

HEAR OUR VOICES

13th – 14th March 2014

Summary Report





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For further information about this report please contact:

Ms Yabbo Thompson
Project Coordinator
Migrant Resource Centre Southern Tasmania
ythompson@mrchobart.org.au
Tel + 61 3 6221 0999

Dr Regina Quiazon
Senior Research & Policy Advocate
Multicultural Centre for Women's Health
regina@mcwh.com.au
Tel + 61 3 9418 0912

Author's Note:

The Multicultural Centre for Women's Health (MCWH) was invited to speak at the event as the national voice for immigrant and refugee women's health and wellbeing. Dr Regina Quiazon represented MCWH during the proceedings and facilitated the group discussions over the two days.

'Hear Our Voices' Planning Committee:

Aloysianne Misumba (Congolese community)

Angela Pate (Youth Officer, Glenorchy City Council (GCC))

Deborah van Velzen (Population Health Services, Tasmanian Department of Health and Human Services)

Jeanette Williams (Hobart Community Health Nursing, Tasmanian Health Organisation South)

Jill Sleiters (Coordinator, Community Development, GCC)

Julie Marsaban (Multicultural Council of Tasmania, Soroptimist International of Hobart)

Leanne Chisholm (Hobart Women's Health Centre)

Nancy Roldan (Hobart Women's Shelter)

Pamela Leach (Respectful Relationships Program, Phoenix Centre, MRC South)

Paw Htoo Lei (Karen, Burmese community)

Rebecca Eli (Bi-Cultural Community Health Program, Aus. Red Cross)

Sabine Wagner (Hobart Women's Shelter)

Yabbo Thompson (Migrant Resource Centre, Southern Tasmania -MRC South)

Acknowledgements

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Australian Government Department of Social Services
Bendigo & Adelaide Bank Ltd, Glenorchy
Cassy O'Connor, Greens MHA, Denison
Senator Christine Milne, Leader of the Australian Greens
Elise Archer, Liberal MHA, Denison
Glenorchy City Council
Hobart Women's Shelter
Lisa Singh, Tasmanian Labor Senator
Migrant Resource Centre Southern Tasmania
Multicultural Council of Tasmania
Multicultural Centre for Women's Health Melbourne, Victoria
The Premier's Office, Tasmania
Red Cross Migration Support Programs, Tasmania
Scott Bacon, Labor MHA, Denison
Soroptimist International of Hobart
Tasmanian Department of Health and Human Services
Will Hodgman, Tasmanian Leader of the Opposition-Liberal Member for Franklin
Zonta Club, Derwent Valley

Thanks to the following women for interpreting:

Hirut Seboka (Amharic)
Nene Massaneh (Arabic)
Rebecca Eli (Arabic & Swahili)
Dhan Maya Thapa (Bhutanese)
Menuka Koirala (Bhutanese)
Paw Htoo Lei-Karen (Burmese)
Najibeh Jafari (Dari/Pashto/Hazaragi)
Roya Rahimi (Dari/Pashto/Hazaragi)
Nancy Roldam (Spanish)
Tsige Kiflay (Tigrinya)

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Save the Children
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Glenorchy City Council

Catering generously provided by *The Global Kitchen*, Moonah, Tasmania.

Background

There had been talks between The Hobart Women's Shelter (HWS), Migrant Resource Centre South (MRC), about establishing a women's support group. It was thought that a strategy to form the group might be accomplished by holding a gathering or forum with groups of women.

Following the Australian Migrant and Refugee Women's Alliance (AMARWA) National Conference in Canberra in 2013, attended by representatives from HWS and MRC, the need for a link in Tasmania to hear the voices of Tasmanian women became more apparent. Sabine Wagner (HWS) made contact with Jennie Gorringer from *Population and Health* in the *Department of Health and Human Services* because of the history of delivering culturally and linguistically diverse (CALD) specific domestic violence workshops together. At that meeting, Glenorchy City Council (GCC) was suggested for possible collaboration. An agreement was then reached within the Council's division of Community Development to hold a two day gathering.

Purpose of Gathering

The original purpose of holding a gathering of women to enable a support group through the Hobart Women's Shelter was broadened to encompass all health and wellbeing issues that women might want to discuss. A first meeting was held at GCC, after which there was a call for interest in an organising committee.

The committee was formed, chaired by Jill Sleiters, Coordinator, Community Development, GCC and met on a regular basis from November 2013. A consultation process was initiated in the lead up to the Gathering to ascertain core themes and issues of interest and/or concern. The process involved focus groups with bi-cultural workers as well as looking at themes and issues that evolved from other recently held events such as; the *Women's Leadership Dialogue* held by MRC in November 2013, the Women's Health and Wellbeing Day and the consultation with participants of the MRC's Phoenix Centre's Xpect Respect Project.

The purpose of the Gathering therefore was to hear the voices of women through discussion groups to then bring to the issues to the forefront, to be presented as recommendations to take to Local, State and Federal governments as well as to enable support group (s).



Photo: 'Hear Our Voices' participants during a break

Participants

Immigrant and Refugee Women

A total of 133 participants attended over the two days from ages ranging from

Participants included immigrants and former refugees from 24 countries including Afghanistan, Bhutan, Burma (Karen), Congo, Columbia, Eritrea, Estonia, Ethiopia, Indonesia, Iran, Iraq, Madagascar, Nepal, Philippines and Sudan. Asylum seekers from Sri Lanka also attended

Organisers and expo participants were from Canada, Chile, Germany, Italy, Ireland, Lithuania, UK, and Wales.

Expo Stalls

There was a total of 25 stalls over the two days:

- Family Planning Tasmania
- Centrelink
- Public Trustees
- Hobart Women's Shelter (HWS)
- Hobart Women's Health Centre (HWHC)
- Breast Screen, Population Health Services, Department of Health and Human Services Tasmania
- Blood Pressure Checks, Hobart Community Health Nursing, Tasmanian Health Organisation South

- Pulse Youth Health Service, Tasmanian Health Organisation South
- Community Breast Care, Tasmanian Health Organisation South
- Cancer Council (Screening & Control)
- Women’s Legal Service
- S.H.E. (Support, Help and Empowerment Inc.)
- Glenorchy LINC Literacy programs
- Migrant Resource Centre South (MRC)Settlement/Phoenix, English programs
- Multicultural Council of Tasmania (MCOT)
- Women’s International League for Peace and Freedom
- Glenorchy City Council-Glenorchy on the Go-GCC, Glenorchy Community Plan Consultation display, Tasmanian Elder Abuse referral-GCC
- Kidsafe Display
- Red Cross Bi-Cultural Community Health Program
- Office of the Anti-Discrimination Commissioner
- Save the Children-Multicultural Playgroup
- Baptcare & Mission Aus. Gateway Services
- Soroptimist International of Hobart
- Family Violence Counselling & Support Services
- Midwives Association of Tasmania



Photo: Participants playing the ‘Gender Game’

Opening of Gathering, Welcome to Country & Launch of the Family Violence Z Card

Alison Overeem, Director, The Aboriginal Children Centre, delivered *Welcome to Country* each day in language as well as English, and participated in the discussions throughout the two days.

Senator Lisa Singh launched the Family Violence Z Card, translated in a number of languages with a list of contact numbers for support and services.

Presenters

Regina Quiazon, Senior Research and Policy Advocate, MCWH

Regina spoke about the Centre's work and about emerging health and wellbeing issues in the various States and Territories. She discussed the ways in which health is not merely about the absence of disease or ill health, but also the contexts in which a person lives, works, plays and studies can impact on health and wellbeing.

Al Hines, Manager Migration Programs, Red Cross

Al's presentation spoke to women's experience of the health system by giving her own personal reflections of recovering in hospital from a car crash, how it made her feel vulnerable and the importance of understanding and directing your own health care. Al shared her own belief that health is in four domains: physical, mental, emotional and spiritual and that all these facets of health need to be attended to and balanced.

