



Talking about health and experiences of using health services with people from refugee backgrounds

FINAL REPORT

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Preface

This report carries the opinions of over 300 people from refugee backgrounds including people seeking asylum. By developing a grassroots strategy, working with bicultural workers experienced in community engagement, we had an opportunity to hear a range of opinions on health outcomes and health service access. Those consulted have provided an insight into how they view health, wellbeing and the barriers they have experienced.

It is vital that diverse community voices help to shape health services. Language and culture affect the way that people make meaning out of their experiences, and this can lead to differing cultural expectations and understandings of health. Consultation and participation strategies should build mutual understanding between services and the communities they work with, and include people with low English proficiency. Incorporating community advice into planning, design and delivery of services ensures that they are more accessible and responsive to the needs of the people who use them. Failure to do so may mean that essential information and services are not delivered.

Bicultural workers play an important role in helping services engage with people from refugee backgrounds, including people seeking asylum. When planning to consult with communities from refugee backgrounds across Victoria as part of this project, the Victorian Refugee Health Network sought to do so in collaboration with bicultural workers employed in Victorian health, community and settlement agencies. A significant finding of the project relates to the important role bicultural workers can play in facilitating conversations between services and communities from refugee backgrounds. It also identified that many bicultural workers lack opportunities to build their skills and knowledge.

Eight key themes were identified in the consultation responses. These were: healthy eating and food security, social connectedness, opportunities for physical exercise and sport, health information and knowledge about health service systems, communication with health providers, accessibility and appropriateness of services, mental health, and income and employment. These findings reflect broader understandings of the determinants of health and wellbeing that are concerned with social and environmental, as well as bio-medical factors. Many of the findings reflect the health concerns of the broader Victorian community. In these cases, the response required may be to ensure that existing services designed for the broader community, such

as activities funded under Victorian state government Integrated Health Promotion plans, are accessible and inclusive of people from refugee backgrounds.

We were pleased that a commissioner from the Victorian Multicultural Commission has undertaken to review the findings of this report, and we hope that the findings will be similarly welcomed by other areas of government and services. We also hope that the report will prompt services to facilitate conversations with their local communities from refugee backgrounds.

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Abbreviations

AKO	Australian Karen Organisation
ASRC	Asylum Seeker Resource Centre
CALD	Culturally and Linguistically Diverse
CEH	Centre for Culture, Ethnicity and Health
CMY	Centre for Multicultural Youth
FARREP	Family and Reproductive Rights Education Program
Foundation House	Victorian Foundation for Survivors of Torture
HSS	Humanitarian Settlement Services
NAATI	National Accreditation Authority for Translators and Interpreters
NDIS	National Disability Insurance Scheme
the Network	Victorian Refugee Health Network
PAG	Project Advisory Group
SRSS	Status Resolution Support Services
VMC	Victorian Multicultural Commission



Issues for consideration

Bicultural workers conducted 115 consultations with individuals and groups from refugee backgrounds across Victoria. Consultations identified a range of issues impacting on the health and health service access of people in this cohort.

Key themes arising from the consultations were:

Healthy eating and food security

Issues associated with healthy eating and food security were the most common themes identified through the consultations. This included the interplay between cost, access to familiar food and physical activity. Cost was identified as a significant barrier to eating well. Departure from traditional diets can contribute to poor health; conversely some traditional dishes can be excessively fried or fatty, which when combined with a more sedentary lifestyle in Australia may contribute to poorer health. People said they needed more information about the nutritional value of different foods, to make informed choices about healthy eating. Some women reported not knowing how to cook with ingredients in Australia that are new and unfamiliar to them, others experience time-related barriers to cooking and eating well. Overweight and obesity were identified as problems for some communities from refugee backgrounds.

Social connectedness

Many people said that social isolation, loneliness, and separation from family members and friends makes people in their community unwell. Many people identified that they lack opportunities to socialise due to limited access to transport, language barriers, and lack of connections with the broader Australian community. Social connections were identified as sources of health advice and support for people from refugee backgrounds to access health services.

Physical exercise and sport

People said that they need opportunities for physical exercise and sporting activities. Cost and a lack of culturally appropriate sporting facilities, including female-only facilities, were identified as barriers. People reported their lifestyles are more sedentary in Australia than they were in their home countries, as they drive or take public transport rather than walking. Opportunities for physical exercise and sport were particularly important to young people, and parents reported having limited opportunities for physical activity.

Health information and knowledge about health service systems

People identified that they need better access to information about health and health services. They wanted health education in the diverse areas such as healthy eating, oral health, sexual health, preventative health, menopause and cancer screening. Low health literacy, including understanding local health services and how to navigate the Australian health system, restricted access to health care. Preventative health and early intervention are unfamiliar concepts in many communities. People recommended that services should provide health education sessions and information on the Australian health system for people from refugee backgrounds. They advised that health information should be provided in many formats, such as translated brochures, information sessions delivered to community groups, orientation sessions at services, and via community media.

Communication with health providers

People said limited English skills and not having access to an interpreter create significant barriers to service access. Some people from refugee backgrounds have a strong preference for bilingual GPs. People reported that seeing a GP or other service provider who speaks their language makes communication easier, and for some people may increase levels of trust and comfort. Preference to see a bilingual GP was stronger for adults and older people than for younger people.

Accessibility and appropriateness of services

People identified several barriers to accessing health services, including language, cost, distance to the service, lack of transport options and not being familiar with using public transport, long waiting times for appointments, difficulty making appointments and difficulty filling in forms. Caring responsibilities, not having access to childcare, lack of confidence, and inability to see or request to see a female health practitioner were identified as barriers by women. Men from refugee backgrounds reported being less likely to seek help for their health problems. Enablers of service access were identified, including convenient location; availability of public transport; co-location of services; employment of bilingual GPs, bicultural workers and AMES community guides; drop-in clinics where no appointment is required; and a referral from a GP or caseworker. People recommended several approaches individual health professionals can take to work better with clients from refugee backgrounds, including improving cultural competence and cultural understanding, being friendly and welcoming, listening and being respectful, being patient and sensitive to people's difficult past experiences, taking time to develop the client's trust, and maintaining confidentiality.

Mental health

Those consulted were more likely to mention a range of feelings or symptoms that are indicative of poor mental health such as stress, worry, sleep problems, and thinking about the past, than to use labels like poor 'mental health', 'depression', 'anxiety' or 'trauma'. Alcohol, drug use and smoking were identified in some cases as being linked to people's worry or stress levels. People said their community members experience poor mental health as a result of social isolation, separation from and worry about friends and family, worry about visa processing, uncertainty about the future, and having nothing to do. Stress and worry were of particular concern to people seeking asylum, and their uncertain visa status was linked by those consulted to poor mental health. People said that stigma, taboos, denial, and reticence to acknowledge mental health issues can create barriers to accessing mental health services.

Income and employment

Income and employment featured strongly in the responses. People identified that living on low incomes impacts on their community members' health in a number of ways, including financial stress and worry, and by creating cost barriers to purchasing healthy food, accessing health services, and accessing exercise and sporting facilities. Some people wished to access volunteering opportunities. Income and employment were of particular concern to people seeking asylum.

A key finding from conducting the project relates to the role of bicultural workers:

Bicultural workers

Due to the skills they possess in language and culture, and their understanding of how health is regarded in the communities they work with, bicultural workers are ideally placed to support people from refugee backgrounds to engage in service processes such as surveys, consultations, advisory groups, and complaints mechanisms. Bicultural workers often lack opportunities to attend training that is specifically tailored to their roles, and to network with others employed in similar roles. Stressors of working in a bicultural role include difficulty managing boundaries between community and work expectations, and differences between professional and cultural values. Bicultural workers may require additional support and supervision to manage these challenges.



Introduction

This report presents the process and the findings from a project conducted by the Victorian Refugee Health Network (the Network) from July 2015 to July 2016. The project aimed to consult with people from refugee backgrounds, including people seeking asylum in Victoria about what they need to stay healthy in Australia, and some of the barriers and facilitators of people's access to health services. Section 1 provides the background and rationale for the project. Section 2 outlines the project methods and our reflections on the project methods. Section 3 describes the findings from the community consultations. The report commits the Network to several actions and provides recommendations for different levels of government and service providers. The recommendations are based on what was learnt in conducting the project, the advice of the Project Advisory Group, the advice of the community members surveyed in this project, and the previous experience of the Network.

Language

Refugee background

This report uses the term 'people from refugee backgrounds' to refer to people who have arrived on humanitarian visas, people seeking asylum, and those who come from refugee backgrounds who arrive on another visa type, including family migration and skilled migration (State Government of Victoria Department of Health, 2014).

Culturally and linguistically diverse

The term 'culturally and linguistically diverse' (CALD) refers to the range of different cultures and language groups represented in the population who identify as having particular cultural or linguistic affiliations by virtue of their place of birth, ancestry or ethnic origin, religion, preferred language or language spoken at home (State Government of Victoria Department of Health and Human Services, 2009)

Bicultural worker

The diversity of the Australian population is such that most workplaces include workers who are CALD. This report uses the term 'bicultural worker' to refer to people for whom biculturalism and/or bilingualism form one of the identified employment criteria for their role (Centre for Culture Ethnicity and Health, 2007).

The term 'bicultural' should not be taken to literally mean 'having two cultural backgrounds'. The refugee experience is often characterised by displacement and people may have lived in several different countries for extended periods before settling in Australia. This may result in people from refugee backgrounds identifying as multicultural – sharing experiences and understanding with multiple cultural groups (Centre for Multicultural Youth, 2011).

The Centre for Multicultural Youth (2011) has developed the following definition of a bicultural worker:

'A person employed to work specifically with people or communities with whom they share similar cultural experiences and understandings, and who is employed to use their cultural skills and knowledge to negotiate and communicate between communities and their employing agency.' (p. 3)



1. Background

This section of the report provides an overview of humanitarian settlement in Victoria and introduces the Victorian Refugee Health Network. It also explores the background and rationale for the project, and discusses the policy context for consumer participation in health.

