often not factored into funding agreements and can therefore be too costly to use on a regular basis. Finding other interpreting and translating services is complicated and generally quite expensive. This was certainly the case when items for this research had to be translated. While somewhat frustrating for a researcher, this lack of affordable and reliable translation services can have dire impacts on the health and wellbeing of women from CALD backgrounds.

The expense involved in accessing TIS was also raised by representatives of women's services in the community sector, who reported being in the same situation as aged care providers; that is, the use of TIS is not factored into funding agreements. SAAP services are no longer able to access TIS as a free service because around two years ago, the contracts went through without the Memorandum of Understanding (MOU) which provided for it.

Whether they are properly understood or not, many women of CALD backgrounds regard their GP as something of a one-stop-shop, and trust their doctor's advice without question. The unwavering trust the women have of someone in a position of power means they are vulnerable to being exploited by doctors. Accessing a GP for all health concerns can also raise some problems when the GP has limited information on the issues women are experiencing. For example, in some cases women have become addicted to a drug (whether prescribed or illicit) and have sort the advice of their GP. However, this has not been the best health care option due to lack a thorough understanding of the issues contributing to addiction in general practice. As such, many women have gone without adequate treatment and support services.

Women's access of adequate health care can be further complicated when the woman does not understand English. As mentioned in section 4.4, some women are prescribed medication without knowing anything about it or its side effects. Addiction to such drugs is common; a representative of WIREDD confirmed this, indicating that women of CALD backgrounds seem to be at higher risk of addiction to benzodiazepines. There is a serious lack of funding in the area of drug and alcohol services for women of CALD backgrounds, and subsequently there is a notable gap in service provision.

Women from CALD backgrounds in the ACT reported feeling vulnerable to exploitation and discrimination through the legal system, particularly if they did not speak English. Women in domestic violence situations were in particular need for legal services. As noted in results, workers in residential domestic violence services asserted that it could be very difficult to find legal representatives to represent women who could not speak English, especially because English speaking perpetrators already had an advantage. Legal Aid was a great support on some occasions, however this was not consistent. Because women of CALD backgrounds (especially new arrivals) often have limited finances available to them, workers must

find legal representation to work pro bono. This information supported the claim in an earlier WCHM report that there is a “lack of affordable legal services.”⁷⁷

In addition to domestic violence, another common legal problem in the CALD community is driving a car without a license or registration. This was raised as particularly pertinent to Sudanese youth. While the Sudanese community has been very proactive in addressing their current legal issues in a collaborative manner, the fact remains that not all cultural groups are formalised to this extent. And what of those individuals who are so isolated so as not to even know the existence of these groups or organisations? They fall through the gaps and must endure their legal problems in isolation.

Any person new to Canberra faces a range of difficulties which can potentially result in social isolation. They might encounter problems in being able to establish social networks, with the public transport system, or even simply finding their way around. Add to this being in a new country, and having limited understanding of the language, and that person becomes even more vulnerable to social isolation. Again, a report commissioned by the WCHM in 2008 noted that CALD women are one of the most marginalised and socially isolated groups in the ACT, and that their health and wellbeing is negatively impacted as a consequence.

In particular, the results of this research suggested that the move from such a mutually supportive society to one that is largely individualistic could have an impact that should not be underestimated. The sudden lack of this support system at a time when important decisions needed to be made can be incredibly stressful. This was supported by material presented in section 2.⁷⁸ Even when women from CALD backgrounds have been living in Canberra for a number of years, they still may be at risk of isolation. Several examples of the social isolation that still occurs in Canberra were raised in section 4. These refuted any myth that Canberra is a society of equal opportunity. How could this be the case when some women had never had a coffee at a café, or had been nowhere but her local supermarket in five years?! This kind of isolation not only has an emotional toll on the woman, but also influences her access to health information and promotion.

Research suggests that CALD women are a difficult group to target for health promotion, and the barriers that they face in accessing medical services negatively influences rates of preventative health behaviours. The results of this study indicated that this information could be transferrable to the ACT. As noted in section 4, a Tongan woman explained that women of her culture have higher incidences of breast cancer because of low rates of health screening.

Tongan women are not the only cultural group who have poor levels of preventative healthcare. Many cultural groups demonstrate similarly low levels, and do so for a range of reasons. A review of the available literature purported several explanations for this, including (but not limited to) lack of culturally appropriate information and the various beliefs around health in different CALD communities. One study reported that there is often minimal health information available in languages other than English, and that women of CALD backgrounds are then forced to rely on family and friends for health information.⁷⁹ This becomes problematic when women feel that their health

⁷⁷ Sarah Maslen, *Marginalised and Isolated Women in the Australian Capital Territory*, (Canberra: Women’s Centre for Health Matters, 2008), 35.