Multicultural Young Women's Leadership Group, GCC with Alison Pate, GCC Youth and Community Safety Coordinator provided a dance performance of *One Billion Rising*-Women standing up against violence

Barbara McMullen, Family Planning

Barbara spoke about the sexual rights of people within a relationship, specifically a partnership or marriage. She advised that sexual assault, either within or outside marriage, is a crime and that each individual has ownership of their bodies. Barbara also referred to respectful relationships and the services available to assist those experiencing difficulties in asserting their rights under law.

Maha Abdo, Manager Muslim Women's Refuge, President United Muslim Women's Association

Maha spoke of her experience working with Muslim women and talked about how working in domestic violence can often be seen as sad, but it can be viewed differently. Maha described it as 'happy' (once women are in a refuge); as 'happier' (when they are learning skills and gathering strength) and finally when independent as 'happiest'. She spoke of the language of the heart, how everyone can understand that communication without the need for language.

Julie Marsaban, Soroptimists International and MCoT

"The Gentler Gender Game" Raising Awareness and Eliminating Violence against Women. Julie introduced the concept and facilitated the "Gentler Gender Game" that she had developed based on her work experience. The GG Game is a practical hands-on activity using "flash cards" where the facilitator along with members of the community, in this case the CALD Women's Forum attendees, participate in assessing the community awareness, attitudes and behaviors in regard to traditional,

social and domestic situation vis-à-vis male-female relationships, including acts of violence against women and girls in their respective communities and regarded as “normal”.

By playing the game, participants were able to recognise gender inequities and violence against women and girls in the home and community and their detrimental implications and consequences. The GG game enabled discussion and debate and in the end the participants were able to express (using the cards) what they thought to be the ideal situation in terms of the relationship between men and women. Julie, summarized that it was everyone’s responsibility and to achieve that “ideal” by being the change agents themselves and change the situation bit by bit, starting “now”. The participants came away feeling they can make a difference. They were empowered.

Group Discussion

Over the two days, women were asked to gather in small groups and to discuss issues that were important to them. They could also pick up on themes from the various presenters. Women were asked firstly, **what would you like to talk about?** Group discussion then focused on answering the question, **what needs to change?**

A scribe, facilitator and/or an interpreter were assigned to each group.

Interpreters were available for the following languages: Hazaragi, Farsi, Dari, Karen, Amharic, Tigrinya, Arabic, Nepali.

Group Discussion: Summary of Issues

English language proficiency

“The workplace is difficult if you can’t speak English very well...I want to explain how I feel but I’m always worried about offending others.”

“I want to be reunited with my family who are overseas but to make that happen you need English to know what to do.”

“Who can help me read?”

(Group discussion participants)

Communicating in English was overwhelmingly cited as an issue women wanted to discuss. Many women felt that their inability to communicate in English proficiently (if at all) was a barrier to finding paid work; accessing health services and making social connections. All believed that an inability to communicate in English contributed greatly to stress, depression and social isolation.

Some women stated their children were also experiencing stress because they felt

there is an expectation to settle into school quickly despite having little or no English.

While some expressed satisfaction with telephone interpreter services, women still rely on family and friends to interpret and assist in their day-to-day lives, ‘Our Chinese shopkeeper orders the food we want.’

Almost all group participants stated a need and a desire to learn English at every opportunity so that they could connect with others in their immediate community—‘I want to be able to speak to my neighbours.’ Others also expressed a need to read English well so that they could read letters, especially those containing important information.

Others also cited English as an important conduit to being reunited with family members who are living overseas. Many women felt they were doubly disadvantaged because immigration and family migration policies are difficult to understand, let alone in another language.

Health and Wellbeing

‘We know about health, our mind, body, soul, and emotions, but with all our problems, how can we look after ourselves?’

(Group discussion participant)

Chronic and multiple conditions

The aforementioned quote highlights the concerns of most of the women. Chronic and multiple health issues, especially those sustained through conflict in their home countries and the transition process, were proving to be financially and mentally burdensome. Women spoke about the impacts on caring responsibilities and disruptions to their English language class. In this regard, women said it was difficult to prioritise their own health because of the cost (actual or perceived) and other competing issues.

There was general acknowledgment that holistic care is needed in dealing with multiple health conditions. Lack of strong language skills plays a role in accessing health care and increasing understanding about promoting health in the family. This is typical of how the problems women face are so often intertwined.

Communication

For some of the women who had accessed health services, either through hospital or a GP, receiving treatment was seen as sufficient and satisfactory. However, not all those who had received treatment were satisfied with the service. As one woman commented, ‘I went to the doctor, but I didn’t get any help with my headache.’ The comments point to concerns voiced by many of the women about, on the one hand, not being able to be understood because language difficulties; and, on the other hand, GPs lack of knowledge about different cultures. Women felt that doctors sometimes made diagnoses about their health based on cultural assumptions.

Women also felt that GPs were not making referrals to specialists because, women felt, doctors either assumed they couldn't afford the service and/or were of the opinion a specialist wasn't needed.

A positive experience recounted by one woman demonstrates the value of effective communication:

'We're happy with our doctor; we use interpreters; our doctor listens to us and refer us to others for help for stress, sleep or when something is not feeling right. They care about our physical bodies. My doctor even checks how my social life is going with my teacher and others.'

Access

Women said accessing bulk billing GPs is difficult and that some services and programs time-specific.

The links between the GP and other support services were unclear to many, especially those needing mental health support. Women said they needed to know more about the health system in order to advocate for themselves.

Interpreters

Women stated that finding a female doctor was often a challenge and that family members sometimes acted as interpreters when a professional interpreter was not readily available.

Mental Health

Almost all participants spoke about the need to be emotionally healthy and happy by keeping busy, active and being with friends. However, many stated that achieving such a state of mind was difficult, 'We have a busy life and even when you're not busy enough, you keep thinking of sad things.'

One woman spoke about the chronic health problems suffered by her husband as result of injuries inflicted on him in their country of origin. Although she did not enter into details about his experience as a survivor of torture, she conveyed through the interpreter that she was more worried about his mental health.

Many also expressed their sadness and frustration at not being able to be reunited with family members living overseas. This was felt more acutely by those who had either attempted to apply for family reunion and had been rejected or had their efforts hampered due to language barriers.

"We have a lot of time to walk [and do other things], but being alone feels sad."

"Men drink, they are sad too but they don't talk about it."

"We want to talk about how we feel, but we don't know where to go or who to speak to."

(Group discussion participants)

The need to feel valued was another issue that was raised, especially in relation to women's identities as 'immigrants' and being 'non-Australian'. Several women objected to being labelled a 'refugee'. Others felt that, although they were not yet Australian citizens, they should be valued as global citizens, and treated accordingly.

Finding ways to be included and accepted, whether by their neighbourhood or the wider Australian community, was seen as important to women's positive state of mind. As one woman commented, 'Sometimes when I'm out, children wave at me. It's nice.' In addition to gaining independence, learning English and learning how to drive were also seen as opportunities to give back to and to be part of the community.

Constraints to women's mobility was also seen to increase women's sense of isolation. Many women spoke about the difficulties of relying on public transport to carry out day-to-day chores, especially in areas where transport services are unreliable, infrequent and unsafe. Many women expressed the desire to learn how to drive. However, many thought the current learner driver requirements was difficult to meet given the many competing settlement challenges.

Maintaining family relationships and communicating with young/adolescent children were also cited as issues important to women. Women felt they needed support in managing and understanding teenagers' attitudes and behaviours, especially towards money; computers/social media; and seeking independence. Adolescents are generally more integrated and have better language fluency than their female elders; they also run into intergenerational differences around values and lifestyle, as well as long term aspirations and the role of women in the home.

Some women felt that the use of technology, both within and outside of their families, has replaced face-to-face contact and has become an additional barrier to making social connections.

Racism

Some women shared stories of being verbally abused on public transport. Many felt unsafe taking public transport, especially at night and asked whether they could receive information about being safe at home.

During the event, two women were supported to make separate complaints about physical and racial abuse they had each endured.

'Sometimes I don't feel safe to be alone. I like to walk but, even when I was pregnant, people would shout at me and I feel shocked, shaken and scared.'

'I had to flee the war, from my country and I thought I would be safe here away but...'

(Group discussion participants)

The first woman, who was walking home from the first day of the 'Hear Our Voices' event, was kicked and pushed to the ground by a young man, who yelled at her while pulling on her *hijab*.