1.1 Humanitarian settlement in Victoria

Approximately a third of people who arrive as refugees or asylum seekers in Australia settle in Victoria. Each year, this includes around 4,000 people who arrive as refugees under the offshore Refugee and Humanitarian Programme, 10–15 per cent of whom settle in rural and regional areas. Another approximately 10,000 people are currently seeking asylum in Victoria, living in the community on bridging visas while they wait for the determination of their refugee status (State Government of Victoria Department of Health, 2014). Furthermore, the number of people settling in Victoria will soon increase, due to the additional 12,000 humanitarian program places made available for people escaping the conflicts in Syria and Iraq in 2015 (Australian Government Department of Immigration and Border Protection, 2016b), and planned increases to the size of the humanitarian program intake by 2018–19 (Australian Government Department of Immigration and Border Protection, 2016a).

Due to the nature of the refugee experience, many people who arrive in Australia as refugees or asylum seekers will have experienced interruptions to the basic resources required for health, such as safe drinking water, adequate food supply, shelter, and education. They are likely to have had limited or disrupted access to health care in their home countries and/or countries of first asylum. People are very likely to have been exposed to traumatic events, such as human rights violations, torture, loss of loved ones, perilous journeys, and periods of uncertainty (Victorian Foundation for Survivors of Torture, 2012). As a result of these experiences many new arrivals experience significant health inequalities and require targeted support in order to access appropriate health care in Australia (Duell-Piening, Maloney & Casey, 2013).

1.2 The Victorian Refugee Health Network

Since 2007, the Victorian Refugee Health Network (the Network), under the auspice of the Victorian Foundation for Survivors of Torture (Foundation House), has provided a unique forum to bring together primary and specialist health services, government departments, settlement and asylum seeker support agencies, to identify and respond to the needs of people from refugee backgrounds, including people seeking asylum.

The Network is a vehicle for sharing emerging issues and practice, collaborative development of good-practice resources for the sector, communication with Commonwealth and state government departments about trends in refugee and asylum seeker health, and dissemination of information to the sector. The Network has worked in policy and service development in areas including access to primary and specialist health services, maternity care, sexual and reproductive health, oral health, asylum seeker access to health care, and immunisation. The work of the Network is guided by an expert Reference Group that includes members from primary and specialist health services, settlement and asylum seeker health services, peak bodies, government departments and community advisors.

1.3 Rationale for the project

This project was initiated in response to an external review of the Network conducted by Tony McBride and Associates in 2013. Recommendation 10.2.2 – Facilitate greater community engagement – recognised the need to involve refugee communities more strongly in the work of the Network, to better inform projects, submissions and other work areas (Tony McBride & Associates, 2014).

In 2014, the Network team¹ developed a brief on 'Increasing participation of community members from refugee backgrounds in the Network', outlining several models of community participation for the consideration of the Network Strategy Group.² The two models endorsed by the Strategy Group were:

¹ The Network team includes paid staff employed by the Victorian Refugee Health Network under the auspice of Foundation House. Specifically the Network coordinator and sector development and policy advisors.

² The Network Strategy Group was a small sub-group of the Network's Reference Group, convened in 2014 to guide the implementation of the findings from the 2013 review of the Network. It has now disbanded.

1. Background

- community representation on the Network Reference Group.
- Network participants consult with their local community advisory groups. Information is compiled, aggregated and analysed by the Network team.

The first model was progressed in the first half of 2015, when three community advisors joined the Network Reference Group. This project concerns the second model.

1.4 Policy context

There is increasing recognition that consumers should be meaningfully involved in decision making, not just about their own health care, but also at the level of health policy, planning and service delivery. There is evidence that consumer involvement leads to improvements in quality, safety and patient experience of healthcare services (Victorian Auditor-General, 2012).

The former Victorian State Government Department of Health outlined its commitment to involving community members in decision making about health services in *Doing it with us not for us: Strategic direction 2010–2013* (2011). This policy document provides a guide for community participation and introduces participation standards and indicators to facilitate the implementation of community participation in health. The policy requires health services to develop and maintain a community participation plan and to report annually against each participation standard.

The Australian Charter of Healthcare Rights (Australian Commission on Safety and Quality in Health Care, 2008) has been adopted by all states in Australia, and applies to all health services in Victoria. The Australian Charter of Healthcare Rights in Victoria (State Government of Victoria Department of Health, 2010) takes a rights-based approach to consumer participation in health care, outlining the rights of consumers to participate in the planning, design and evaluation of public healthcare services and to share their views 'by filling in surveys, joining a community advisory committee, writing letters, or telling staff about your experience' (p. 14).

The Health Services Act 1988 (Parliament of Victoria, 1988) is the primary legislation for health services in Victoria, and includes specific requirements relating to consumer participation in health. Section 65ZB of the Act requires boards of public health services to appoint

a community advisory committee, comprised of persons who are able to represent the views of the communities served by the service.

The Australian Government Department of Health's Agency Multicultural Plan 2013–2015 (2013) recognises that effective engagement with stakeholders is essential to ensuring that the policies and programs they develop and deliver are successful. Section 2 of the policy states that health policies and programs that successfully engage culturally and linguistically diverse communities 'are more likely to meet patient needs, be sustainable long-term, and gain support by the community' (Australian Government Department of Health, 2013 p. 5).

Despite this strong policy and legislative commitment to consumer participation in health, the Network has received anecdotal evidence suggesting that people from refugee backgrounds are under-represented in mechanisms designed for the wider population to provide feedback about health services, such as consumer advisory groups and complaints processes. Language barriers, unfamiliarity with Australian systems and processes, power imbalance between health professionals and patients, and past experience with abuses of power mean that people from refugee backgrounds are not empowered to challenge power structures or make complaints (Preston-Thomas, 2015). The Victorian Auditor-General's Office found minimal evidence that feedback from consultations with Victoria's CALD communities was being used to inform service design and delivery (Victorian Auditor-General, 2014).



2. Project methods

This section outlines how the project methods were developed in partnership with a Project Advisory Group comprised of bicultural workers who work with refugee background communities. It describes the process of developing the approach to consultation, the recruitment and skills development of bicultural workers to conduct the consultations, and the analysis of the consultation findings. It also discusses the approach to evaluating the project, reflections on the project methodology, and recommendations based on what was learnt in conducting the project.

2.1 Project objectives

The objectives of the project were:

- to create opportunities for under-represented groups to provide advice about their health and experiences of using health services
- to combine information from consultations with refugee background communities to inform the work of the Network and help ensure that we are responsive to refugee community concerns
- to document the process and findings from the project into a publicly available report to share with Victorian health services and policy-makers.

2.2 Project facilitator

The Network allocated approximately two days per week of sector development and policy advisor staff time to support the project over a period of 12 months. The project facilitator supported the recruitment and meetings of the Project Advisory Group, organisation and promotion of the Bicultural Workers Forum and analysis of the consultation data, documented feedback provided by the Project Advisory Group, conducted desktop research, and led the writing of the final report.

2.3 Project Advisory Group

The Project Advisory Group (PAG) was established in September 2015 to advise the Network about the development and implementation of the consultation framework, and strategies for engaging with under-represented refugee background communities (see Appendix 1 for the Terms of Reference for the PAG).

In recognition of the expertise of the Centre for Culture, Ethnicity and Health (CEH) in health and wellbeing, cultural competence and cross-cultural communication, CEH's general manager Michal Morris was invited to

chair the PAG and provide strategic and content advice about the development of the project.³

PAG members were invited based on their expertise in community engagement and experience of working with refugee background communities as bicultural community engagement workers or community access workers. Eight people employed in such roles at Foundation House, ISIS Primary Care, cohealth, Dianella Community Health, CEH, the Asylum Seeker Resource Centre (ASRC), and the South Eastern Melbourne Primary Health Network agreed to join the PAG. As the Network did not have the capacity to pay PAG members for their participation in the project, endorsement was sought from their managers to participate as part of their paid roles. It was important to have a mix of ages, genders, and experience working with different refugee background communities on the PAG. To ensure that young people's perspectives were considered, a young person was engaged through the Centre for Multicultural Youth (CMY) Shout Out Program,⁴ and paid an honorarium to attend meetings.

The time commitment for the PAG was approximately 15 hours over a nine month period. This included travel to and attendance at three 1.5 hour meetings, plus time for reviewing and providing feedback on project materials between meetings. PAG meetings were held in October and December 2015, and June 2016. Where a PAG member was unable to attend a meeting, the project facilitator made a time to call them after the meeting to receive their input over the phone.

First Project Advisory Group meeting

At the first PAG meeting in October 2015, the group discussed barriers and facilitators to consulting with people from refugee backgrounds about their health needs, and how the project should consult with refugee background communities.

PAG members suggested that when consulting with refugee background communities:

- informal approaches work best
- literacy and technology can be barriers, and people can have a distrust of paperwork so verbal approaches are best
- trust is required

³ Michal Morris resigned from her position at CEH mid-way through the project, but was available to chair the final PAG meeting and review the final report.

⁴ Shout Out is a leadership program of CMY that trains and supports young people from migrant and refugee backgrounds to share their views and experiences as public speakers.

2. Project methods

- some people are hesitant to speak honestly with services
- culture affects how people think and talk about health – especially for sensitive health topics
- language can be a barrier
- established community groups are frequently consulted with, they are often made up of people who have been here many years and are often men. It can be difficult to reach people who are newly arrived, people seeking asylum, and women.

Recommendations from the PAG for how the project should consult with refugee background communities:

- consultations should take place where the community already is, rather than asking them to come to another appointment.
- use informal approaches and contexts, for example conducting consultations with mothers during a playgroup, or with young men after a sporting activity.
- it is important for the person conducting the consultations to understand the culture of the people with whom they are consulting.
- approaching people who work with people who are newly arrived, people seeking asylum, and women helps to reach those groups.
- tap into community leaders and bicultural workers with health expertise.
- using bicultural workers who understand the context is often more effective than using an interpreter.

Based on the advice provided at the first PAG meeting, the PAG chair proposed the following consultation approach for the project:

In order to consult with refugee background communities about their health needs, the person conducting the consultation needs to be skilled in language, culture, health, and communication. Bicultural workers are employed because of their cultural and linguistic skills. The Network and CEH should host a forum for people employed in bicultural roles focusing on skills development in the areas of health, communication and community consultation. Following the forum, each bicultural worker will be asked to conduct five consultations on behalf of the project with the refugee background communities they work with and submit the data from the consultations to the Network.