⁷⁸ Miriam Stewart et al, “Multicultural meanings of social support among immigrants and refugees,” *International Migration* 46, no.3 (2008).

⁷⁹ Sansnee Jirojwong and Robert MacLennan, “Health beliefs, perceived self-efficacy, and breast self-examination among Thai migrants in Brisbane,” *Journal of Advanced Nursing* 41, no. 3 (2003).

concerns are too personal (or even taboo) to share with others.⁸⁰ This is common among women who have experienced rape, sexual assault, domestic violence or addiction (among others), and was raised by several participants. This is further supported by research conducted through SHFPACT:

I think that one of the things...with translators and interpreters...it's part of a small community. If I am the person who has needed to use the services of that translator to discuss something very intimate and personal with a service provider, I see them the next time in the mosque I'm very likely to shy away from them and suspicious that they have told other people in the community what has happened to me.⁸¹

As mentioned in earlier, it is not always in the woman's best interests to divulge information about such factors if there is a risk that confidentiality and impartiality might be compromised. It is important to note that this concern that confidentiality might be breached is not an unfounded fear, as it has occurred in Canberra. The impact of cultural beliefs around illness can also influence some CALD women's reluctance to engage in screening behaviours. Research outlined in the section 2 argued that Chinese women who migrated to Australia were less likely to undertake breast screening because of their beliefs regarding predestination. These women felt that screening was pointless because illness and death is beyond individual control.⁸²

A woman who had worked with South East Asian women regarding diabetes agreed, and added that the Western concept of health, and preventative measures were literally foreign to those women. Workers in the community sector suggested that mental illness can also be a huge issue in relation to differing cultural values because it is often not accepted or even believed. The belief that mental illness is "evil eye" and can be cured by a Magic Man (along with a range of other ailments such as cancer, diabetes and bad luck) was relatively common, particularly among some Middle Eastern and African cultural groups. Beliefs such as these do not tend to hold much faith in health screening, and thus should be considered in health promotion activities.

While several women gave examples of places health information should be advertised (such as ethno-specific radio and newspapers, halal butchers, supermarkets and buses), perhaps one of the most effective protective factors is a strong social network. One woman felt that if she'd possessed more extensive networks then she might have been able to understand her husband's mental illness sooner, and even been told where she might go for formal support. Another woman felt that the post-Church gossip session in her cultural community was an ideal opportunity to share information. These occasions have the potential to dispel health related myths, and create connections so that women feel safe in accessing services. Such outreach-based work can make a real impact in many CALD groups. Even when women find out about services, there is potential for powerful emotional barriers, and therefore establishing a rapport during outreach can support women to overcome these.

⁸⁰ Cannas Kwok and Gerard Sullivan, "Influence of traditional Chinese beliefs on cancer screening behaviour among Chinese-Australian women," *Journal of Advanced Nursing* 54, no. 6 (2006).

⁸¹ Cheryl Bateman, *Seen, but not heard! Understanding Islamic women's perceptions of sexual and reproductive health: Identifying barriers to access in order to improve service provision in the ACT*, (Canberra: Sexual Health and Family Planning ACT, 2003), 81.

⁸² Cannas Kwok and Gerard Sullivan, "Influence of traditional Chinese beliefs on cancer screening behaviour among Chinese-Australian women," *Journal of Advanced Nursing* 54, no. 6 (2006).

In addition to assisting outreach-based health promotion, good social networks had a positive impact on social inclusion. As discussed in the section 2, social networks are imperative in nations such as Australia, where government responsibilities and settlement services for refugees are generally associated with time limits.⁸³ When this time is up, these people can only rely on themselves and the limited support networks they have developed in such a short timeframe. This was demonstrated in this research when the women involved in the Mon focus group shared that Centacare worked with them for a maximum of six months. Through the course of the focus group (during a weekday) there was a literal open door policy, and people came and went as they pleased. There was a very social atmosphere, and thus if Mon women were engaged with their cultural group, one would imagine that there would be sound social connection. But what of those women who do not have a cohesive cultural community in the ACT? They often remain unsupported and in isolation.

