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Australian Government Department of Health
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National Women's Health Strategy 2020-2030 DRAFT for consultation

SECTION A – DEMOGRAPHICS

SECTION B – THE STRUCTURE OF THE STRATEGY

11. Overall structure of the Strategy

Is the overall structure of the Strategy appropriate and easy to follow?

Yes **No**

12. Overall structure of the Strategy – comments

Please provide comments on your selection below (200 word limit)

Australia is increasingly diverse with a quarter of Australia's population born overseas and 43 percent of people having at least one overseas-born parent (ABS 2016). The Strategy must give appropriate recognition of the barriers and inequities faced by CALD Australians through targeted actions. One barrier for CALD women and girls in accessing health care is a lack of Australian health literacy. Only 33 percent of people born overseas have adequate or better than adequate health literacy, compared to 43 percent of the Australian-born population. This figure drops to 27 percent for those who arrived in Australia during the past five years and to 26 percent for people whose first language is not English (Migration Council of Australia 2015). Low health literacy can result in less access to the services that they need; less understanding of issues related to their health; social isolation, impacting physical and mental health; risk of mismanaging medication; and inadequate understanding of health issues. Improving health literacy amongst CALD women and girls should be explicitly covered in this Strategy.

13. Adequate context and background for the Strategy

Do the sections: About the Strategy, The Strategy in context, Women's health at a glance, Priority populations, Life course approach and what we want to achieve provide adequate context and background for the Strategy?

Yes **No**

14. Is anything missing from context and background?

Relating to Question 13, is there anything missing or anything that should be changed? (400 word limit).

Given Australia's migration trends, requirement for access to CALD appropriate health services will continue to increase into 2030 but 'Women's health at a glance' does not address CALD women and girls. The specific health risks for CALD women and girls and their barriers to accessing health services needs to be explicitly acknowledged and addressed in this section.

The existing information in 'Priority populations' does not address the diversity and different knowledge levels within the CALD community in regard to health literacy and engagement with health services. The Strategy does not acknowledge that 'CALD women and girls' are not a homogenous group and that varied levels of engagement with preventative health services, mental health services and written sources of health information, exist between different communities depending upon English language proficiency, length of stay in Australia and other factors.

Common amongst CALD Australians is a lack of trust in the health care system which may stem from experiences with health care in their country of origin or in Australia. Other barriers such as a lack of culturally appropriate health care services, lack of familiarity with the healthcare system, perceived and experienced racism, difficulties communicating with healthcare providers, methods of learning inconsistent with education offered by health care providers, religious and cultural practices, continued use of traditional medicines and therapies, and low health literacy need to be addressed. These issues contribute to lower rates of participation among migrants in a range of programs including cancer screening, mental health care, and pre-emptive care for preventable conditions.

CALD women who are also members of the LGTBIQ community, live in rural and remote areas, are aging or living with a disability are at increased risk of being overlooked by health policy and practice. Intersections between priority populations and the increased barriers women face in accessing health services should be acknowledged.

For the life course approach to successfully include CALD women and girls, the differing experiences of migrants at various stages of life and the impact of the age of migration need to be acknowledged and integrated to ensure new gaps are not created. An example of this is the advocacy and interpreter role often played by recently arrived CALD children to their families or the experiences of migrants who arrive in Australia in older age.

15. Strategy blueprint, Policy principles and Strategy objectives

Do the sections: Strategy blueprint, Policy principles and Strategy objectives adequately frame the approach for, and intent of, the Strategy?

Yes **No**

16. Strategy blueprint, Policy principles and Strategy objectives – comments

If no was selected, please provide your comments and explain your selection below (400 word limit).

The policy principles and strategy objectives do frame the approach of the Strategy however the priority populations are absent from this section. Principle 2, health equity between women, can only be achieved when all women have knowledge of health services and there are measurable improvements to access and outcomes for CALD women and children. Principle 3 should recognise that 'life course' for migrants may be different from other populations and

adult new arrivals will need special attention to ensure information in communicated and further gaps are not created. Principle 5 is important to improved health access and outcomes for CALD women and girls. For adequate data to be collected, methodology must be culturally sensitive understanding that a lack of Australian health literacy is not just due to language barriers, it also includes other factors including varied concepts of health and disease, a lack of institutional knowledge, and a lack of confidence in engaging with health providers. Currently there is no longitudinal data on health outcomes for migrants to gauge the impact of poor health literacy, gaps in current health care services and barriers to access. All health data and research must be inclusive and reflective of Australia's culturally diverse population.

SECTION C - PRIORITY AREAS

17. Do you agree with the priority areas identified for the Strategy?

Yes No

18. Priority areas – comments

If no was selected, please provide comments and explain your selection (200 word limit).