This approach was endorsed by the PAG and the Network Reference Group.

Second Project Advisory Group meeting

At the second meeting, PAG members provided advice about the format and content for the forum, who should be invited to attend the forum, and the consultation questions.

The PAG advised that bicultural workers should be paid for their time conducting the consultations. As the Network did not have the budget to pay people to conduct the consultations, the decision was taken to only invite people to participate in the project who were able to do so as part of their paid roles.

Recommendations from the PAG members about the consultation questions included:

- Framing the questions to ask the person to comment on the health of their community, rather than their own health, may elicit more honest answers.
- Concepts like 'barriers' to accessing services may not be well understood in all languages. It was suggested to ask people about what makes it hard to go to a service.
- It is important to ask people about what works well, as well as what doesn't.

Third Project Advisory Group meeting

At the third and final PAG meeting in June 2016, the group discussed thematic issues identified in the consultation data. PAG members were invited to provide recommendations for Victorian health services and government based on the findings of the consultation data. The PAG members were asked to share approaches or programs they knew of that support people's wellbeing in each of the key thematic areas identified in the data. Some of these are shared as case studies in Section 3: Findings from the consultations.

Review of the report and recommendations

Recommendations were formulated by the project facilitator and Network coordinator, informed by the advice of community members surveyed, the PAG, and previous experience of the Network. The PAG members were asked to review and provide feedback on a draft version of the full final report. They were asked to check that the recommendations accurately responded to the issues that were raised in the consultations and discussed at the last PAG meeting.

2.4 Recruitment of project participants

Letters were sent to 78 Victorian health, community, and settlement services, formally inviting bicultural workers working with refugee background communities to participate in the project. The letters were addressed to managers of the bicultural workers in the organisation, and jointly signed by Michal Morris and Paris Aristotle, CEO of Foundation House (see Appendix 2). PAG members were also asked to circulate information about the project to colleagues in their networks.

The letter outlined that participation in the project involved attendance at a full-day forum, consultation with five people or groups from refugee background communities over a five-week period following the forum, and submitting all of the data from the consultations to the Network by a specified date. The letter requested endorsement from the organisation for people to participate in the project as part of their paid roles. We advised that all participants and their organisations would be acknowledged in the final report for the project.

2.5 Bicultural Workers Forum

The full-day Bicultural Workers Forum was held on 22 March 2016 at Foundation House in Brunswick (see Appendix 3 for the Agenda for the Bicultural Workers Forum).

The forum was attended by 40 people employed as bicultural workers in Victorian health, community, and settlement services from across metropolitan Melbourne and regional Victoria. In order to encourage participation of bicultural workers from regional areas, the Network offered a \$50 travel subsidy to people travelling more than 50 kilometres to attend the forum. Four people attended from Shepparton and Geelong and were eligible for the subsidy.

The forum included:

- A keynote speech delivered by Sonja Vignjevic, Commissioner from the Victorian Multicultural Commission (VMC). Ms Vignjevic committed to take a copy of the final report from the project to the VMC for consideration.
- A panel discussion, designed to create greater understanding of the context of health issues facing people from refugee backgrounds, featuring presenters speaking on the topics of mental health,

physical health, access issues, sexual health education and prevention, and maternal and child health.

- Case study presentations delivered by bicultural workers, designed highlight programs or projects where having a person employed as a bicultural worker was integral to improving access to health services or health information for people from refugee backgrounds.
- A workshop delivered by staff from CEH, designed to build skills in conducting community consultations.
- A self-care workshop delivered by a facilitator from the Foundation House professional and organisational development team, designed to encourage participants to reflect on the key stressors and challenges inherent in their roles, and strategies for coping with them.

2.6 Consultation questions

Design of the consultation questions involved a number of steps, including consultation with the PAG, input from the Network team, and discussions with colleagues at Foundation House and CEH with expertise in community consultation. Based on this advice, a draft of the consultation questions was developed by the project facilitator and circulated via email to the PAG for comment. The consultation questions were modified to incorporate feedback received by PAG members over the phone and via email (see Appendix 5 for the Consultation Questions).

Themes covered in the consultation questions include:

- What keeps people healthy, and what makes them unhealthy
- Where do people go for help for their health problems
- What makes it easy and hard for people to go to health services
- Advice for health services for working better with people from refugee backgrounds.

2.7 Consultations

Bicultural workers who attended the forum were asked to conduct consultations with five people or groups of people from refugee backgrounds over the five-week consultation period in March and April 2016. Bicultural workers were provided with a one-page plain language statement to help them talk to participants about the project and advise them how the consultation data would be used (see Appendix 4 for the Plain Language Statement).

2. Project methods

To evaluate the consultation process, phone interviews were conducted with a sample (n = 7) of bicultural workers who conducted the consultations.

2.8 Approach to data analysis

The qualitative data from the consultations was entered into a spreadsheet. Thematic analysis was applied whereby the data was coded, organised into categories, and recurring themes identified. Illustrative quotes were also identified for use in the final report. Thematic analysis of the data may be reviewed in Section 3: Findings from the consultations.

2.9 Evaluation of project methodology

Mixed-method evaluation was used to evaluate the project methodology. This included interviews with four PAG members at the conclusion of the project, a written questionnaire circulated at the Bicultural Workers Forum, which was completed by a majority (n = 32) of the attendees (see Appendices for the Bicultural Workers Forum Evaluation), and interviews with a sample (n = 7) of the bicultural workers who completed the consultations.

2.10 Reflections on the Project Advisory Group

The PAG members were instrumental in providing community perspectives, advising on community engagement, ensuring the questions and processes for collection were acceptable, helping to interpret the consultation findings, and providing examples of best-practice approaches to supporting the wellbeing of people from refugee backgrounds.

Evaluation interviews with PAG members indicated high levels of satisfaction with their participation. Members felt that they had opportunity to contribute to the development of the project, that their input was taken seriously, and that the dynamics of the group were inclusive, supportive and conducive to the sharing of opinions. Members felt that diversity of cultural backgrounds and sectors the PAG members were working in enriched the discussions, and helped them to learn about other parts of the health system they do not usually engage with. Participants enjoyed the opportunity to share and discuss the challenges their clients face in accessing health services.

PAG members appreciated the opportunity to meet face-to-face, and felt that collaborating virtually over email between meetings did not work as well. There were varying views on the time commitment and meeting frequency for the project. While some found juggling commitments to the project with their regular work schedule a challenge, others suggested increasing the frequency of meetings to monthly throughout the duration of the project.

PAG members regarded their participation in the PAG as a professional development opportunity. A few PAG members spoke about the benefits of learning about other services and getting to know other people working in the sector. Another spoke about it complementing a current study course, providing the opportunity to incorporate the knowledge gained from each into the other. A few PAG members reported that their participation in the project had created opportunities to showcase their work within their organisations, via formal updates on the project at their team meetings, and sharing relevant findings from the project with staff in other departments.

2.11 Reflections on the recruitment of project participants

The recruitment phase of the project took a considerable amount of time, including time taken to identify services that employ bicultural workers (advice was provided by PAG and Reference Group members), phone calls to services to identify relevant senior managers, and a number of follow-up calls to discuss the project.

Correspondence inviting bicultural workers to participate in the project was addressed to senior managers as allocation of staff time and resources was required to participate in the project. One bicultural worker who participated in the project reflected that knowing their senior managers were supportive helped them to be more engaged, because they understood that it is important and recognised at a high level.

When contacting services, the project facilitator encountered four agencies that were unable to endorse their bicultural staff to participate in the project due to funding constraints. Many bicultural workers are casually employed, with funding for their positions tightly aligned to specific activities or key performance indicators, such as playgroup facilitation, or bilingual

health education. There was no funding allocated within those organisations to cover bicultural workers' attendance at a full-day forum and the time required to conduct the consultations. Some managers expressed interest in attending in lieu of their bicultural staff, but were declined as the forum and project were targeted at bicultural roles.

2.12 Reflections on the Bicultural Workers Forum

It was great to have the opportunity for networking with other [bicultural] workers. I only know people from my service, I don't know others working in other services.
(forum participant)

The objectives of the Bicultural Workers Forum were to provide a platform for networking, professional learning and sharing among people employed in bicultural roles, and skills building to undertake community consultations. Evaluations with forum attendees and PAG members indicate that these objectives were largely met.

Evaluations were generally very positive. A self-reported pre and post measure of knowledge indicated increased knowledge across the following domains after attending the forum: (a) health issues and barriers to accessing health services for people from refugee backgrounds and people seeking asylum; (b) approaches to engage people from refugee backgrounds in their own health; (c) conducting community consultations; (d) self-care strategies.

Open-ended responses indicated that people valued the opportunities for networking, enjoyed learning from and sharing experiences with people working in similar roles, and learnt a lot of new information about the range of services available to their clients from refugee backgrounds. Many people said they would like more regular opportunities to attend professional development activities tailored for people working in bicultural or bilingual roles. Suggested improvements included running shorter sessions more frequently, as it was felt that too much information was presented in a one-day session; and that more opportunity for group work, discussion and participation by participants would be helpful.

Forum participants indicated that they would apply and share some of their new skills when they returned to their workplaces. Specific skills included listening skills, self-care skills and consultation planning skills

(group selection, question development and testing, and organising focus groups).

I will consult more, listen more, with a view to being better at bridging the gap between my community and health supports. (forum participant)

Participants at the forum reflected on the difficulty in managing boundaries between community and work expectations as a particular stressor of working in a bicultural worker role. People spoke about the pressures of being 'all things to all people', and the inability to 'leave work at work', due to being seen as a source of information in the community. They also spoke about the difficulty in managing circumstances where professional and cultural values may not align, such as the best approach to take in dealing with family violence.

2.13 Reflections on the approach to consulting

On advice from the PAG, the approach the project took to consulting with refugee background communities differed from the original approach endorsed by the Network Strategy Group. The originally endorsed approach involved regional refugee health working groups consulting with established local community advisory mechanisms and feeding the information from the consultations back to the Network.