Social networks in Canberra seemed to be improved by the use of the internet. This was also evident in the effectiveness of snowball sampling in this study, as many women learnt of the project via email. Given the geographical nature of Canberra, it is not surprising that women found it much easier to remain in contact via email, rather than in person. This is perhaps also a solution to the concern that many women raised in relation to transport difficulties visiting friends who lived several suburbs away, albeit a poorer substitute. This does, however, raise the concern that many women of CALD backgrounds do not have access to a computer or the internet, and may not be computer literate. A recent successful initiative by the WCHM was a computer course for women who spoke Cantonese or Mandarin, which, in addition to developing computer literacy, also served to help women engage in social networks.

The importance of recognising the diversity within the label of 'CALD' should not be lost. There are many sub-groups within this label, and each of these may face different barriers to achieving social inclusion. Even when people do come from the same country, they can have vastly different cultures depending on the point at which they migrated. Croatians who migrated before the war, for example, and those who came later as refugees had enormously different experiences. Women should therefore be treated as individuals rather than with expectations according to their culture, and this diversity should be valued. Yet another example of the diversity within cultural groups was provided in section 4: two young, Muslim women separated from their husbands through domestic violence had very individual responses (both personally and familial) to their experiences. The importance of the awareness of culturally appropriate practice was also noted in section 2, when an international study suggested that Western nations (who generally accept significant numbers of legal immigrants) are often lacking in this area.⁸⁴

The individual way in which different cultures deal with survivors of sexual assault and rape was raised. Some women stated they would be shamed and isolated by their cultural community if they were sexually assaulted or raped, and thus workers needed to be aware that women may have good reason not to voice their trauma. One woman of CALD background interstate was publically shamed within her community after she was raped and became pregnant. Two and a half years after the woman gave birth, the man who raped her sought visitation rights to the child. The

⁸³ Celia McMichael and Lenore Manderson, "Somali women and well-being: Social networks and social capital among immigrant women in Australia," *Human Organisation* 63, no.1 (2004).

⁸⁴ Miriam Stewart et al, "Multicultural meanings of support among immigrants and refugees," *International Migration* 46, no.3 (2008).

trauma that this woman would have been experiencing during this process was raised, particularly after being shamed and isolated for something over which she had no control, the man who caused it all returned and demanded rights in relation to her baby. She ultimately threatened suicide as a result. Research conducted in the ACT also notes that trauma can have a significant impact on women's health and wellbeing, and also on their emotional capacity to access healthcare. With regard to "sexual and reproductive health, many of those women who have been tortured, the very thought of someone touching them in their virginal (sic) area is a real anathema to them, because the last time somebody did that it was to put probes in them and electrocute them."⁸⁵

PTSD can develop in any timeframe and it therefore can become a serious concern after women have settled and spent some time in Australia. Workers who may encounter migrants or refugees in the course of their work should have the training to be mindful of the historical and political history of various nations, and the subsequent risk that these groups have been through traumatic circumstance. It is also important to understand the different responses that women have to trauma. As noted earlier, one woman deliberately isolated herself in order to work through the trauma and grief in her life. This was her way of coping with her experiences, as it would have been impossible for her to describe to anyone the enormity of her feelings. The fear, grief and loss that this woman and her family encountered was huge. They literally saw the world as they knew it crumbling around them. While, for some of us, the idea of our society being destroyed in war seems completely unreal and even impossible, there are many civil wars that exist at any one time with equally devastating and traumatic effects on the people within.

Depression, suicidal ideation and suicide attempts were alarmingly common among women of CALD backgrounds, especially those who had been in domestic violence situations. Ironically, the excuses that the perpetrators of this violence gave to their cultural communities for the absence of the woman at various events, was often related to accusations of mental illness. As mentioned above, mental illness can be an issue in different cultures because it's not necessarily even believed. It can be seen as a curse or black magic of some description, and some believe it can be cured by a Magic Man. Even when mental illness is not seen as a curse, it can still cause social exclusion and discrimination. Furthermore, mental illness is not something that everyone has been exposed to and when faced with it in a foreign country without support, one's own self efficacy can suffer.

Compounding existing feelings of grief and loss was the shift from all that was familiar to the unknown. Several women reported that the lack of recognition of their qualifications was very difficult for them. This was supported by research outlined in section 2.⁸⁶ While some women returned to university for new qualifications, many remain working in the community in positions well below their educational level. Some workers felt that many women of CALD backgrounds have qualifications in 'caring' professions, and thus their experience could be easily transferrable to child care if a suitable bridging course was developed. While this could be a good solution for concerns around child care, one must question why these women shouldn't be able to maintain their own career direction with such a course. Having said this, qualifications do not necessarily help women of CALD backgrounds find employment as discrimination and racism remain common in our educated society.