In one of the group discussions, another woman provided details of an abusive neighbor who, over several occasions, had: strewn animal faeces and litter onto their driveway and doorway; thrown lit objects, including a soiled baby nappy, into their open back door; and thumped on their bathroom window, while her teenage daughter was taking a shower. She had reported the incidents to the

police, but was told there was little that can be done to stop the perpetrators. The woman had also requested that they be moved into other public housing, but was told there would be a wait.

Each incident was immediately referred to the police and the Racial Discrimination Officer, respectively for immediate action and follow up.

Employment

The highlighted quote sums up the main concerns for many of the participants in that learning English and employment are inextricably tied. Many felt that the current allocation of 510 hours of free English classes was not sufficient in gaining employment.

Almost all women found the job hunting process complex and challenging, especially given the

language barriers, as one woman asked ‘what type of jobs are available for low English speakers?’ Even when women were not in the position to apply for employment, women said they often took on more responsibilities around the home to allow their husbands and other family members to focus on finding a job. Whether by male restraint or their own choice, this often leaves them more isolated and less well integrated than their male counterparts, and consequently less equipped to work.

Participants expressed the need for more training opportunities as a way of both practising English and securing long-term employment. Yet many express “managing the home” as their primary responsibility above all else.

“In our community, women give priority to men to work and women look after the children, but we also want the opportunity to earn an income, so that we can buy clothes and one day own our own home. We don’t know how long the government can help us and we need jobs to support ourselves.”

(Group discussion participant)



Photo: A group discussion

Policy & Programs

Discussion participants felt there is a lack of continuity about receiving settlement information, including specific information about local services. Many felt that settlement information, the bulk of which is given pre and post arrival, should be repeated and updated during settlement. They are often swamped upon arrival and the importance of some information only becomes apparent on a needs basis.

Women felt there should be more programs that can provide practical support such as learning English; learning how to drive; and language/interpreter services. Courses and programs should also be made available to those on bridging visas or in Community Detention.

Participants also requested support in seeking family reunion, as well as navigating the health system. Although communicating in English was seen as a barrier in this regard, participants stated that immigration and health policies and systems are difficult to understand even with an interpreter. There was agreement from those who did have more fluent English that the system is extremely complex to navigate, and the fact that it changes frequently exacerbates the seeming complexity.

Participants felt that politicians need to directly engage with communities. They were pleased to hear directly from a panel of female politicians who did attend, representing all main parties, at the State and federal levels. However, the fact that the panel happened the day before the state election did sway the contents and dynamic of the conversation between panel members and participants. There was significant unity from the politicians about the importance of women's issues and interest in further interaction. They all expressed interest in attending future gatherings.

Domestic Violence

Women spoke about the violence they had experienced, including sexual assault, family violence, adolescent violence and violence in public spaces. It was a safe space for women to disclose and it particularly happened in one of the groups. This session was facilitated by Maha Abdo following her presentation about her work. It opened up opportunities for women to share their stories and became a very moving session for all.

Conclusion of Gathering

Regina Quiazon (MCWH) brought the gathering together and agreed to draft a report from the discussions, which could be used to further advocate for changes at the local, state and federal levels. MCWH would then distribute the final report, in the first instance, to relevant federal ministers.

The gathering ended with dancing and a real sense of community.

Evaluation & Feedback

Women expressed their appreciation in being able to share knowledge. Several women said that while they were aware of the many organisations that could assist them, they still found it difficult accessing services because information and/or interpreters are not readily available in their first language. However, there were some women who also felt that ‘no matter how many services we have, it is up to us to make changes.’ This proactive sentiment was echoed by others who felt that the gathering provided them with the knowledge and confidence to now seek out opinions and advice about their health and wellbeing.

For many of the women who participated, the gathering was an affirmation and practical demonstration of their strength as a group, as one group declared, ‘we all come from strong backgrounds.’ At the end of the event, women expressed their desire to ‘be the voice for the voiceless’ and to spread the various messages learnt over the two days.

It was suggested that the results of the group discussion be used to advocate for changes at the state and federal levels and that further funding be sought to run the event annually.

“We had lots of questions answered that we’ve had for some time.”

“We didn’t know that women are so important and we learnt about laws that protect us as women.”

“There were lots of good speakers and I learnt a lot.”

“I want to say something good: my children are studying and I am learning English.”

(‘Hear Our Voices’ participants)



Photo: Aloysianne Misumba during question time

Recommendations

“We are happier and more confident than before. Some of us have a job, we now have car so we can travel further, we know some English and we have our farm with chicken and eggs, but we still want to have more women in our community driving and working.”

(Group discussion participant)

Recommendations from the discussions:

THEME	ISSUE	RECOMMENDATION	COMMENTS
Communication	Interpreters - Need more for new & emerging communities	More support for people to become interpreters including pre-NAATI courses	People need more support before they can fulfill NAATI requirements
	English classes - Need for additional classes	More than 510 hours required plus more in community-based settings	Many women need longer to acquire enough English skills and it is problematic finding additional classes after that
	Practicing English - Need for more informally-based opportunities	More English practice community-based classes beyond the 510 hours	Broadening programs in the LINCS (Libraries) would be helpful.
Employment pathways	Need for more ways to enter the workforce after completing English courses	Widening of programs such as CONNECT (MRC south) Better opportunities to start small businesses	More basic entry levels ways into work force. Employment is very challenging in regional places as most occupations require a certain level of English and there is a higher unemployment rate
Housing	Additional information about availability of affordable (Public housing)	More and larger public housing required Need for more rental options including larger housing with more than 3 bedrooms	Need to be practically living on the street to access public housing. Private rents are high. Need for houses suitable for larger families.
Health information sessions	Learning about the health system and patients' rights	More funding for SGP programs and/or bi-cultural community health programs to do more of this	These sessions need to be repeated as one off doesn't convey enough information
Child care	More affordable care required	More subsidised child care and family day care	
Transport	Public transport - More public transport in new and regional areas	Need more frequent and dependable public transport	
	Driving lessons - Support required for women to access	Required for women to access female instructors if preferred	MRC Driving experience program assists people with pathways from L1 to L2 but can only support a certain number with driving practice at L2

THEME	ISSUE	RECOMMENDATION	COMMENTS
Food Security	Community gardens - Need for more of these gardens in accessible areas and support, training provided	More of these gardens near bus routes and plots available without waiting lists. Support to be provided at these gardens or in people's own gardens towards food self-sufficiency	MRC engaged with a program with Sustainable Living but need more funds for more of this
	Community kitchens - Learning to cook with local produce	Opportunities required for this learning that could also lead to employment e.g., catering or working in the industry	Need more funds to assist women in learning to cook with local produce and also become caterers if desired
Making connections with other women formally/ informally	Finding support and/or exercise groups, including women and girls swimming lessons	More opportunities required Women only pools needed	MRC has some groups but more funding would allow expansion For swimming separate time at pools would be beneficial but this costs. HWS wants to start support group of women re DV
Obtaining citizenship	Support & information required	More funding for groups like MRC or community associations to give this support	MRC does support, but more funding required
Family Reunion	Support & information required	Government to raise numbers for family reunion	MRC through Migration Support but more support and funding required
Youth programs/ sessions	Need ongoing resources required to hold various activities	After school activities; self-defence classes for young women & girls. Teaching boys about respectful relationships. Sexual health & safe sex. Girl's only New Year parties for Aghani/Hazara, in particular, was requested	
Speak to members of Parliament	Additional opportunities to speak with members of Parliament	Require more ways to engage with members of Parliament	Multicultural Friends of Parliament has been one method but broader opportunities still required

THEME	ISSUE	RECOMMENDATION	COMMENTS
Domestic Violence	It is in communities but not spoken about	Need resources to address this issue through education and need for a support group	The original idea for the gathering involved need for support group