Advice received from the PAG indicated that existing advisory groups are over-consulted and that targeting bicultural workers who work with people who are newly arrived, people seeking asylum, and women would help the project to consult with under-represented communities not usually engaged in consultations. This approach appears to have been effective, as 40% of the people who participated in the consultations were women, around a third of the participants were seeking asylum, and a few people indicated that they had only been in Australia for a few months.

The PAG members advised that due to their shared understanding of language, culture, health and communication, bicultural workers were best placed to conduct consultations with refugee background communities. Evaluations with PAG members and bicultural workers who conducted the consultations widely agreed that working with bicultural workers greatly improved the project's ability to consult with different refugee background people and groups.

2. Project methods

The fact that I knew them and they were from the same country and community as me. This meant that they felt comfortable speaking with me.

(bicultural worker who conducted consultations)

Because I am from the same community, as well as a worker, it wasn't a struggle for me to know who to contact. I knew who the people are in our community who know the context of the community well. I could therefore approach people who would be able to speak not just as an individual, but who also know our community well as a whole. **(bicultural worker who conducted consultations)**

The connection that bicultural workers have with the community makes them a very effective way to reach and consult with the community. The trust they have with the community, and their knowledge of the community, is very important. **(bicultural worker who conducted consultations)**

If you can get someone who is from the same community to do the consultations, and help to empower them to do that, then that is the best approach to community consultations. That way communication is easy, and there is understanding about health meanings.

(Project Advisory Group member)

Through the bicultural workers you got to get in contact with people who were not generally included in consultations. **(Project Advisory Group member)**

The project facilitator sent a number of reminder emails to the bicultural workers during the consultation period, which may have contributed to the high consultation data return rate. Of the 32 bicultural workers who attended the forum and committed to undertake consultations,⁵ 25 returned data from consultations (a return rate of 78 per cent). The project facilitator followed up with a number of people who didn't return the data. A number of things had prevented their ability to participate, including busy work schedules, a change in work role, illness and personal issues. One bicultural worker advised that there had been a death in the community, which meant community members understandably cancelled their participation in the consultation. Another person identified after attending the forum that conducting the consultations was not a good fit for her role, and it would have been more suitable for someone else in her organisation to participate in the project.

Feedback from people conducting the consultations indicated that the consultation skills workshop at the forum was beneficial and supported people to conduct the consultations. Many people indicated that a longer consultation period would have been beneficial, as community engagement can take time, and many bicultural workers are employed part-time. This recommendation was supported by the fact that a number of bicultural workers were only able to conduct two or three consultations in the five-week period rather than five, due to their own busy work schedules and community members being busy and cancelling appointments.

One thing that I would want is more time, our communities take time to engage.

(bicultural worker who conducted consultations)

People [from refugee backgrounds] are very busy because they are struggling to make ends meet. It's not that they don't want to participate, often they do, but they are just struggling with so many other competing demands. So consulting with them needs patience and time.

(bicultural worker who conducted consultations)

2.14 Dissemination of the findings

One of the bicultural workers we interviewed told us that it was important for the community members who participated in the consultations to hear about the outcomes of the project. She said:

People from refugee backgrounds often don't feel like their democratic participation has value. So it's good to let them know about the outcomes of the projects they participate in. **(bicultural worker who conducted consultations)**

2.16 Limitations

The Network would have liked to engage more workers in rural and regional areas to participate in the project. Bicultural workers from the largest refugee settlement locations in regional Victoria (Geelong and Shepparton) participated in the project. We also received initial positive engagement from services in Mildura, Swan Hill and Wodonga. This included interest in sending staff to attend the forum and conducting consultations regionally without attending the forum. Future projects may need to give further consideration to the barriers to participation faced by regional services. Just under 10 per cent of the

⁵ Some of the 40 bicultural workers who attended the forum were PAG members and presenters who did not commit to conducting consultations.

consultations were conducted in regional areas, below the 10–15 per cent regional settlement rate.

Methods of recruiting consultation participants through bicultural workers will have created a sampling bias, as all of the participants were engaged with services. People who are not engaged with services will have been missed.

PAG members and bicultural workers who conducted the consultations also indicated that the project may have benefited from engaging more directly with communities, via a community event to let community members know about the project.

2.17 Recommendations

Based on the advice of bicultural workers who consulted on behalf of the project, and the advice of the PAG:

The Victorian Refugee Health Network will:

- 2.16.1** Develop a plain language one-pager outlining the project findings to disseminate to community members via bicultural workers.
- 2.16.2** In future consultations:
 - Recruit a PAG comprising of bicultural workers to oversee future community consultation processes.
 - Allow a longer community consultation period than five weeks (to be discussed with the PAG).
 - Provide a forum for consultation skills development training.
 - Provide travel subsidies to future forums to encourage participation from rural and regionally based bicultural workers.
 - Develop targeted strategies to encourage rural and regional participation.
 - Consider utilising community events to disseminate information about the project.

The Victorian Refugee Health Network recommends:

Peak bodies, ethnic and multicultural organisations, and health training providers:

- 2.16.3** Provide professional development opportunities targeted specifically at people working in bicultural worker roles.

Service providers:

- 2.16.4** Allocate sufficient time for support and supervision of bicultural workers, particularly in managing the boundaries between community and work expectations.

- 2.16.5** Provide professional development opportunities to meet the particular needs of bicultural workers, including forums, skills development workshops and communities of practice.

- 2.16.6** Utilise the skills of bicultural workers to engage local refugee background communities in feedback mechanisms such as consultations, advisory groups and complaints processes.

2. Project methods



3. Findings from the consultations

The 115 consultations with individuals and groups identified a range of issues impacting on the health and service access of people from refugee backgrounds in Victoria. Findings are presented thematically in this section. Eight main themes were identified in the consultation responses. In order of the strength of the finding, they were:

1. Healthy eating and food security
2. Social connectedness
3. Physical exercise and sport
4. Health information and knowledge about health service systems
5. Communication with health providers
6. Accessibility and appropriateness of services
7. Mental health
8. Income and employment

This section summarises the consultation findings followed by reflections from the PAG members in each of the eight theme areas. Selected quotes have been included to illustrate the feedback provided during the consultations and PAG meetings. Blue boxes indicate findings that were particularly strong for specific sub-groups within the consultation respondents. Green boxes include case studies⁶ of good-practice approaches that support the wellbeing of people from refugee backgrounds in each of the key theme areas, provided by our PAG members. Recommendations informed by the consultation, PAG feedback and previous experience of the Network are made within in each of the key theme areas.

3.1 Characteristics of the consultation respondents

Twenty five bicultural workers conducted 115 consultations with people or groups of people from refugee backgrounds. Characteristics of the consultation participants are listed in Table 1.

Table 1: Characteristics of the consultation participants (n = 115)

Characteristic	Number
Consultation type	
Group consultation	58
Individual consultation	57
Gender	
Male, or all-male group	52
Female, or all-female group	46
Mixed gender group	17
Age	
Young people (<25)	36
Adult (25–59)	62
Older people (60+)	17
Visa status	
Permanent visa	76
Bridging visa (seeking asylum)	39
Region	
South East Metro Melbourne	32
West Metro Melbourne	31
North Metro Melbourne	25
East Metro Melbourne	7
Shepparton	7
Geelong	4
Cultural background (as described by bicultural workers)	
Afghan	21
Iranian	17
Tamil	15
Karen	13
Eritrean	9
African	6
South Sudanese	6
Bhutanese	3
Burmese	3
Arabic speaking	2
Assyrian Chaldean	2
Iraqi	2
Malaysian	2
Somali	2
Sri Lankan	2
Syrian	2
Vietnamese	2
Egyptian	1
Fijian	1
Filipino	1
Hazara	1
Nepalese	1
Papua New Guinean	1

⁶ The case studies have been written up based on advice provided by PAG members, and information that is available about the programs online. Programs may have changed since this information was current, so readers are encouraged to follow up with the relevant agencies directly for further information.

3. Findings from the consultations

3.2 Healthy eating and food security

Unhealthy food is cheaper. Also people are unfamiliar with how to cook with new and different foods they haven't used in the past. (Arabic speaking community group)

What did the community members say?

When we asked people what their community needs to stay healthy, access to healthy and nutritious food and knowledge about healthy eating were by far the most commonly cited concerns. Cost was frequently identified as a barrier to eating well, with many people saying that unhealthy food is cheaper and that living on limited incomes restricts their ability to purchase healthy ingredients. People commonly identified that eating too much fast food makes people in their community unhealthy. Some people identified a departure from their traditional diets as contributing to poor health; conversely others mentioned that traditional dishes can be excessively fried or fatty, combined with a more sedentary lifestyle in Australia. People also identified knowledge-related barriers to eating well. There was a strong finding that people need knowledge about the nutritional value of different foods, and that many people do not have the required information to make informed choices about healthy eating. Some women said that they do not know how to cook with ingredients commonly found in Australia that are new and unfamiliar to them, and other women mentioned time-related barriers to cooking and eating well. Overweight and obesity were identified as problems by some communities.

What did the Project Advisory Group say?

In reflecting on the findings, PAG members discussed that cost may not be the only factor influencing people to eat fast food restaurants – for some communities it can be considered a status symbol. It was reported that in some African countries, only upper-middle class people can afford to eat at American chain restaurants, so when people come to Australia and find that they can afford to eat there, they consider it a source of pride and indication of a rise in their social status. Similarly, for people who come from countries that do not have such restaurants back home, fast food outlets can be new and exciting.

PAG members recommended several approaches to supporting people's wellbeing in the area of nutrition. It was agreed that cooking classes that show rather than tell people how to cook healthy and nutritious food are a good approach. Programs and resources

should include communities' own traditional foods – teaching people to substitute unhealthy ingredients for healthier alternatives when preparing traditional meals. The PAG recommended involving people from the community – either as peer educators or bicultural workers. This allows delivery of health education in the community's own language and helps with engagement. Involving experts such as a dietitian or nutritionist is also important for providing credibility to the messages. For people who are newly arrived, cooking classes could be combined with a tour of the local shops or fresh food markets, to discuss the different foods that are available and support people to access healthy ingredients nearby to where they live. It was agreed that this type of program works best when participants can share a meal they have cooked, and when childcare is provided to improve access for women with children.