⁸⁵ Cheryl Bateman, *Seen, but not heard! Understanding Islamic women's perceptions of sexual and reproductive health: Identifying barriers to access in order to improve service provision in the ACT*, (Canberra: Sexual Health and Family Planning ACT, 2003), 99.

⁸⁶ Miriam Stewart et al, "Multicultural meanings of support among immigrants and refugees," *International Migration* 46, no.3 (2008).

While it is perhaps more reasonable to expect discrimination occurring in the 1950s, as one woman reported was her parents' experience, the results of this research suggest that it is certainly still occurring in contemporary society. Several women reported racism and discrimination in the workplace, and felt that they had been excluded from employment opportunities on this basis. The email that one woman sent after her research interview was a clear example of this (see section 2). So honest in nature, it epitomises what so many women of CALD backgrounds experience throughout their lives, and this is when they actually are able to get employment! Other women applied for many positions and were turned down.

Given the abilities and passion that so many of these women have, one can only assume that they are not receiving opportunities on the basis of cultural background. This suggestion is supported by Challenging Racism: The Anti-Racism Research Project, which recently found that 28 per cent of ACT respondents believed that some ethnic groups do not fit in to Australian society.⁸⁷ The most common groups reported were Muslims or people from the Middle East.⁸⁸ Although the ACT had the lowest response rate of this type, local media should certainly not convey that 28 per cent is an acceptable rate of racism, let alone that it is something to be proud of. Several women shared that racism and discrimination can have a profound impact on one's self esteem and can cause depression and anxiety.

⁸⁷ Author unknown, "1 in 10 Australians outwardly 'racist,' but not in the ACT," *The Canberra Times*, September 29, 2008. Accessed on October 2, 2008, at [<http://www.canberratimes.com.au/news/local>].

⁸⁸ Ibid.

6 Conclusion

Many barriers exist to accessing services in the ACT by women of CALD backgrounds. The results of this research confirm that these barriers play a significant role in women's social isolation and their subsequently reduced health and wellbeing status. Research on international, national and local levels support the results presented in this report, indicating a range of issues that women of CALD backgrounds encounter which can affect their health and wellbeing. These studies included research on: the lack of understanding around culturally appropriate support in Western nations; the importance of social networks; barriers to accessing services such as language, insufficient childcare, problems navigating systems, immigration status, transport, discrimination and changes to family dynamics; the impact of trauma; challenges for health promotion; domestic violence; the financial situation of many CALD women; the experience of refugees; acculturation; and the social determinants of health. These topics proved to be common themes in the qualitative data collected as part of this research project, suggesting that the experience of CALD women on both national and international levels is able to be generalised to that of CALD women in the ACT.

There were fifteen major themes identified in the data. These were immigration and emerging communities, language concerns, domestic violence, drugs and/or alcohol, legal issues, isolation, the need for cultural sensitivity, children and child protection, loss of qualifications and careers, discrimination and racism, limited transport, unfamiliarity with available services, mental health, trauma and the elements that enhanced social connectedness. Each theme was based on information invaluable in determining what steps might now be taken to address the gaps in services, and the barriers that women of CALD backgrounds face even when services exist. As noted above, these themes were quite consistent with the issues raised in the available literature.

Women of CALD backgrounds in the ACT experience a range of issues that can adversely affect their health and wellbeing, and this should not be accepted. Australia, like most Western nations, prides itself on its human rights and air of equality for all. The experience of many women involved in the research process indicated that, for some, this is nothing but a façade. Steps need to be taken to ensure that CALD women in the ACT are able to achieve social inclusion, and associated good health and wellbeing. If, as has been suggested, the number of refugees coming to Australia grows, both government and community sectors will need to be ready so as not to fail them.

Bibliography

Anonymous, "Ethno-specific homes to help dementia patients," *Australian Nursing Journal* 12, no. 1 (2004), 33.

Australian Bureau of Statistics. 'B09 Country of Birth of Person by Sex, Canberra.' 2006 Census of Population and Housing. 2006. Accessed on January 28, 2009, at [<http://www.censusdata.abs.gov.au/>].

Author unknown, "1 in 10 Australians outwardly 'racist,' but not in the ACT," *The Canberra Times*, September 29, 2008. Accessed on October 2, 2008, at [<http://www.canberratimes.com.au/news/local>].