Photo: 'Hear Our Voices' Participants

Appendices

**HEAR OUR VOICES WOMEN'S GATHERING
PROGRAM
Thursday 13th March**

MORNING

Time	Speaker	
9.00-9.30		Sign in & Registration – (refreshments)
9.35-9.45	Alison Overeem	Welcome to Country
9.50	Senator Hon Lisa Singh	Official opening & Launch of Zcard (information card for women experiencing family violence)
10.00		Housekeeping & introduction
10.15	Regina Quiazon	Multicultural Centre for Women's Health
10.35	Anna Reynolds	Multicultural Council of Tasmania.
11.00-		Group discussions
12.00		Lunch break and Expo

AFTERNOON

time	Speaker	
1.00		Multicultural Young Women's Leadership Group Dance Performance
1.30	Al Hines	Manager Migration Programs, Australian Red Cross Tas
2.00		Small Groups Session 2
3.00	Regina Quiazon	Round up of sessions & reflections with the participants.
3.30	Kristy Lee	One Billion Rising
4.00		Finish

**HEAR OUR VOICES WOMEN'S GATHERING
PROGRAM**

Thursday 13th March

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following for their support for the Gathering**

The Premier's Office

Elise Archer – Liberal MP Denison

Senator Christine Milne – Leader of the Australian Greens

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Multicultural Council of Tasmania

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Hobart Women's Shelter

Red Cross Migrant Support Programs

Department of Health and Human Services

Bendigo & Adelaide Bank Ltd - Glenorchy

**HEAR OUR VOICES WOMEN'S GATHERING
PROGRAM
Friday 14th March**

Morning

Time	Speaker	
9.00-9.30		Registration, refreshments & expo
9.40	Alison Overeem	Welcome to Country
10.00	Maha Krayem Abdo	Executive Officer-United Muslim Women's Association. Family violence and equality issues.
10.20	Barbara McMullen	Family Planning Tasmania Sexual rights within a relationship
10.50		Group discussions
11.25	Julie Marsaban	Soroptimist International of Hobart & Multicultural Council of Tasmania The Gentler Gender Game
12.15		Lunch & expo

Afternoon

Time	Speaker	
1.30		<u>Guest Panel Discussions:</u> Cassy O'Connor-Greens MHA Denison Elise Archer-Liberal MP Denison Adriana Taylor- Member for the Division of Elwick in the Legislative Council Lisa Singh – Tasmanian Labor Senator Senator Christine Milne – Leader of the Australian Greens
2.20		Small Group Discussions
3.20	Regina Quiazon	Round up of sessions & reflections with participants.
3.30	Kristy Lee	One Billion Rising
3.45		Finish

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Migrant Resource Centre Southern Tasmania

Hobart Women's Shelter

Red Cross Migrant Support Programs

Department of Health and Human Services

Bendigo & Adelaide Bank Ltd - Glenorchy

On Her Way: Primary prevention of violence against immigrant and refugee women in Australia

Another world is not only possible, she is on her way. On a quiet day, I can hear her breathing.

Arundhati Roy (Indian novelist, essayist and activist)
Confronting Empire

Poljski C. (2011) *On Her Way: Primary prevention of violence against immigrant and refugee women in Australia*. MCWH: Melbourne.

VIOLENCE AGAINST WOMEN

Violence against women is a significant global public health issue that impacts negatively on women's and children's physical and mental wellbeing and limits access to human rights. It is a multi-dimensional problem which can occur in the home, the general community, workplaces, educational institutions, and at the hands of the state.

In the Australian context, violence against women occurs among all cultural, religious and socio-economic groups. However, women marginalised by age, culture, ethnicity, sexual identity and visa status are more vulnerable to violence and are less likely to have the resources to act to report it.

Violence against immigrant and refugee women in Australia can be prevented. Because significant diversity in women's life stages and circumstances affect their exposure to situations in which violence is more likely to occur, there is a need for violence prevention strategies that recognise the complex dynamics of violence against different groups of women, including those who are newly-arrived, from well-established communities, in precarious employment, or from visible minority groups.

THE 'ON HER WAY' REPORT

The *On Her Way* Report is underpinned by three guiding principles:

1. promotion of respectful relationships between men and women;
2. promotion of non-violent social norms and the reduction of the effects of previous exposure to violence; and
3. improvement of access to services and systems of support.

These themes were adopted from the publication *Preventing violence before it occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria* (VicHealth, 2007).

REPORT RECOMMENDATIONS

Adherence to good practice principles will ensure culturally-appropriate violence prevention efforts that are effective in the long term. These principles include: balanced and representative leadership, with immigrant and refugee women at the forefront of violence prevention efforts; regular community consultation; specifically-tailored messages, visuals, language and strategies for each individual community; positive messages, visuals and language; message reinforcement via different mediums; extensive involvement of female and male bilingual community workers in violence prevention strategies; recognition of all facets of social diversity; and ongoing improvement of strategies.

Primary prevention of violence against immigrant and refugee women in Australia will involve major cultural and social change, so long-term stakeholder commitment (particularly from governments) is essential to generating and maintaining change. Numerous actions are required, including:

- The development of a **solid evidence base** on the prevention of violence against immigrant and refugee women.
- **Community** leadership involving influential and respected immigrant and refugee community leaders—both male and female and of

A solid evidence base would include:

- **High-calibre research** which provides an overview of the prevalence and dynamics of violence against immigrant and refugee women is required

- A **comprehensive mapping** exercise designed to collect information about previous or existing violence prevention strategies across Australia

- A **central clearinghouse** which collates and maintains evidence on violence prevalence and effective prevention;

different ages—from a range of backgrounds;

- The **leadership of immigrant and refugee women** and their representative groups, multicultural and/or ethno-specific agencies and organisations at all stages of violence prevention and advocacy efforts;
- The use of **constructive messages and positive images** which inspire and empower women and children rather than stigmatise victims of violence;
- **Consultation** with individual immigrant and refugee communities, to ensure that violence prevention messages, visuals, language and strategies are tailored to each community;
- The use of a variety of **communication and social marketing strategies**, such as community forums, electronic media, printed communication materials and multi-media communication campaigns;
- **Professional training, resources and collaborative networks**, to facilitate dialogue about strategies and lessons learned from violence prevention efforts;
- **Workplace interventions**, such as greater workplace regulation and monitoring, training for employers and information sessions for employees; and,
- A comprehensive review of relevant **legislation and policies** that may affect immigrant and refugee women's experiences of violence

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Fact sheet 1:

Primary Prevention of Violence Good Practice Principles

WHY IS VIOLENCE AGAINST WOMEN A HEALTH ISSUE?

Violence against women is a significant public health issue worldwide.

Defined as 'any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life'¹, violence against women impacts negatively on women's and children's physical and mental wellbeing, and limits their access to human rights.

HOW DOES IT AFFECT IMMIGRANT AND REFUGEE WOMEN IN PARTICULAR?

In the Australian context, violence against women occurs across all cultural, religious and socio-economic groups. However, as gender relations are intersected by factors such as age, culture, ethnicity, sexual identity and visa status, women who are marginalised by these factors are more vulnerable to violence and are less likely to have the resources to act and report it.

Language and cultural barriers also limit access to support services for many immigrant and refugee women. Within some ethnic communities, issues such as forced early marriage and child-bearing are a concern for young women.

Women who have experienced war, civil unrest and/or dislocation in their countries of origin have also been more vulnerable to rape and sexual assault at the hands of the State.

HOW CAN IT BE PREVENTED?

Violence against immigrant and refugee women in Australia can be prevented.

However, the complexity of women's experiences of violence highlights the need for culturally-appropriate strategies that address the core issue of gender equality by working to improve the status of women.

It is equally important that violence prevention efforts address the specific and diverse situations of immigrant and refugee women, within the cultural, religious and socio-economic contexts of their lives.

¹ United Nations. 1993. *Declaration on the Elimination of Violence against Women*. UN Resolution 48/104. Proceedings of the 85th Plenary Meeting, United Nations General Assembly, Geneva. Accessed on 8 March 2011 from <http://www.un.org/documents/ga/res/48/a48r104.htm>

HOW IS PRIMARY PREVENTION DIFFERENT FROM OTHER PREVENTION STRATEGIES?

Primary prevention targets whole populations and/or high-risk groups with the aim of preventing violence *before* it occurs.²

Traditionally, efforts to prevent violence against women have been secondary (early intervention) and tertiary (an intervention implemented after violence has occurred) in nature.