PAG members recommended targeting women with healthy eating messages or interventions as they are often responsible for making decisions about food for their families. It was observed that creating opportunities to prepare and share a meal together may be especially important for single male asylum seekers who are here without their families. The PAG felt that it is important to target people with information about healthy eating as early in their settlement as possible, before unhealthy eating habits are established. However, it was acknowledged that early in their settlement people will have many other pressing demands, and attending a healthy eating program may not be a high priority. Therefore, providing new arrivals with written information in their own language about the nutritional value of different foods in Australia, including messages about only eating fast food in moderation was identified as a good approach. The PAG also advised that people from refugee backgrounds may require support to understand food labels.

Cooking classes are a good approach, but you need to use the community's own food – and show them how to substitute healthier options for the foods they're already cooking with. The approach needs to be done in a way that's not telling people that they're doing the wrong thing, but rather giving them more options – 'You have more options available to you here in Australia, and here is how you can use them in your cooking'.

(Project Advisory Group member)

Mothers are key to food and cooking in the home. Mothers decide 95 per cent of the time what their family will eat, so targeting them is very important.

(Project Advisory Group member)

It's not just about buying foods, it's also about growing your own food – if people are not in stable accommodation it's hard to grow food. Growing your own food also has benefits of physical activity, as you get out in the garden and don't just sit inside all day.

(Project Advisory Group member)

CASE STUDY

Asylum Seeker Resource Centre Foodbank Recipe Book

The *ASRC Foodbank Recipe Book* was created in collaboration with members of the ASRC, and provides a guide to preparing healthy nutritious meals for people seeking asylum. Recipes are laid out with images to support people with various levels of English language proficiency and utilise ingredients commonly found in the ASRC Foodbank and Australian grocery stores. The project seeks to improve the food security of people seeking asylum by ensuring they have both access and means to prepare healthy meals to support their physical and mental wellbeing.

Purchase a copy of the [ASRC Foodbank Recipe Book](#)

CASE STUDY

Asylum Seeker Resource Centre Food Justice Truck

The ASRC Food Justice Truck is a mobile fresh food market that enhances food security for people seeking asylum in the Victorian community by offering locally sourced produce including fresh fruit, vegetables, grains, legumes, tea and bread at a 75 per cent discount to people seeking asylum. The social enterprise model enables the general public to purchase quality fresh food and reinvests the profits to provide subsidised access to affordable and nutritious food to address food insecurity experienced by people seeking asylum.

Learn more about the [Food Justice Truck](#)

Recommendations

Based on the advice of community members surveyed, the Project Advisory Group, and previous experience of the Network:

The Victorian Refugee Health Network will:

- 3.2.1** Conduct a 'resource round-up' of contemporary resources developed to support the delivery of healthy eating programs with people from refugee backgrounds and make these resources available on the Network website.
- 3.2.2** Produce a themed edition of the Network e-Bulletin, circulated to 1,500 health professionals, highlighting these findings and directing services to resources.

The Victorian Refugee Health Network recommends:

The Victorian Department of Health and Human Services:

- 3.2.3** Invest in health promotion programs that engage and meet the needs of people from refugee backgrounds. Including funding:
 - the development of high-quality multilingual resources for people from refugee backgrounds, including information such as the nutritional value of different foods available in Australia, including fast food.
 - programs that address food security that are inclusive of people from refugee backgrounds, such as foodbanks, food cooperatives, community kitchens, and community gardens.

Local government and service providers:

- 3.2.4** Develop nutrition programs in collaboration with local refugee background communities and groups, taking cultural needs and access issues into consideration (see Section 3.2 for some considerations).
- 3.2.5** Develop programs that address food security that are inclusive of people from refugee backgrounds, such as foodbanks, food cooperatives, community kitchens and community gardens.

3. Findings from the consultations

3.3 Social connectedness

I would like to meet and talk with many people and get together to socialise and learn from each other. But due to limited access of transportation and illiteracy in English I cannot go anywhere alone. (older Bhutanese man)

What did the community members say?

Social connections and opportunities to socialise with family, friends and the wider community were named as essential requirements for health; and social isolation, loneliness, and separation from family members and friends were frequently cited as making people unhealthy.

Many people expressed that they lack opportunities to socialise, due to limited access to transport, language barriers, and lack of connections with the mainstream Australian community.

Social connections were also identified as sources of health advice and support for people to access health services:

- approximately a third of the consultation respondents said they go to family members, friends, community leaders or religious leaders for help with their health problems.
- many older people said that they rely on family members, friends and members of their community or church for assistance with attending health appointments.

Older people identified family and community supports (such as friends and community or church members) as facilitators to accessing health services more than other groups surveyed

I seek help from my family members [to go to health services]. I don't have much knowledge of health services myself. (older Bhutanese man)

What did the Project Advisory Group say?

In reflecting on these findings, PAG members advised that community-led initiatives work best for developing social connections, but that governments and services have a role to play in supporting and resourcing communities to develop social groups and initiatives, for example by providing free or low-cost venues for groups to meet in, transport to help people access the group, or funding for catering or materials.

One PAG member said that food binds people together in every culture, so when designing programs to address social isolation it is a good approach to involve food.

PAG members agreed that bilingual supported playgroups are a good way to address social isolation for new mothers. It was identified that women who come to Australia on spousal visas can be a very socially isolated group.

CASE STUDY

Bhutanese Senior Citizens Club

Foundation House conducted focus group discussions with a group of older people from the Bhutanese community in late 2011. Limited English language proficiency and lack of familiarity with 'how things work' in Australian society was preventing the older people from feeling part of their local communities. A Bhutanese program was developed and implemented in 2012, addressing a range of needs identified by the group participants and linking them to a range of community resources. One of the identified needs was to meet together regularly with their peers to prevent social isolation. A counsellor advocate from Foundation House linked the group with the Aged and Disability Services Team at Moreland City Council, who supported the group to become an independent incorporated seniors group. The council provided an interpreter to assist with filling out all the forms, explaining the process, and answering questions from the group over several sessions. Becoming incorporated meant that the group could access free meeting space two afternoons a week at the Glenroy Senior Citizens Centre and be covered by council's public liability insurance. It also meant that they were eligible to receive council community grants. Moreland City Council arranged for the group to access to English classes and physical exercise activities, and ordered reading materials in Nepali on request from the group for the library.

CASE STUDY

Hampton Park Women's Friendship Cafe

The Hampton Park Women's Friendship Cafe was established to overcome the social isolation experienced by women who are starting a new life in Australia. It is a place for all women, especially new migrants and refugees, to share conversation and activities like sewing; hear information sessions on topics like the law, health, and safety; find links to services and opportunities for education and employment; and especially make new friendships and support each other with everyday problems. The group meets on a weekly basis from 9 am to 1 pm during school terms.

The program is auspiced by the Victorian Immigrant and Refugee Women's Coalition. The sustainability of the group relies on volunteers and funding for costs including venue hire, food and drink, outings and materials for activities.

Watch a video about the [Hampton Park Women's Friendship Cafe](#)

CASE STUDY

Buddha of Bamyán project

Southern Migrant and Refugee Centre, Eastern Region Mental Health Association, and Keysborough Learning Centre's Men's Shed partnered to run a project with Hazara men on bridging visas who were socially isolated and didn't have much to do. When they asked the men what they would like to do, they said they would like to carve a replica of the Buddha of Bamyán, an important part of Hazara cultural heritage that was destroyed by the Taliban. The men's shed provided the space, and a bus to help people get to the shed, and the men cooked and shared meals. Friendships developed between the men, some of who knew each other and others didn't. Many of the men who participated in the project are in Australia by themselves, so social isolation is a big issue. Reducing social isolation was one of the key goals of the project. Many of the men are separated from their families and worry about the future. The project gave

them a safe space to come together and provide peer support to one another. The Buddha was displayed publicly after the project, and the men reported that they were proud to be able to share their culture with the wider Australian community.

Watch a video about the [Buddha of Bamyán project](#)

Recommendations

Based on the advice of community members surveyed, the Project Advisory Group, and previous experience of the Network:

The Victorian Refugee Health Network will:

- 3.3.1** Share good-practice examples through forums, reports, website, e-Bulletin and social media that promote social connectedness for people from refugee backgrounds.

The Victorian Refugee Health Network recommends:

The Commonwealth Department of Social Services, the Victorian Department of Health and Human Services, the Victorian Department of Education and Training, and local governments:

- 3.3.2** Invest in programs to support social connections and reduce social isolation for people from refugee backgrounds with a particular focus on more vulnerable groups such as those who are newly arrived and older people.
- 3.3.3** Continue to fund and otherwise support bilingual supported playgroups for mothers from refugee backgrounds.

The Victorian Multicultural Commission, the Office of Multicultural Affairs and Citizenship, local governments, and service providers:

- 3.3.4** Develop opportunities for people from refugee backgrounds to form social connections, particularly for more vulnerable groups such as people who are newly arrived and older people.
- 3.3.5** Provide free or subsidised access to meeting places for community groups from refugee backgrounds.
- 3.3.6** Provide support for refugee background community groups to become incorporated, access community grants, and understand and comply with relevant legal obligations such as public liability insurance.

3. Findings from the consultations

3.4 Physical exercise and sport

We are not physically active here in Australia. Back home we do lot of walking but not here, as we take public transport and car everywhere. (mother from Burma)

Parents need more opportunities for participating in physical activities, our kids are lucky there's plenty of time allocated to play during school hours. (Eritrean family)

What did the community members say?

There was a strong finding that people need opportunities for physical exercise and sporting activities. Cost was identified as a major barrier to sports participation, including the cost of access fees and gym memberships. Lack of culturally appropriate sporting facilities and lack of female-only sporting facilities or exercise programs were also identified as barriers. Some people noted that their lifestyles are more sedentary in Australia than they were in their home countries, noting that they drive or take public transport to get to places that at home they would have walked to. Opportunities for physical exercise and sport were particularly important to young people, though some parents did indicate that they have fewer opportunities for physical activity than their children.