Bateman, C. *Seen, but not heard! Understanding Islamic women's perceptions of sexual and reproductive health: Identifying barriers to access in order to improve service provision in the ACT*, (Canberra: Sexual Health and Family Planning ACT, 2003).

Bowles, R. *Social work with refugee survivors of trauma and torture* (Sydney: STARTTS, year unknown).

Cheong, P., Edwards, R., Goulbourne, H. and Solomos, J. "Immigration, Social Cohesion and Social Capital: A Critical Review," *Critical Social Policy* 27, no. 1 (2007), 24-49.

Choudhry, U. "Health promotion among immigrant women in Canada," *Journal of Nursing Scholarship* 30, no. 3 (1998), 269-274.

Costa, D. "Health Care of Refugee Women," *Australian Family Physician* 36, no. 3 (2007), 151-154.

Crandall, M., Senturia, K., Sullivan, M and Shiu-Thornton, S. "'No way out'; Russian women's experiences with domestic violence," *Journal of Interpersonal Violence* 20, no. 8 (2005), 941-958.

Greig, A., Lewins, F. and White, K. *Inequality in Australia* (Cambridge: Cambridge University Press, 2003).

Harris, M. and Telfer, B. "The health needs of asylum seekers living in the community," *The Medical Journal of Australia* 175, no. 12 (2001), 589-592.

Jirojwong, S. and MacLennan, R. 'Health beliefs, perceived self-efficacy and breast self-examination among Thai migrants in Brisbane,' *Journal of Advanced Nursing* 41, no. 3 (2002), 241-249.

Kokanovic, R. and Manderson, L. "Social support and self-management of type 2 diabetes among immigrant Australian women," *Chronic Illness* 2, no. 4 (2006), 291-301.

Kwok, C. and Sullivan, G. "Influence of traditional Chinese beliefs on cancer screening behaviour among Chinese-Australian women," *Journal of Advanced Nursing* 54, no. 6 (2006), 691-699.

Marmot, M. and Wilkinson, R., eds. *Social Determinants of Health*, 2nd Edition (Oxford and New York: Oxford University Press, 2006).

Maslen, S. *Marginalised and Isolated Women in the Australian Capital Territory*, (Canberra: Women's Centre for Health Matters, 2008).

Maslen, S. *Social Determinants of Women's Health in the Australian Capital Territory* (Canberra: Women's Centre for Health Matters, 2008).

- McMichael, C. and Manderson, L. "Somali women and wellbeing: Social networks and social capital among immigrant women in Australia," *Human Organisation* 63, no. 1 (2004), 88-99.
- Menjivar, C. and Salcido, O. "Immigrant women and domestic violence: Common experiences in different countries," *Gender and Society* 16, no. 6 (2002), 898-920.
- Omeri, A., Lennings, C. and Raymond, L. "Beyond Asylum: Implications for Nursing and Health Care Delivery for Afghan Refugees in Australia," *Journal of Transcultural Nursing* 17, no. 1 (2006), 30-39.
- Refugee Council of Australia, Who bears the cost of Australia's Special Humanitarian Program? Research into the impact of travel costs on new Special Humanitarian entrants and their proposers (Melbourne: Refugee Council of Australia, 2008).
- Savage, J. and Becker, R. *Refugee women, sexual assault and communities* (Sydney: STARTTS, 2003).
- Smith, M. "Asylum Seekers in Australia," *Medical Journal of Australia* 175, no. 12 (2001), 587-589.
- Sowey, H. *Are refugees at increased risk of substance misuse?* (Sydney: Drug and Alcohol Multicultural Education Centre, 2005).
- Stewart, M., Anderson, J., Beiser, M., Mwakarimba, E., Neufeld, A., Simich, L. and Spitzer, D. "Multicultural meanings of social support among immigrants and refugees," *International Migration* 46, no. 3 (2008), 123-159.
- Taylor, R., Mamoon, H., Morrell, S. and Wain, G. "Cervical Screening in Migrants to Australia," *Australian and New Zealand Journal of Public Health* 25, no. 1 (2001), 55-61.
- Timotijevic, L. and Breakwell, G. "Migration and Threat to Identity," *Journal of Community and Applied Social Psychology* 10 (2000), 355-372.
- World Health Organisation, *Constitution of the World Health Organisation*, 45th Edition (Geneva: World Health Organisation, 2006).