Whilst it is essential that women experiencing violence are supported, addressing violence in its early stages, or after it has been perpetrated, maintains women's overall risk of violence and its negative health outcomes.

Primary prevention attempts to change the culture that allows violence against women to occur in the first instance.

GOOD PRACTICE PRINCIPLES FOR CULTURALLY-APPROPRIATE VIOLENCE PREVENTION EFFORTS INCLUDE:³

1. **Immigrant and refugee women** should be at the **forefront** of violence prevention efforts.
2. **Community consultation** needs to be a regular component of prevention efforts. Identify leaders to engage and provide feedback during evaluation.
3. **Effective leadership** will facilitate community participation in initiatives. Leadership also needs to be balanced and representative of men and women from immigrant and refugee communities.
4. Prevention messages and strategies should be **specifically tailored** for each individual community, guided by cultural norms and within an appropriate and meaningful cultural context.
5. Messages must be **positive** and focus on the importance of respectful gender relations and healthy family relationships.
6. Prevention messages need reinforcement using **different mediums**.
7. **Bilingual** female and male community workers need to be extensively involved in prevention strategies.
8. Strategies should recognise **all facets of social diversity**: age, gender, culture, ethnicity, class, disability, sexual identity and religion.
9. To remain culturally relevant, strategies need to undergo **continuous improvement**.
10. Violence prevention efforts require **long-term funding** to generate **lasting outcomes**.

² VicHealth. 2007. *Preventing violence before it occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria*. VicHealth: Carlton South. Available from <http://www.vichealth.vic.gov.au/~media/ProgramsandProjects/MentalHealthandWellBeing/DiscriminationandViolence/PreventingViolence/framework%20web.ashx>

³ Poljski C. 2011. *On Her Way: Primary prevention of violence against immigrant and refugee women in Australia*. MCWH: Melbourne.

Fact sheet 2:

Primary prevention of violence: recommended strategies

WHAT DOES PRIMARY PREVENTION MEAN?

Primary prevention refers to a public health approach that targets whole populations and/or high-risk groups with the aim of preventing violence *before* it occurs.⁴

Traditionally, efforts to prevent violence against women have been secondary (early intervention) and tertiary (an intervention implemented after violence has occurred) in nature.

Whilst it is essential that women experiencing violence are supported, addressing violence in its early stages, or after it has been perpetrated, maintains women's overall risk of violence and its negative health outcomes.

Primary prevention attempts to change the culture that allows violence against women to occur in the first instance.

WHAT INITIATIVES HAVE BEEN MOST EFFECTIVE?

Whilst the primary prevention of violence against women is gaining momentum in the wider Australian community, initiatives that specifically aim to prevent violence against immigrant and refugee women are still lacking in comparison.

Nevertheless, there are programs and projects conducted in cross-cultural settings internationally, which have contributed to culture change, and from which much could be learnt about good practice principles for violence prevention.

⁴ VicHealth. 2007. *Preventing violence before it occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria*. VicHealth: Carlton South. Available from <http://www.vichealth.vic.gov.au/~media/ProgramsandProjects/MentalHealthandWellBeing/DiscriminationandViolence/PreventingViolence/framework%20web.ashx>

HOW DO I GO ABOUT IMPLEMENTING THE STRATEGIES?

The strategies outlined here build on the good practice principles for culturally appropriate primary prevention efforts, specifically within immigrant and refugee communities.⁵

It is important to remember that immigrant and refugee women are not a homogenous group. Whilst there are many similarities across this population, there is significant diversity in women's life stages and circumstances which make a difference to their exposure to situations in which violence is likely to occur.

HOW DO I ENSURE CULTURAL APPROPRIATENESS AND RELEVANCY?

When developing and implementing violence prevention strategies, you should ensure that strategies take into account the specific and diverse situations of immigrant and refugee women, within the cultural, religious and socio-economic contexts of their lives.

In addition to English language proficiency, you will also need to consider the length of time a woman has lived in Australia and her migration status. For example, issues that are relevant for women from well-established communities will be different for newly-arrived women or for women who are on student or temporary visas.

⁵ For further information see Poljski C. 2011. *On Her Way: Primary prevention of violence against immigrant and refugee women in Australia*. MCWH: Melbourne. Chapter 3 provides detailed examples of good practice or promising initiatives.

RECOMMENDED STRATEGIES FOR CULTURALLY-APPROPRIATE PRIMARY PREVENTION EFFORTS INCLUDE:

1. **Research, monitoring and evaluation** should comprehensively document the extent and dynamics of violence against women. Aim to conduct research within, rather than across, communities in order to provide a more accurate, consistent and reliable overview of women's experiences.
2. Recognition of the issue and the call to action requires the identification and support of leaders in government and influential and respected community leaders from a range of backgrounds. However, immigrant and refugee women and their representative groups and organisations need to be the instigators and be at the forefront of **advocacy** efforts.
3. **Community strengthening** initiatives such as leadership development programs with a specific focus on violence prevention are needed to support and enable community leaders to advocate for change.
4. **Communication and social marketing** tools such as community forums, electronic media, printed communication and multi-media campaigns have been used to increase immigrant and refugee community awareness across Australia about violence against women.
5. **Direct participation programs**, such as education and mentoring programs provide children, young people, men and women with the knowledge, skills and resources required to develop and maintain respectful relationships.
6. **Organisational and workforce development** involves building the capacity of workplaces and organisations to engage in violence prevention efforts and includes training, collaboration, and resourcing.
7. **Legislative and policy reform** should be broad-based and take into consideration laws and policies that both directly and indirectly reduce women's risk of violence.



Sexual & Reproductive Health Data Report

Summary

Current evidence indicates that immigrant and refugee women have poorer health outcomes and are at a greater risk of developing adverse health conditions than Australian-born women. These poorer health outcomes are due to a range of factors, including language, barriers to accessing health services and the lack of culturally appropriate support.

The lack of available evidence-based information also places immigrant and refugee women at greater risk. There is currently no national reporting of maternal and birth outcomes and health data are not commonly collected according to ethnicity, with region of birth, country of birth and/or language groups being used as a measure for ethnicity.

This data report summarises current available data across a range of areas which impact on the sexual and reproductive health of immigrant and refugee women.

The research shows that immigrant and refugee women:

- are at a greater risk of suffering poorer maternal and child health outcomes.
- are less likely than Australian-born women to have adequate information and familiarity with modern contraceptive methods. This is more likely to be the case with newly-arrived immigrant and refugee women, especially those among whom there is a higher birth rate than among the Australian-born.
- are at a greater risk of contracting a sexually transmitted condition (such as HIV and hepatitis B), especially migrant women who are from countries where the condition has a high prevalence.
- are less likely to use health and social/support services. Low access to prevention programs leads to higher representation among crisis and acute service-users.
- do not have access to evidence-based and culturally relevant information which will enable them to make decisions about their health. The current evidence base is lacking in specific data about immigrant and refugee women;
- are well-placed to improve sexual and reproductive health through preventative health education;
- establish health literacy more effectively through the preferred methodology of small, same-sex, education in their preferred language, delivered by trained bilingual educators.

Fertility ratesⁱ and contraceptive useⁱⁱ

According to 2008 data, the fertility rate among Australian born women is 1.93 births per woman. Among overseas-born women, rates vary widely, with the highest rate at 3.75, almost double the Australian-born rate. The highest rates are among women from a range of countries in North Africa and the Middle East.

The rate of contraceptive use around the world may serve as an indicator of the likelihood that a newly-arrived woman will be familiar with the range of available contraceptive methods on arrival in Australia. The contraceptive-use rate in Australia is 71%. By contrast, the rate is significantly lower in the countries of origin of women who have the highest birth rates in Australia.

A campaign for informed contraceptive choices highlighted the need to improve access to information on contraceptive options for immigrant women in particular.ⁱⁱⁱ Investigations found that immigrant and refugee women were more likely to be prescribed low-control contraceptives such as Depo Provera and Implanon, and were less likely to be provided with information about these contraceptives, or about the full range of available contraceptive options.