Sport and physical exercise were especially important for young people

We need recreation facilities and more affordable sporting services to stay healthy. Provide affordable and culturally appropriate recreation programs and facilities. (young African man)

What did the Project Advisory Group say?

In reflecting on these findings, PAG members noted that many local swimming pools have allocated times during the week when swimming facilities can be used by women and girls only, as well as very young boys under a certain age. It was noted that these are usually only for 1–2 hours per week, which does not provide a lot of opportunity for women who use these sessions. It was also felt that in some communities men may prefer male-only times for swimming, which are not widely offered.

PAG members suggested:

- that local councils provide reduced-cost or free entry to leisure centres for people from refugee and asylum seeker backgrounds

- that community organisations could hire the local gym for an hour a week and take groups of clients from refugee backgrounds there to exercise free of charge
- that community health services run free weekly exercise groups for clients from refugee backgrounds.

The PAG discussed community-led sporting activities or groups that they knew of, such as soccer teams, adding that groups may require support with access to venues and public liability insurance. One PAG member suggested that creating opportunities for parents to exercise while they take their children to sporting activities may be a good approach.

Many parents take their kids to sporting activities, but the parents just sit and watch, or sit and wait in the car. It would be a good idea to run some light physical activity sessions for the parents while they wait for their kids. Many people say they can't afford gym fees, but this would be a free or low-cost activity. And they couldn't say that they don't have time – as they're already there!

(Project Advisory Group member)

CASE STUDY

Sunday Sport Program

This program was initiated by a group of young Afghan people associated with the Noor Foundation, who recognised a need in their community for opportunities for recreation and sport. The young people approached their former high school, Cranbourne Secondary College, which agreed to provide free access to the school gym and sporting equipment on Sundays. The Noor Foundation provided letters of support and public liability insurance to support the program.

The program runs every week on Sunday and provides a place for young mostly Afghan people living in the City of Casey to come together to play sports such as soccer and badminton, as well as have an opportunity to socialise.

The popularity of the program has grown from under 10 people attending the first session in February 2016, to 50 or 60 young people now attending each week.

Watch a video about the [Sunday Sport Program](#)

CASE STUDY**Asylum Seeker Resource Centre exercise program**

Every Friday morning a volunteer personal trainer takes a group of ASRC members to a local gym for a circuit training session. ASRC has formed a partnership with The Exercise Room that donates time and space for ASRC members to exercise free of charge on a weekly basis.

CASE STUDY**Primary Care Connect partnerships to promote physical exercise in Shepparton**

The Refugee Health Program at Primary Care Connect in Shepparton has formed a number of internal and external partnerships to promote physical and emotional wellbeing for people from refugee backgrounds. The Refugee Health Program works with the health promotion team to deliver an Afghan and Iraqi women's exercise group. External partners are involved in delivering other exercise programs, including a fortnightly lawn bowls program with Mooroopna Bowls Club, and weekly hydrotherapy sessions in partnership with Aqua Moves, the local swimming pool.

3.4.3 Identify people from refugee backgrounds as a priority population group to access subsidies and grants for structured sporting or exercise programs.

3.4.4 For policy and program areas that utilise 'universal design principles', ensure that they take into account access requirements for communities from refugee backgrounds.

Victorian state sporting associations:

3.4.5 Provide support for sports clubs to be inclusive of people from refugee backgrounds.

Service providers:

3.4.6 Develop partnerships to support people from refugee backgrounds to engage in physical activity across the lifespan, taking cultural and gender needs into consideration (see Section 3.4 for some considerations).

3.4.7 Provide support to develop community-led sporting programs.

Recommendations

Based on the advice of community members surveyed, the Project Advisory Group, and previous experience of the Network:

The Victorian Refugee Health Network will:

3.4.1 Share good practice examples through forums, reports, website, e-Bulletin and social media of programs that provide opportunities for people from refugee backgrounds to engage in physical activity.

The Victorian Refugee Health Network recommends:

The Commonwealth Department of Health, the Victorian Department of Health and Human Services, the Victorian Multicultural Commission, the Office of Multicultural Affairs and Citizenship, and local governments:

3.4.2 Invest in programs that engage people from refugee backgrounds in physical activity across the lifespan.

3. Findings from the consultations

3.5 Health information and knowledge about health service systems

We have a cultural tendency to avoid health check-up and wait until the health issues has become bigger before seeking help. (South Sudanese woman)

What did the community members say?

There was a strong finding that people needed better access to information about health and health services. Respondents identified a need for health promotion and education in the following topic areas: healthy eating, oral health, sexual health, preventative health, menopause, and cancer screening.

Respondents also identified lack of knowledge about Australian health services and difficulty in navigating the Australian health system, and that this acts as a barrier to accessing health services. Furthermore, preventative health and going to the doctor for check-ups when not unwell are unfamiliar concepts in many communities. Respondents suggested that services should provide education sessions on the Australian health system for refugee clients.

Consultation respondents suggested that health services should provide communities with information about health and health service availability via:

- translated brochures
- information sessions delivered to community groups
- orientation sessions at services
- community media.

What did the Project Advisory Group say?

PAG members recommended providing people with written information in their own language to reinforce the health promotion messages, but cautioned against relying on written information alone to improve health literacy. They noted that not all people from refugee backgrounds know how to read and write in their own language. Advice for services producing written resources included that they should not be too text-heavy, they should provide brief and to-the-point information, and should include culturally appropriate visuals. The PAG identified a lack of high-quality multilingual resources explaining the health sector in Australia.

One PAG member said that when services are designing health education and promotion strategies for people

from refugee backgrounds, they should consult with communities in order to identify approaches that are likely to meet the varying needs of different communities.

PAG members recommended targeting community leaders with information about health service availability and how to refer people to services, as many people from refugee communities go to community leaders for help with their problems. Bicultural supported playgroups were identified as a good place to provide health information to new mothers, for whom language barriers and lack of childcare make it difficult to access health services or other health promotion activities. English language schools were identified as a good place to deliver health information to newly arrived young people. PAG members also advised that libraries and Centrelink offices are frequently accessed by newly arrived people from refugee backgrounds, so providing outreach at these locations may assist health services to engage people with health promotion messages and information about their service.

PAG members advised that even if people are aware of the availability of services, many are not aware of priority access and fee waiver arrangements for refugees and asylum seekers.

PAG members suggested using innovative ways to engage communities that are enjoyable or provide them with an opportunity for social interaction. For example, a community barbecue in a park where people can socialise while learning about local health services; or a teeth brushing competition for children to promote good oral health practices.

PAG members identified that people from refugee backgrounds need information about sexual and reproductive health, but that many people feel uncomfortable talking about it because it is taboo subject in their culture. One PAG member recommended using contexts such as male-only sports activities as an opportunity to talk informally to men about sexual health and safe sex practices. Another PAG member advised that sex education sessions for young people in schools may need to be tailored for some cultural groups in order to make the messages more acceptable to young people.

One PAG member suggested that when young people receive health education in schools, they should also be provided with translated materials to take home to share with their families. This extends the reach of the health messages to parents and allows them to support young people to adopt positive health behaviours.

CASE STUDY

The Water Well Project

The Water Well Project is a Victorian not-for-profit health promotion project that aims to improve the health and wellbeing of people from migrant, refugee and asylum seeker backgrounds by improving their health literacy. The project partners with organisations that work with migrant, refugee and asylum seeker clients to deliver interactive, culturally sensitive and free health education sessions that are tailored to the needs and interests of the group. All sessions aim to increase participants' understanding of a particular health topic and improve their awareness of resources available within the Australian healthcare system. Health education sessions are delivered by volunteer health professionals including doctors, nurses and midwives, and allied health professionals, with professional interpreters provided to translate the sessions where required.

See the range of [health education sessions](#) the project can deliver.

CASE STUDY

Afghan health literacy videos

The Afghan Community Engagement Project conducted by the South Eastern Melbourne Medicare Local included the development of a video available in simple English and three commonly spoken Afghan languages; Dari, Hazaragi, and Pashto.

Members from the local Afghan community were used in lieu of actors in the videos, and as such the videos were very popular and shared widely in the community via social media. It was felt that using people from the community created ownership of the videos and increased the relevance and trustworthiness of the messages.

Watch the [Afghan health literacy videos](#)

CASE STUDY

Health Translations Directory

The Health Translations Directory is a Victorian Department of Health and Human Services initiative that is managed by the Centre for Culture, Ethnicity and Health. The Health Translations Directory provides health professionals and community members with reliable, accurate and up-to-date health information in many different languages, by linking to multilingual resources published by government departments, peak health bodies, hospitals, and community health, and welfare organisations. Only resources that meet certain editorial criteria are included in the directory. Resources must be designed for health consumers with low English proficiency, not for health professionals; improve health literacy of consumers and motivate them to participate more fully in healthcare decisions; and take into consideration cultural sensitivity and linguistic diversity of consumers. To ensure reliability of the information, resources must have been translated by a NAATI-accredited translator and/or have been focus tested with consumers. Resources are reviewed by the submitting organisation every three years from the date of publication or the last review date.

Access the [Health Translations Directory](#). Resources can be searched for by [language](#) or by [topic](#).

I don't agree with using only written information to improve health literacy. It's too hard for people to take in if there is too much written information. Flyer or poster formats are okay, using visuals and with very short and to-the-point written information, especially if they have cultural elements. (Project Advisory Group member)

Short videos are a good way to improve health literacy, and video formats are very acceptable in the Afghan community. Dandenong library has a big screen out the front. Community groups can send a video to them and they play it on the big screen, and it also plays on smaller screens in the library. People who are newly arrived or people with no work rights often go to the library to access the internet, meet friends, or read. So you could reach them with health messages that way. (Project Advisory Group member)

3. Findings from the consultations

Many people use ethnic community radio and community newspapers, so it would be easy to engage people with health information and information about services in this way. (Project Advisory Group member)

When running community education sessions, PowerPoint format does not work, especially with older people.