19. Priority area 1 – Mental health and wellbeing

Do the priorities and actions specified for Priority area 1: Mental health and wellbeing, adequately address the specific health needs of women and girls in Australia?

Yes **No**

20. Priority area 1 - anything missing?

With regard to Priority area 1, is anything missing or should anything be changed? Please provide your comments below (400 word limit).

When providing resources and support to women and healthcare professionals, the social influences on mental health experienced by CALD women including; migration, racism and discrimination must be directly addressed. The circumstances around an individual's migration to Australia can be traumatic and have considerable impact on an individual's mental health, including adjusting to a new culture, the stress and pressure individuals feel to be successful and the lack of awareness of where to seek help. The Scanlon Foundation found that the reported experience of discrimination on the basis of 'skin colour, ethnic origin or religion' has significantly increased from 15 percent in 2015 to 20 percent in 2017 which has a significant impact of mental health and wellbeing.

When investing in service delivery for CALD women, engagement with CALD community groups is important to building trust and understanding in Australian health care services. The capacity and funding of CALD community groups and services who already effectively reach CALD women and girls should be increased to provide resources, guidance and information regarding referral pathways for mental health. Supporting community groups to deliver information about mental health and health service availability can help remove barriers and bias within communities.

To ensure increased service delivery for CALD women, they must be accurately represented by statistics of mental health. For this to happen methodologies must be re-visited as migrants from a non-English speaking background are less likely to communicate that they have a mental health disorders compared to Australian born people (AIHW 2010). The creation and support of more CALD-specific mental health services, including a multilingual mental health

counselling help-line would help to reach more of the community. Additionally it is widely recognised that the current methodologies for assessing mental health are not appropriate in cross-cultural contexts even once translated because concepts, scales and norms vary between populations (Cultural diversity and mental health Australasian Psychiatry 2015). This lack of communications and difficulty in assessing CALD Australians using current methodologies needs to be addressed to ensure the entire population is receiving adequate health services.

When using a co-design approach to identifying language preferences to reduce stigma around mental health, this needs to be extended to any translations as well as the English-language version and all versions should be tested with diverse communities of CALD women and girls.

21. Priority area 2 - Chronic disease and preventive health

Do the priorities and actions specified for Priority area 2: Chronic disease and preventive health, adequately address the specific health needs of women and girls in Australia?

Yes **No**

22. Priority area 2 - anything missing?

With regard to Priority area 2, is anything missing or should anything be changed? Please provide your comments below (400 word limit).

To ensure priority 2 meets the needs of all women and girls services, awareness campaigns, policy and practice need to recognise the inequity of health. For example, breast cancer is recognised in the Strategy as an area that needs more attention and in 2012-2013 BreastScreen Australia reported that women who spoke a language other than English at home participated in the program at a rate of 6% lower than those who spoke only English at home. This example of inequity in participation is concerning and should be addressed with the creation of more front-line CALD services and specific awareness campaigning to ensure CALD women and girls are adequately targeted in this priority area. When developing the proposed ‘map’ of risk factors across a women’s lifespan, ensure that the impact of CALD specific and migration experiences are included over the life course. Any consultation used to design services for women’s health programs should ensure that CALD women are adequately represented to deliver outcomes for all women.

Cultural competency training is essential for all medical staff to effectively support CALD women and girls. Understanding that these women come from diverse backgrounds, with varied understanding of health and healthcare and with different barriers to accessing adequate health care is important to achieving health equity between women. For example, some women require treatment by female medical practitioners, a translation service may be required for all health related conversations and others only when more complex health information is being communicated. In a Strategy that relies on GPs as the health system gateway, and on individuals to navigate the system and self-manage their healthcare, it is crucial that GPs understand the difference in the expectations of their role based on other healthcare systems/experiences. Support must also be provided to CALD women and children to ensure they recognise their central role as individuals within the Australian health care system to empower participation in their health.

In promoting a healthy lifestyle amongst CALD women and girls the Strategy should acknowledge that for women from diverse cultural backgrounds, a healthy lifestyle may involve a variety of healthy food choices, diverse exercise preferences and the inclusion of alternative medicines. On arrival in Australia, there a numerous factors that can impact upon whether

new migrants establish healthy eating patterns, including income, limited English, and a lack of familiarity with local foods and shopping practices.

23. Priority area 3 - Sexual and reproductive health

Do the priorities and actions specified for Priority area 3: Sexual and reproductive health, adequately address the specific health needs of women and girls in Australia?

Yes **No**

24. Priority area 3 - anything missing?

With regard to Priority area 3, is anything missing or should anything be changed? Please provide your comments below (400 word limit).