According to a three-year National Health and Medical Research Council of Australia study focusing on the reproductive health of African and Middle Eastern immigrant and refugee women, 'inadequate access to information was the overwhelming complaint regarding both the range and side effects of contraceptives'.^{iv}

Australian birth rates 2008		Contraceptive use in country of origin (%)	
Region and countries	Birth rate in Australia	Any method	Modern methods
Australia	1.93	71	71
North Africa and Middle East, including Afghanistan, Iraq, Kuwait, and Saudi Arabia.	3.75		
Afghanistan		19	16
Iraq		50	33
Kuwait		52	39
Saudi Arabia		24	-
Syria	3.7	58	43
Lebanon	3.57	58	34
Pakistan	3.56	30	22
Sub Saharan Africa, including Eritrea, Ethiopia, Somalia and Sudan	3.27		
Eritrea		8	5
Ethiopia		15	14
Somalia		15	1
Sudan		8	6
Cambodia	2.4	40	27
Egypt	2.27	60	58
Papua New Guinea	2.21	26	20
Laos	2.13	32	29
Turkey	2.06	71	43

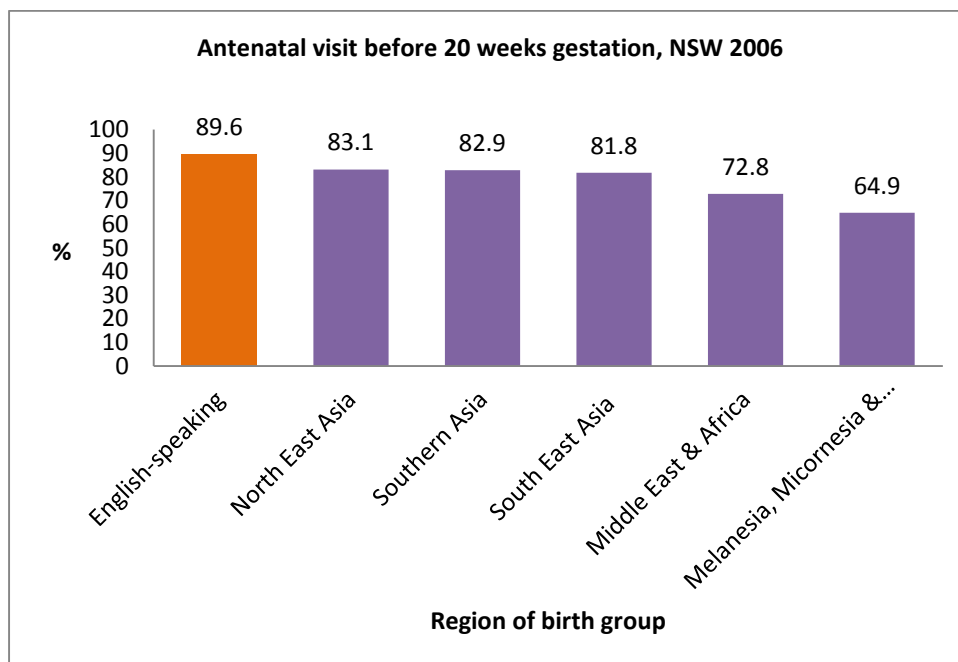
Note: The contraceptive prevalence for any method, refers to the use of contraception regardless of method. The contraceptive prevalence for modern methods refers to the use of the following methods: female and male

sterilization, the contraceptive pill, the intrauterine device (IUD), injectables, implants, female and male condom, cervical cap, diaphragm, spermicidal foams, jelly, cream, sponges and emergency contraception; and excludes the lactational amenorrhea method (LAM), abortions, periodic abstinence and withdrawal.

First antenatal visit^v

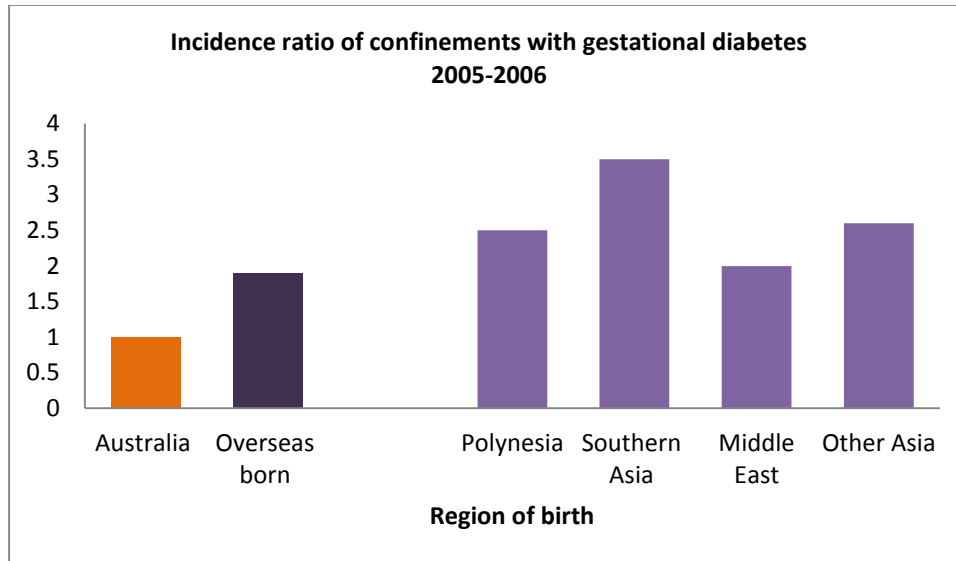
Non-English speaking women are less likely to access antenatal care before 20 weeks gestation when many risk factors could be addressed: mothers born in Melanesia, Micronesia and Polynesia (64.9%), and 72.8% of mothers born in the Middle East and Africa compared to 89.6% of mothers born in English speaking countries.

“A recent UK report concerning maternal deaths showed that some women from ethnic minority backgrounds who died, accessed antenatal either late (after 22 weeks) or not at all”.^{vi}



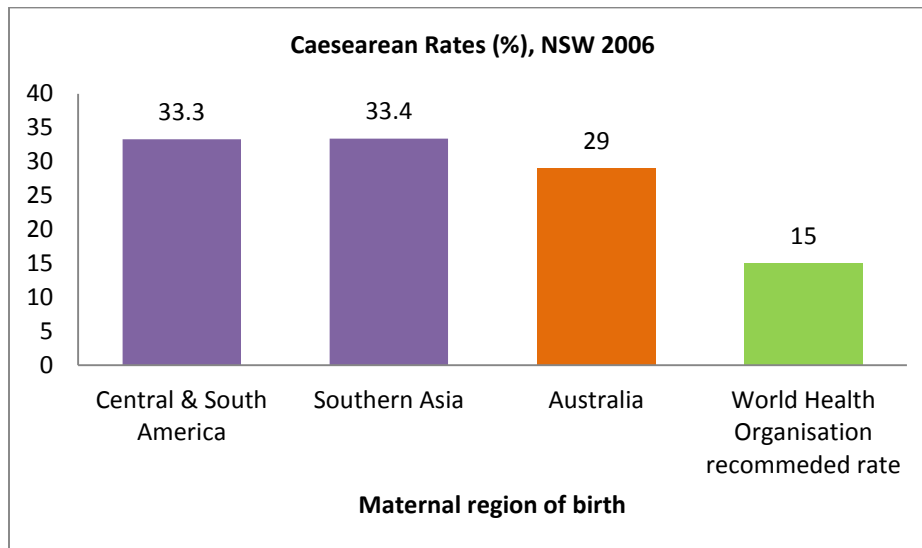
Gestational Diabetes^{vii}

Women born overseas are at a greater risk of developing gestational diabetes (GDM). In 2005-06, women born overseas had twice the incidence rate of GDM compared with Australian born women. The incidence was greatest among women born in Southern Asia: at 3.4 times the rate of women born in Australia.