Theatre and songs are used in Africa to convey messages – this engages lots of people. Services need to adopt ways of delivering health messages that are more suitable for the audience. (Project Advisory Group member)

Small group approaches to community education work well, so does using community champions. Doctors are well placed to be community champions because they are well-respected in the Afghan community. They sit in a position of authority to be able to advise people on what is healthy and what is not healthy ... because of their education they can speak from an informed point of view. (Project Advisory Group member)

Recommendations

Based on the advice of community members surveyed, the Project Advisory Group, and previous experience of the Network:

The Victorian Refugee Health Network will:

- 3.5.1** Continue to promote high-quality sources of translated health and health service system information in the Network e-Bulletin, and at forums.
- 3.5.2** Continue to monitor content gaps in high-quality health and health service information in new-arrival languages.

The Victorian Refugee Health Network recommends:

The Victorian Department of Health and Human Services:

- 3.5.3** Fund the ongoing development of high-quality health information resources.
- 3.5.4** Consult with communities when developing translated/interpreted health and health service information.
- 3.5.5** Utilise community radio and community newspapers to disseminate health and health service information, including information about priority access and fee waiver arrangements for people from refugee backgrounds.

- 3.5.6** Continue to support the Health Translations Directory as a library of high-quality translated health information and health services information, including ongoing funding to monitor existing content and produce new resources.

Service providers:

- 3.5.7** Familiarise themselves with sources of translated health and health service system information (e.g. Health Translations Directory).
- 3.5.8** Translate service brochures into new-arrival languages.
- 3.5.9** Consult with communities or contract a service that consults with communities when developing translated health and health service information.
- 3.5.10** Consult with local communities about the design and delivery of health promotion interventions.
- 3.5.11** Provide clients from refugee backgrounds with health and health service information in multiple formats based on need (verbal, written, pictorial, video, theatre, song).
- 3.5.12** Provide opportunities to improve health and health service literacy and promote preventative health during individual and group consultations.
- 3.5.13** Provide outreach to community groups, community leaders, playgroups, schools, libraries, and Centrelink offices with high-quality health and health service information in many formats (verbal, written, drawn, video, theatre, song).
- 3.5.14** Host activities and social gatherings to engage different communities to disseminate health and health service information.
- 3.5.15** Create opportunities for discussion about sensitive topics with single-gender and similarly aged participants (e.g. sexual and reproductive health education sessions for young Afghan men).

3.6 Communication with health providers

What did the community members say?

The ability to communicate with health providers was one of the strongest enablers to accessing health services identified in the consultations; and language barriers and not being provided with an interpreter were among the most frequently mentioned barriers. That language barriers and not being provided with an interpreter were so frequently mentioned as barriers to accessing health services suggests that interpreters are not always engaged in healthcare settings at times when they should be.

There was a strong preference for bilingual GPs. Seeing a GP who speaks their language not only makes it easier for people to communicate with the GP, respondents also indicated that they felt more comfortable and had higher levels of trust with a GP who is from the same cultural background and language group. Some people mentioned travelling long distances to see a GP who speaks their language. The preference for bilingual GPs was stronger among adults and older people than it was for younger people.

The preference for bilingual GPs and other health professionals was stronger among adults and older people than for younger people.

If the GP speaks the same language, then they feel comfortable with the GP. (older Eritrean man)

What did the Project Advisory Group say?

PAG members agreed that many community members prefer bilingual GPs. They noted that sometimes the importance of effective communication can outweigh concerns people have about the quality of medical care they receive from a particular GP who speaks their language.

Even if they are not happy with them, they just stick with them, because they feel comfortable with them, and they can talk to them. (Project Advisory Group member)

PAG members advised that many people from refugee backgrounds are not aware that they are entitled to an

interpreter in publicly funded health services. The PAG suggested that advising communities of their right to an interpreter should be included in health education initiatives for this group.

PAG members noted the value of services in areas with large refugee communities employing people who are credentialled interpreters and translators who in addition to interpreting for health consultations and translating service brochures, may also perform administration duties such as calling people to remind them about their appointments.

PAG members discussed the difficulty some interpreters have translating complex health information when they do not have a lot of specialised health knowledge or training. One PAG member suggested that having interpreters that have undertaken further training in interpreting in health contexts would assist with understanding medical terms, abbreviations and acronyms that are commonly used in the health sector.

Recommendations

Based on the advice of community members surveyed, the Project Advisory Group, and previous experience of the Network, particularly referencing the recommendations from the Foundation House report *Promoting the engagement of interpreters in Victorian health services* (Vanstone, Szwarc, Casey, Maloney, & Duell-Piening, 2013):

The Victorian Refugee Health Network will:

- 3.6.1** Continue to identify systemic barriers which lead to the underutilisation of language services.
- 3.6.3** Continue to highlight good practice in using language services.
- 3.6.4** Engage bilingual GPs who speak languages from humanitarian source countries in Network activities.

The Victorian Refugee Health Network recommends:

The Commonwealth Department of Health:

- 3.6.5** Include a data field in the National Health Service Directory for language spoken by practitioner and if interpreters are available at the service.

3. Findings from the consultations

The Commonwealth Department of Social Services:

- 3.6.6** Provide pathways for testing and skill development for interpreters that speak humanitarian source country languages through National Accreditation Authority for Translators and Interpreters.

The Commonwealth Department of Immigration and Border Protection, the Commonwealth Department of Social Services, and the Commonwealth Department of Health:

- 3.6.7** Provide information for people entering the Refugee and Humanitarian Programme about Australian Government policies about use of interpreters and pathways for making a complaint.

The Commonwealth Department of Immigration and Border Protection, Commonwealth Department of Social Services, Commonwealth Department of Health, and Victorian Department of Health and Human Services:

- 3.6.8** Plan for and adequately fund the provision of interpreters for people with low English proficiency.
- 3.6.9** Develop and widely advertise language service policies that indicate when an interpreter should be engaged and mechanisms for service users to provide feedback.

Primary Health Networks:

- 3.6.10** Provide targeted capacity building for bilingual GPs and other health providers who speak languages from humanitarian source countries.

Services providers:

- 3.6.11** Inform clients with low English proficiency of their policies about use of interpreters, that if one is not provided they have the right to request an interpreter, how to ask for a change in interpreter, and how to provide feedback or make a complaint.
- 3.6.12** Develop clear policies, procedures and staff training about how to:
- identify if a person requires an interpreter
 - engage and work with credentialled interpreters
 - record on client management systems if an interpreter is required, the language spoken and other requirements (e.g. gender, ethnicity, dialect).

3.7 Accessibility and appropriateness of services

Be patient, listen carefully, and understand that we come from different cultural background with difficult experiences. (young Iraqi man)

What did the community members say?

Consultation respondents identified several factors that make it difficult for people from refugee backgrounds to access services, including language barriers, cost, distance to the service, a lack of transport options or not being confident or familiar with using public transport, and long waiting times for appointments, especially to see specialists. People also identified difficulty making appointments, especially over the phone, difficulty making it to appointments on time when using public transport, and difficulty filling in forms as barriers to accessing services. Caring responsibilities, not having access to childcare, lack of confidence, and inability to see or request to see a female health practitioner were identified as barriers to accessing health services for women. Of the nine consultation respondents who said they do not seek help for their health problems, all were young or adult males.

Consultation respondents identified several enablers to accessing services, such as convenient location or proximity of the service to where they live, availability of public transport options to get to the service, attending services that are co-located, attending services that employ bilingual GPs or other health professionals, drop-in clinics where no appointment is required, and caseworker or GP referral to the service. Some respondents indicated that their GP had referred them to see a specialist that is located far from where they live, is difficult to access using public transport, or that charge high fees, making it difficult for them to access that specialist service. Respondents also identified that bicultural workers help people from refugee backgrounds to access services and recommended employing more bicultural workers as a strategy for health services to work better with people from refugee backgrounds. AMES community guides were also mentioned as facilitators to accessing health services.

Consultation responses indicated a number of approaches that individual health professionals can take to work better with clients from refugee backgrounds. These include cultural competence and cultural understanding, being friendly and welcoming, listening

and being respectful, being patient and sensitive to people's difficult past experiences, taking time to develop the client's trust, and maintaining confidentiality.

All of the consultation respondents who said they do not seek help for their health problems were male.

Most people do not speak about these issues or seek help. (young Tamil man)

What did the Project Advisory Group say?

PAG members endorsed the important role bicultural workers play in helping to make services more accessible and appropriate for people from refugee backgrounds. They acknowledged that community guides provide valuable support for people who are newly arrived to attend health appointments, but highlighted that it is not their role to interpret during health consultations.

The PAG acknowledged that new arrivals are required to attend many appointments across multiple service systems, and can sometimes find it difficult to engage with appointment systems. They discussed the value of sending translated reminders for appointments and discussed different tools that are available online for generating and sending translated reminders.

The PAG discussed the importance of health services making an agency-wide commitment to cultural competence, and providing cultural competency training for all staff working in the health service. They discussed the important role front-of-house staff play in creating a welcoming environment for clients from refugee backgrounds. A few PAG members suggested employing bilingual receptionists as a good approach to welcoming people from refugee backgrounds to health services and helping them to navigate the service. They said that, even if a receptionist does not speak a person's language, they should be friendly, use plain language, speak slowly, and use visual or pictorial cues to help explain the service.

Many people are quite late for appointments, or do not show up because they have forgotten about them. They are not used to having to keep appointments, or they rely on their kids to remind them about their appointments, but their kids are at school so they forget. Most people in the community have mobile phones, but they just use them for talking or texting. It would be a good opportunity to tap into this resource by organising a session to show people how to use their mobile phone calendar to remind them about health appointments.

(Project Advisory Group member)

3. Findings from the consultations

Having posters and brochures available in different languages helps to make people feel comfortable, as well as giving them information.

(Project Advisory Group member)

CASE STUDY

Project YANA

Project YANA (You Are Not Alone) is a project of the Noor Foundation that aims to assist newly arrived refugees with the daily tasks of settlement and in the process, aims to fill service gaps for these particular individuals and families. Community members can call Project YANA and be matched with someone who can speak their language and with whom they feel comfortable, to help them in their home or at another nominated location. The services are provided on a voluntary basis, free of charge, by young people from similar language and cultural backgrounds. Volunteers can speak English and one of the following languages: Dari, Pashto, Urdu and Farsi. The project has a secondary aim of providing a platform for young people to engage in a positive manner with their community.