Maternal health care services must include the provision of culturally safe maternity services (all staff involved in providing maternity services are trained in cultural competence) and maternity services in a woman's preferred language (including translator services and the increased engagement of bilingual and bicultural workers). There is no systematically collected national data in Australia on the prevalence of FGM and whilst the practice is illegal in Australia many migrant women have emigrated from countries where FGM is known to be practiced. Awareness of and skills for working with women who have experienced FGM, including their long term health requirements, amongst practitioners needs to be improved.

Sexual and reproductive health services are underutilised by migrant and refugee communities resulting in a lack of information for informed decision-making and poor sexual and reproductive health outcomes among these women. In a report based on focus groups and one-on-one interviews, titled Sexual and Reproductive Health of Migrant and Refugee Women (Western Sydney University 2017), women highlighted their need for information on sexual and reproductive health. Participants wanted more information on: menstruation, menopause, contraception, sexual health screening, STIs, sexual education of young people and painful sex. These results indicate that information on sexual and reproductive health literacy is not reaching all women. There is a need for health providers to recognise the social norms and practices of sexual and reproductive health within migrant and refugee populations, in order to provide culturally safe medical care, health education, and health promotion, and to increase capacity to access sexual and reproductive services. Access to female doctors and translator services are also important for CALD women including ensuring that the translator is not from her own community (due to possible stigma). Actions to reduce stigma and increase trust in confidentiality in sexual and reproductive health services is important to removing barriers for CALD women and children.

25. Priority area 4 - Conditions where women are overrepresented

Yes **No**

26. Priority area 4 - anything missing?

With regard to Priority area 4, is anything missing or should anything be changed? Please provide your comments below (400 word limit).

CALD women are a vulnerable group to family and/or intimate partner violence for a range of reasons, including the impact of the immigration system in perpetuating dependence with visa sponsorship, therefore it is essential that the Strategy targets these communities in a meaningful way.

There are many barriers to women from non-English speaking backgrounds reporting experiences of family, intimate partner and/or sexual violence including: being excluded for their community, the limited availability of appropriate translator/interpreter services and access to support services, limited support networks, dependence on partner/family for visa sponsorship, reluctance to confide in others, lack of awareness about the law, continued abuse from immediate family, cultural and/or religious shame and religious beliefs about divorce. Immigration can also cause increased: financial and family pressure; social and cultural dislocation and exacerbate existing disputes. FECCA recommends that further research examine cultural and systemic barriers to accessing support or reporting sexual violence. Certain CALD cohorts are particularly vulnerable to sexual violence, including international students. This cohort face additional barriers in reporting or seeking support for abuse, because they often lack understanding of the local healthcare system, hold insurance that does not cover these services and/or have lower levels of English language proficiency. There may be cultural reasons as to why victims do not want to disclose sexual assault to a medical service, or they may fear their families at home finding out. A lack of CALD services, or services that are not appropriate to the needs of LGBTIQ students, also increase these difficulties for CALD or LGBTIQ students who experience sexual violence. It is important that services are CALD specific and intersectional issues relating to sexual violence are considered in this Strategy for women's health.

Involving community elders, leaders and individuals in developing culturally appropriate prevention strategies is important to ensure the right message is being received by all CALD communities on family and intimate partner violence, sexual violence, marital sexual communication and consent.

27. Priority area 5 - Healthy ageing

Yes **No**

28. Priority area 5 - anything missing

With regard to Priority area 5, is anything missing or should anything be changed? Please provide your comments below (400 word limit).

Almost one in three older Australians were born overseas, with a significant number of these coming from CALD backgrounds. Almost 40 per cent of all migrants from non-English speaking countries are aged 50 years and over, compared to 32.4 per cent of Australia's total population aged 50+ years. This large proportion of older Australians need to be specifically targeted when considering healthy ageing.

In adopting a life course approach to healthy ageing, the Strategy should resolve the potential for creating new gaps for CALD women who may migrate at different life stages and have varied levels of knowledge about healthy ageing. Older people of refugee backgrounds are particularly vulnerable to physical and mental health issues due mostly to their migration experiences and reasons for migrating.

When addressing key risk factors that reduce quality of life for ageing women, CALD women need to be considered. Many elderly migrants from non-English speaking backgrounds lose their acquired language skills which can contribute to underreporting of medical conditions and increased feelings of isolation. Bilingual workers, bi-cultural workers and translator services must be included in this strategy to ensure these women are included in all existing and recommended services.

People with dementia who speak a language other than English at home are expected to increase 3.4 fold to around 120,000 (113,000 and 124,000 in the low and high cases

respectively) in 2050. Research relating to older people from CALD backgrounds with dementia suggests that a poor understanding of dementia and a cultural stigma relating to dementia can lead to denial of the condition and/or delayed diagnosis for some older people.

SECTION D - RESEARCH, PARTNERSHIPS AND PROGRESS

29. Investing in research

Do the actions specified for investing in research, adequately address the specific research needs to improve health outcomes for women and girls in Australia?