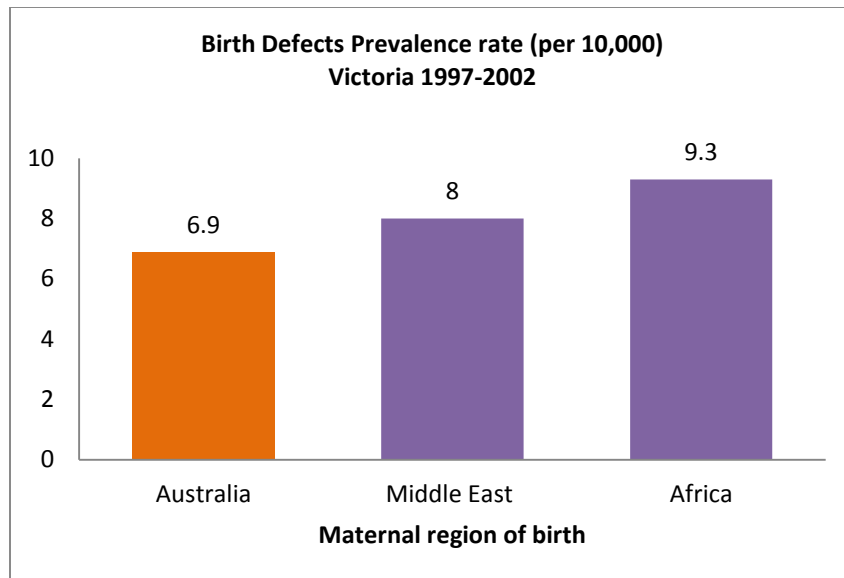
Caesarean section^{viii}

Caesarean section rates are highest among mothers born in Southern Asia and Central & South America compared to English-speaking countries (29%).



Birth Defects^{ix}

According to 1997-2002 Victorian data, the birth defect prevalence rate was highest for women born in Africa and the Middle East (9.3 and 8.0 per 10,000) compared to Australian-born women (6.9 per 10,000).



Fetal and perinatal deaths^x

In 2008, fetal and perinatal deaths were higher amongst overseas born women compared to Australian-born women.

Maternal country of birth	Fetal deaths	Perinatal deaths
	Rate per 1,000 births	
Australia	7.1	10
Other	7.9	10.7

Maternal Morbidity^{xi}

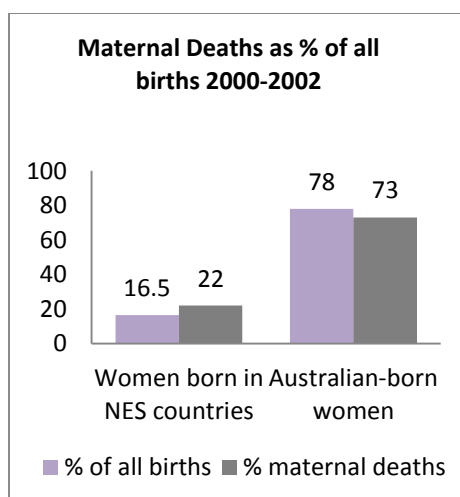
According to a UK-based research study, non-white ethnicity (in particular, black African, Carribean and Pakistani ethnic groups) is a significant risk factor for 'near miss' maternal morbidity.

Ethnic Group	Morbidity risk per 100,000 maternities	Risk ratio
White	80	1.0
Indian	89	1.11
Pakistani	119	1.49
Bangladeshi	126	1.57
Black African	188	2.35
Black Carribean	196	2.45

Maternal Deaths^{xii}

In 2000-02, 16.5% of all the births in Australia were to women born in non-English speaking (NES) countries; yet women born in non-English speaking (NES) countries accounted for at least 22% of all maternal deaths (where country of birth was known).

Similar differences—inequalities—in maternal death rates have been observed in the UK and the Netherlands.^{xiii}

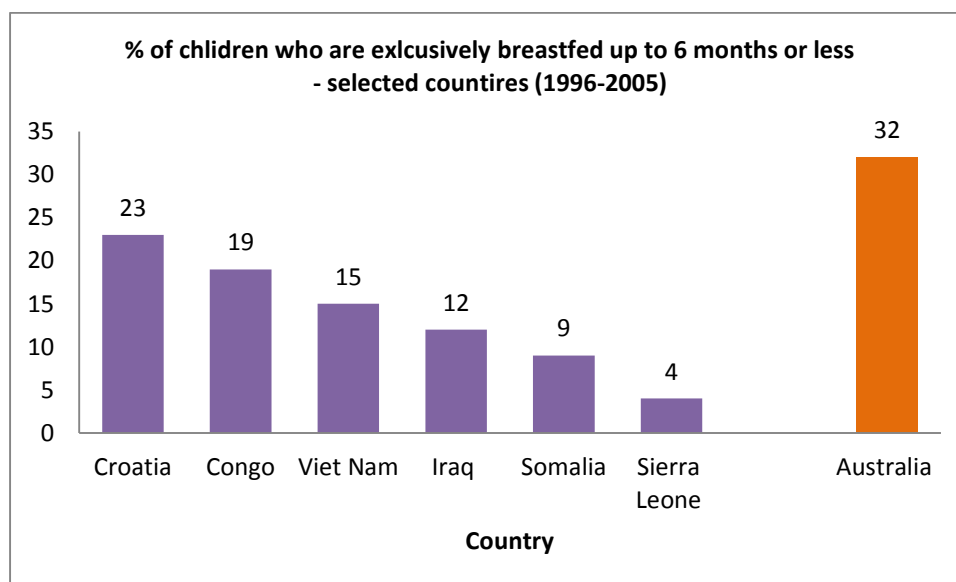


Breastfeeding^{xiv xv}

Current Australian and World Health Organisation recommendation guidelines recommend infants should be breast fed exclusively up to 6 months of age. According to 2001 Australian data, 32% of Australian babies were breastfed exclusively to 6 months of age or less.

In a recent Victorian study, women from culturally and linguistically diverse backgrounds were considered as one of the groups assessed as at high risk of not breastfeeding. The report state, 'there is lack of evidence to recommend specific intervention components for women from CALD backgrounds.' However, the report identified one relevant study that increased breastfeeding initiation amongst Vietnamese-born women living in Sydney using a cultural and language specific education program.^{xvi}

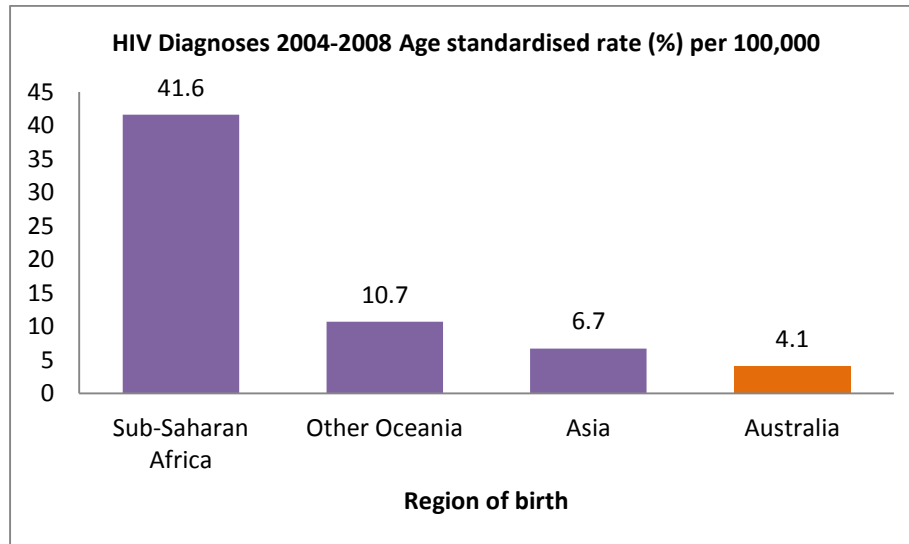
Given the lack of culturally-specific national data, the rate of exclusively breastfed infants to 6 months of age around the world could provide important background information in relation to sociocultural factors that might influence breastfeeding practices.



Note: Graph data refers to the most recent year available for the period 1996-2005. Australian data refers to 2001.