Appendix A: List of Acronyms

Adult Migrant English Program	AMEP
Apprehended Violence Order	AVO
Australian Bureau of Statistics	ABS
Australian Capital Territory	ACT
Australian National University	ANU
Australian Public Service	APS
Canberra Institute of Technology	CIT
Canberra Rape Crisis Centre	CRCC
Culturally and Linguistically Diverse	CALD
Department of Immigration and Citizenship	DIAC
Domestic Violence Crisis Service	DVCS
English as a Second Language	ESL
Equal Employment Opportunity	EEO
General Practitioner	GP
International Organisation for Migration	IOM
Memorandum of Understanding	MOU
Migrant and Refugee Settlement Services	MARSS
Migrant Resource Centre	MRC
Multicultural Women's Advocacy	MWA
Post Traumatic Stress Disorder	PTSD
Sexual Health and Family Planning Australian Capital Territory	SHFPACT
Special Humanitarian Program	SHP
Supported Accommodation Assistance Program	SAAP
Translating and Interpreting Service	TIS
United Kingdom	UK
United Nations High Commissioner for Refugees	UNHCR
United States of America	USA
Woden Community Service	WCS
Women's Centre for Health Matters	WCHM
Women's Information and Referral Centre	WIRC
Women's Information Resources and Education on Drugs and Dependency	WIREDDD
World Health Organisation	WHO
Young Women's Christian Association	YWCA

Appendix B: Invitation to Participate

Women's Centre for Health
Matters
PO Box 385
Mawson ACT 2607

To Whom It May Concern:

Invitation to share your experiences as culturally and linguistically diverse women in the Australian Capital Territory (ACT)

I am conducting research for the Women's Centre for Health Matters with regard to the experiences of social inclusion (or isolation) of culturally and linguistically diverse women. I plan to explore the issues that impact on the social connectedness and wellbeing of women who are from a culturally and linguistically diverse background, and ultimately plan to use my research to help raise the awareness of these issues. The Women's Centre for Health Matters, and other organisations in the ACT community, will then be able to use the information to advocate for initiatives to promote social connectedness.

In order to get this right, I need your help. I would like to invite you to share with me your experience of social inclusion or isolation. I want to know what it is like to live in the ACT as a woman from a culturally and linguistically diverse background from your perspective. Any difficulties that women have encountered are of particular importance. I understand that some women might be more comfortable writing about their experiences, and others might like to discuss it in person. I also appreciate that women might prefer to speak or write in their own language. I am happy for an interpreter to be present if we meet in person, or if women would like to write in their own language, I will arrange for that to be translated at a later date.

If you choose to participate by writing your experience, the following points are examples of what you might like to include, however you should not feel limited to these topics:

- How often you go out, where you might go, and who you might see in a typical week.
- If you ever feel lonely in Canberra, and if so, how often you feel this way.
- If there are any services or groups that you have made contact with, if so, what they might be, and what they are supporting you with. How helpful you have found the service, and how it might be improved could also be included.
- If you have ever tried to access housing, employment, language lessons or social groups and how that experience was for you.
- If you have someone in Canberra who you can call or visit to share good news with, or if you needed help with something, and if they are a family member, a friend or someone else (such as a service provider).

Any information you could share with me, either written or spoken, would be greatly appreciated. Your stories will remain confidential, and no names will be used in this report. If you prefer to remain anonymous and send your written experience via post,

that is fine. If you wouldn't mind, some demographic information would also be useful. I ask that you include:

- your first language;
- your country of origin;
- the year you were born;
- how long you have lived in Australia; and
- how long you have lived in Canberra.

If you know any other women who you think might have something to say on the topic, please pass this letter on to them. If anyone requires it in another language, please call me at the Women's Centre for Health Matters on 6290 2166 or email student@wchm.org.au and I will arrange a translated copy. Due to time limitations, written and verbal responses will have to be made by close of business on Friday, October 10th. Finally, I ask that women who would like to participate complete the consent form attached.

If you have any questions regarding this research, please feel free to call me on the number above.

Sincerely,

Bec Brewer
Student Social Worker
Women's Centre for Health Matters

Month, Day, 2008

Appendix C: Consent Form

(Can be produced in other languages)

Subject of research project: Issues that impact on the social connectedness and wellbeing of women from a culturally and linguistically diverse background in the ACT.

Name of researcher: Bec Brewer (Women's Centre for Health Matters).

I have read and understood the information provided in the letter attached, and any questions I have asked have been answered to my satisfaction. I agree to participate with either verbal or written responses, and realise that I can withdraw at any time.

Name of participant:

.....

Signature: **Date:**

Name of researcher: Bec Brewer (Women's Centre for Health Matters).

Signature: **Date:**