Yes **No**

30. Investing in research - anything missing?

With regard to Investing in research, is anything missing or should anything be changed? (400 word limit).

All research must be inclusive and reflective of the diversity of the Australian population. CALD participants are underrepresented in medical, health related sociological and other research due to the cost of translation and difficulty is sourcing participants. There is limited availability of data on health access and outcomes for CALD women in Australia with no longitudinal data on health outcomes for migrants to compare with Australian born outcomes. Additionally the available data about CALD women's health is often contradictory and not easily accessible, largely as a result of research methodologies that are not suitable for CALD Australians. FECCA recommends that the Strategy include specific targeted research and data collection of CALD women's access to health services and health outcomes, including how similar to or different from the experiences of non-CALD women and understanding diverse experiences within the CALD community to ensure that those who are most vulnerable are in receipt of timely and culturally appropriate services. Further research must include people from new and emerging communities; small CALD population groups; people from refugee backgrounds; from CALD backgrounds who arrive in Australia at an older age; and CALD Australians who live outside of the most populous states and metropolitan areas.

There is no systematically collected national data in Australia on the prevalence of FGM and whilst the practice is illegal in Australia many migrant women have emigrated from countries where FGM is known to be practiced and these women often have long term health complications due to this practice especially when they become pregnant. Investing in research on the prevalence, implications and improved practices for these women is important to achieving health equity.

To ensure a holistic approach to health, data collected should be disaggregated in relation to a person's cultural background, country of birth, religion, work status, visa status, period of time in Australia, concept of health, language spoken at home and English language competency. Disaggregation of data will allow the review of the effect that intersections between priority population groups has on individuals.

The attraction, retention and appropriate remuneration of bilingual and bicultural workers to health research is essential to the representation of CALD women. The use of bilingual and bicultural workers within organisations and workplaces increases the overall organisational cultural competence, and enhances the knowledge base and capacity of other workers.

31. Strengthening partnerships

Does the section: Strengthening partnerships adequately outline that strong partnerships between government, patients, advocates, healthcare professionals and industry are necessary to implement the actions identified in the Strategy?

Yes **No**

32. Strengthening partnerships – comments

Please provide your comments and explain your selection below (200 word limit).

Various focus groups across CALD communities and Aboriginal and Torres Straight people informed 'Consumer health information needs and preferences: Perspectives of culturally and linguistically diverse and Aboriginal and Torres Strait Islander people' produced by CIRCA on behalf of the Australian Commission on Safety and Quality in Health Care. All groups considered that their confidence in seeking out, accessing and understanding health information was significantly influenced by a combination of their culture and their experience. For this Strategy to be effective in addressing the health of CALD women and girls, FECCA recommends consultation with this priority population to understand the barriers in accessing and attaining positive outcomes from health services. CALD community groups, leaders and services should also be partnered with and supported in implementation. For action to be driven and owned by women, this Strategy must ensure that all services are accessible by all CALD women and children and that their understanding of the Australian health care system is significantly improved.

33. Achieving progress

What specific targets and measures should be used in this Strategy to determine progress towards achieving the overall purpose of the Strategy to: 'improve the health and wellbeing of all women and girls in Australia, providing appropriate, accessible and equitable care, especially for those at greatest risk of poor health'? (400 word limit).

To determine the progress towards achieving the purpose of this Strategy, the current baseline of both access and outcomes of the health system for CALD women and girls will need to be established. For CALD women and girls, access to the appropriate services needs to be specifically recorded and targeted as health literacy is noted as a barrier to overcome for better health outcomes in this population. To consistently and adequately measure the success of this Strategy, care must to taken to ensure the approach to methodology is appropriate to provide accurate data on CALD Australians.

SECTION E – OVERALL COMMENTS

34. Do you have any additional comments? (200 word limit)

It is encouraging to see the inclusion of CALD women and children as a priority population in the Strategy. This explicit acknowledgement will provide opportunity for the needs and interests of CALD women and children to be included in improving health outcomes for women over the period from 2020-2030. However, women from a non-English speaking background and their children need to be factored into each of the priorities listed in the Strategy to ensure they are truly embedded into National health. The 2016 Census revealed that 49 per cent of Australians were born overseas or had one or both parents who were born overseas. There are over 300 languages spoken in Australian homes and over 27 percent of Australian homes speak languages other than English. These figures indicate that Australia's cultural and linguistic diversity is a significant factor in our population demographic.

The intersectionality of CALD women's experiences means that they involve a level of complexity which can be daunting to service providers, policy makers and program designers. Rather than siloing CALD experiences, there should be dedicated analysis of CALD issues woven throughout the Strategy to avoid the danger of a 'tick box' approach.