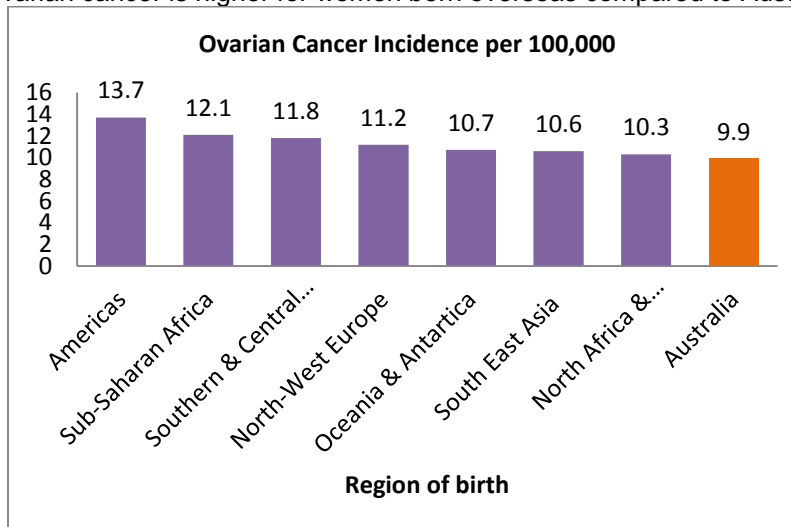
HIV Diagnoses^{xvii}

The spread of HIV among people who are from, or who travel to, countries where there is a high prevalence of HIV, has been identified as an emerging epidemic. In 2004-08, the rate of new HIV diagnoses for people born in Sub-Saharan Africa was ten times higher than for Australian-born. It is recognised that women from South East Asia, sub-Saharan Africa and other regions with high HIV prevalence have special needs.^{xviii}



Ovarian Cancer^{xix}

The incidence of ovarian cancer is higher for women born overseas compared to Australian-born women.

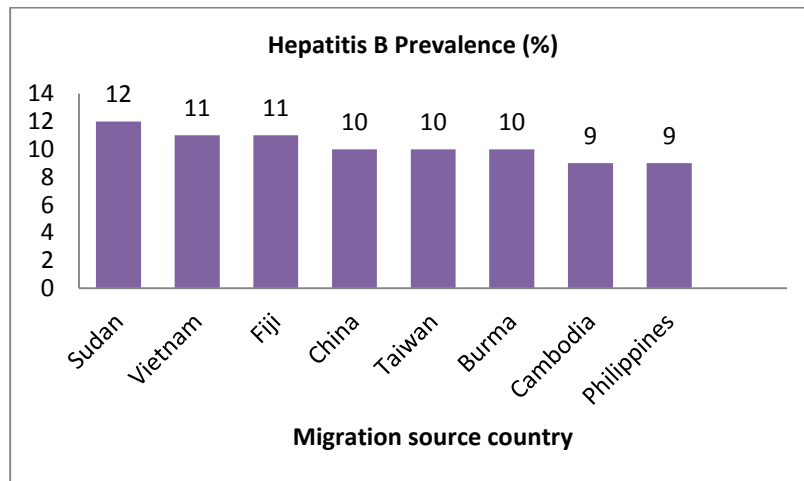


Hepatitis B^{xx, xxi}

Approximately 80% of all chronic hepatitis B notifications in Australia are among people from culturally and linguistically diverse (CALD) backgrounds. Hepatitis B leads to chronic liver conditions, including liver cancer. Estimates of the prevalence of hepatitis B in Australia among people from CALD backgrounds are generally consistent with prevalence in their countries of origin.

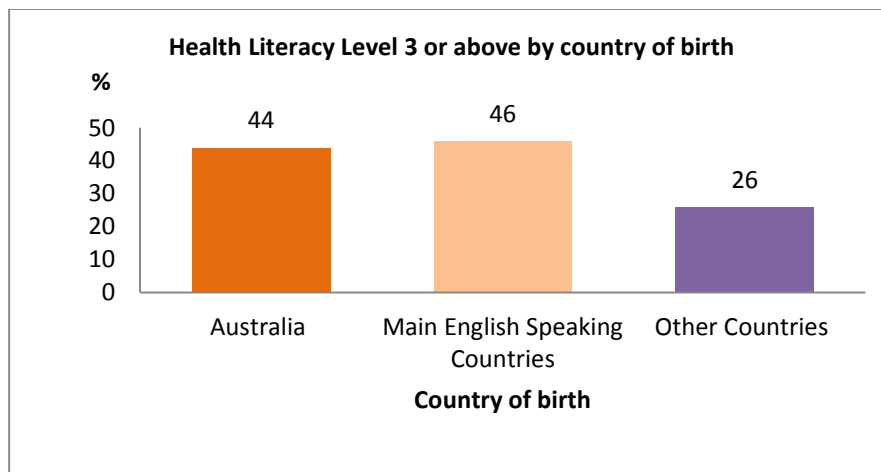
Women are a priority target group for education because Hepatitis B can be transmitted via sexual contact (women are particularly vulnerable in this context due to violence and limited information about sexually transmitted infections).

Only 65% of the affected total Australian population has been diagnosed and only 2% receive treatment for the condition.



Health Literacy^{xxii}

A smaller percentage (26%) of people born in a mainly non-English speaking country scored the same level of health literacy compared with people born in Australia (44%) and those born outside of Australia in mainly English speaking countries (46%).



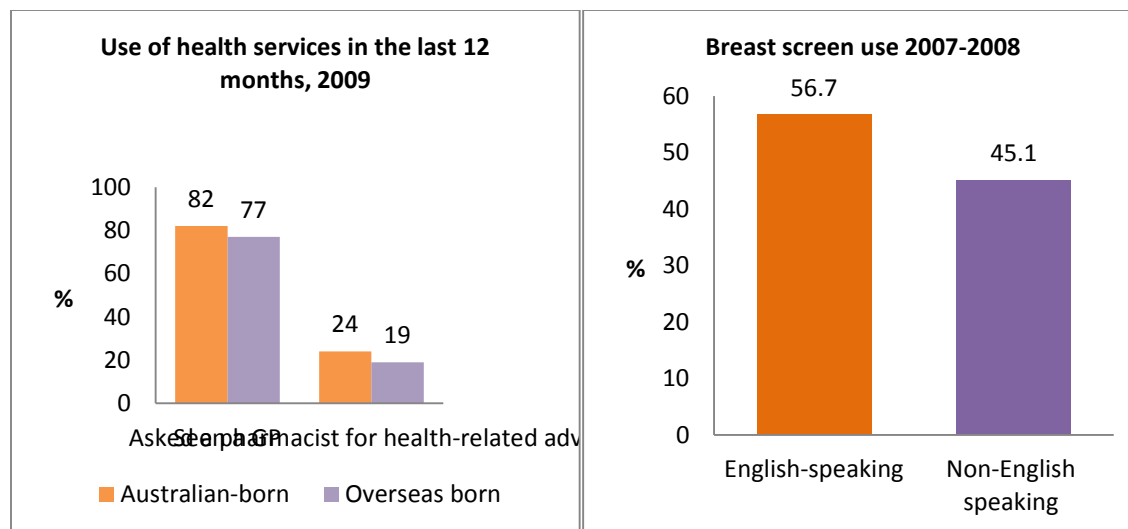
Note: Health literacy in the ABS Adult Literacy and Life Skills Survey is defined as: the knowledge and skills required to understand and use information relating to health issues such as drugs and alcohol, disease prevention and treatment, safety and accident prevention, first aid, emergencies, and staying healthy.

Use of health services^{xxiii, xxiv}

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

People who were not born in Australia were a little less likely to have seen a GP and/or have asked a pharmacist for health-related advice than people born in Australia.

In 2007-2008, women in the target breast-screening population (50-69 years) who spoke a language other than English and who reported being 'non-English speaking' were less likely to participate in breast screening than English-speaking women: 45.1% and 56.7% respectively.



Health Education Preference

There is some research to suggest that verbal, same-sex, group-based education sessions is the preferred mode of health education for immigrant and refugee women.

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

A 2008 Victorian study conducted with resettled youth with refugee backgrounds in relation to the promotion of sexual health, found that gender-matched educators were also cited as a preferred method for learning sexual health issues.^{xxvi}

Research findings from a UK-based study on a peer model of health education found that positive outcomes can be achieved through group *participation* (in addition to knowledge acquisition), as participants are able to negotiate meanings and make information meaningful for themselves.^{xxvii}

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