Project YANA volunteers have assisted community members to access health services, including meeting them at their appointments, helping them fill in forms, helping them talk to the doctor (as a community member, not a professional interpreter), and helping them to make another appointment.

Read more about [Project YANA](#) and the [Noor Foundation](#)

CASE STUDY

ISIS Primary Care drop-in clinic and transport training

ISIS Primary Care Refugee Health Program runs a drop-in clinic one afternoon a week for clients from refugee backgrounds. The clinic is staffed by a bicultural worker, community case worker,⁷ refugee health nurse, and an in-house interpreter. No appointment is required, and clients can drop in to receive assistance with Centrelink, utility bills or housing issues, calling other health services to make appointments, or to ask health-related questions. The brochure for the drop-in service has been translated into Karen and Burmese by the in-house interpreter, and all new clients of the service are advised about the clinic.

A bicultural worker from ISIS Primary Care identified that some clients from refugee backgrounds needed to attend appointments at the Royal Women's Hospital, the Western Hospital at Sunshine, Footscray and Williamstown, and the Royal Victorian Eye and Ear Hospital, but that they didn't know how to get there. She arranged to meet groups of clients at the train station, to show them how to buy a ticket, and take a train, tram and/or bus to the hospital. They then entered the hospital, and practised what they would say to the person at the front desk. The bicultural worker also printed out a map to give to the clients. She says this helped increase the clients' confidence to access the services themselves in the future.

⁷ The community case worker position sits within the ISIS Primary Care Refugee Health Program and provides social support services for vulnerable clients of the service, including case work, advocacy, information and referral.

CASE STUDY

Online Appointment Reminder Translation Tool

The NSW Refugee Health Service's Online Appointment Reminder Translation Tool allows health providers to translate appointment details into their client's language. Providers type the appointment details into the online portal; then they may either print or save the PDF. The form is generated immediately so it may be given to the client at the time of making an appointment. It can also be emailed or posted.

The tool translates reminders for general health, maternity, child health, dental, eye care, imaging, women's health, physiotherapy, home visit and immunisation appointments.

Access the [Online Appointment Reminder Translation Tool](#)

CASE STUDY

New Roots app

New Roots is a smartphone app that has been developed to support the health and wellbeing of men aged 18-45 from Arabic, Farsi and Tamil-speaking backgrounds who have recently arrived in Australia, by helping them overcome daily challenges as they start a new life. The app includes tips and information on eating well, staying fit, managing stress, applying for study and work, accessing sporting clubs, applying for housing and contacting emergency services. The app shares stories and videos from other men who have settled in Australia. It can be used by anyone, but is targeted at men, as they are less likely to access services. The app was developed by Settlement Services International in partnership with beyondblue with funding from the Movember Foundation for men's health. It is free and is available in Arabic, English, Farsi and Tamil for iPhone and Android devices.

Read more and download the [New Roots app](#)

Recommendations

Based on the advice of community members surveyed, the Project Advisory Group, and previous experience of the Network, including reference to the *Guidelines for the community health program on refugee and asylum seeker health services* (State Government of Victoria Department of Health and Human Services, 2014):

The Victorian Refugee Health Network will:

- 3.7.1** Maintain up-to-date referral information on Network website.
- 3.7.2** Showcase good-practice approaches to supporting access to services for communities from refugee backgrounds in the Network e-Bulletin and forums.

The Victorian Refugee Health Network recommends:

The Commonwealth Department of Immigration and Border Protection, the Commonwealth Department of Social Services, the Commonwealth Department of Health, the Commonwealth Department of Human Services, the Victorian Department of Health and Human Services, the Victorian Department of Education and Training, the Victorian Multicultural Commission, the Office of Multicultural Affairs and Citizenship and local governments:

- 3.7.3** Consider further opportunities for co-located services.
- 3.7.4** Continue to consider opportunities for services to be located near public transport.

Primary Health Networks:

- 3.7.5** Provide education and resources for general practices to refer to low-cost/bulk billing specialists which may be easily accessed by public transport.

Local services:

- 3.7.6** Review and further develop systems, policies and procedures to improve access for people from refugee backgrounds, in the areas of:
 - Direct service provision:
 - providing information about the service
 - being transparent about and explaining the appointment system, triaging and waiting times
 - providing support to people in completing forms
 - checking and accommodating people's preferences for choice of gender in practitioners and interpreters

3. Findings from the consultations

- allocating time to see clients on a drop-in basis
- developing targeted responses for population groups that experience specific access issues, e.g. men who are less likely to seek support, older people who rely on others to access appointments, women who need support with childcare.
- Staff development:
 - providing cultural competency training for all agency staff
 - providing staff training on identifying the need for an interpreter and engaging and working with credentialled interpreters
 - providing training to improve health and service literacy for bicultural workers and settlement community guides.
- Service planning:
 - co-locating with other services
 - locating services near public transport hubs
 - locating services close to where the communities are settling (decentralise)
 - providing free or low-cost services
 - providing adequate resourcing for language services
 - employing bicultural workers that speak languages from humanitarian source countries
 - providing outreach services for people who are unable to access the service
 - providing public transport tickets or taxi vouchers for people who cannot access transport options to attend appointments.

3.8 Mental health

What did the community members say?

While some consultation respondents explicitly named poor 'mental health', 'depression', 'anxiety' or 'trauma' affecting people in their community, it was more common for people to mention a range of feelings or symptoms that are indicative of poor mental health such as stress, worry, sleep problems, and thinking about the past. Alcohol, drug abuse and smoking were also frequently mentioned, and in some cases directly linked to worry, stress, or lack of meaningful activity. Respondents indicated that people experience poor mental health as a result of social isolation, separation from and worry about friends and family, worry about visa processing, uncertainty about the future, and lack of meaningful activity. Unsurprisingly, stress and worry were of particular concern to people seeking asylum, who frequently mentioned the impact of uncertain visa status and lengthy processing times on people's mental health. People who were consulted individually were more likely to mention poor mental health or trauma than people who were consulted in groups. Stigma, taboos, denial and reticence to acknowledge mental health issues were identified as barriers to accessing mental health services.

Stress and worry were of particular concern for people seeking asylum.

People who are seeking asylum are suffering from stress and psychological problems, as they are worrying about their visa process. This is a huge problem for both categories of asylum seekers: those who live in detention centre and those live in the community. Therefore, they feel sick mentally.

(young Iranian man who is seeking asylum)

It is first necessary that we be mentally comfortable to feel healthy. Yet this is not possible with our current situation as we are far from our families, don't have good income, and waiting to the result of our protection visa ... It is essential that they expedite the process of visa which is the cause of our problems.

(young Sri Lankan mother who is seeking asylum)

People who were consulted individually were more likely to mention poor mental health and trauma than people who were consulted in groups.

What did the Project Advisory Group say?

The PAG advised that stigma is a big issue in refugee background communities and that denial and shame can prevent people from acknowledging mental health problems and seeking help. PAG members stressed that terminology and language are vitally important when discussing mental health with people from refugee backgrounds, noting that it is sometimes necessary to speak indirectly about mental health in order for it to be acceptable. It was agreed that many people find it easier to talk about feelings and recognise that they may have certain symptoms, than to accept a mental health diagnosis.

The PAG members said that the concept of professional counselling is unfamiliar in many communities. People are used to talking about their problems informally with their family members, neighbours, friends, or community leaders, rather than talking to a stranger. Extensive outreach and community education is required to encourage refugee background communities to use mental health services and seek support. As many people from refugee backgrounds have had no previous exposure to mental health services, it's very important to explain to people what will happen when they attend a mental health appointment, and the role of different mental health professionals.

One PAG member gave an anecdotal example of a client who refused to attend a mental health appointment because the interpreter had incorrectly interpreted the word 'treatment' as 'medication', and so the man thought he would be compelled to take medication if he attended the appointment. After the bicultural worker clarified the mistake, explained counselling and the role of a psychologist and told the man that psychologists cannot even prescribe medication, the man agreed to accept the appointment. PAG members advised that providing outreach services and home visits may help to reduce the stigma associated with going to a mental health service.

One PAG member advised that there is a lack of culturally appropriate mental health services in Australia that accommodate different cultural perceptions of mental health and that this can act as a barrier to people from refugee backgrounds accessing these services. In speaking about young people from refugee backgrounds accessing mental health services, another PAG member indicated that employing bilingual staff in both front-of-house and health professional roles in youth mental health services, such as headspace, helps to make young people feel more comfortable accessing the service.

3. Findings from the consultations

The refugee experience affects everyone in some way. It's just a matter of how much. (Project Advisory Group member)

Language is very important. When speaking with clients, we use the term 'wellbeing', we don't speak about 'mental health'. And people can accept it more when you speak about symptoms and feelings, instead of diagnoses. (Project Advisory Group member)

Approaches to mental health treatment in Australia are very Western-centric, they don't take into account people's way of thinking about mental health; they leave too many people behind. Services should get more information from the community about how they think about mental health in their own context, and how it impacts on their community. (Project Advisory Group member)

CASE STUDY

Foundation House psycho-education programs

Foundation House facilitates psycho-education group programs for people who are newly arrived from refugee backgrounds. The groups aim to promote awareness of the nature of trauma, the effects of traumatic experiences, possible coping strategies, and the availability of support services. The program is mostly conducted with ethno-specific groups that share a common language, supported by two Foundation House counsellors and a community liaison worker who shares language and cultural understanding with the community.

Psycho-education groups conducted with parents and caregivers aim to build understanding of how traumatic experiences affect children and adults, and identify strategies for supporting children to cope and recover from traumatic experiences. Groups conducted with adolescents and young adults aim to provide young people with information about the nature of trauma, normalise the effects of traumatic experiences, and assist them to identify positive strategies to address symptoms, make plans for the future and build a positive life in Australia.

Find more information about [Foundation House](#)

Recommendations

Based on the advice of community members surveyed, the Project Advisory Group, and previous experience of the Network:

The Victorian Refugee Health Network will:

- 3.8.1** Showcase good-practice approaches to supporting the mental health of people from refugee backgrounds on the Network website, in the Network e-Bulletin, and at forums.
- 3.8.2** Broadening mental health sector representation on the Network Reference Group and other Network activities.

The Victorian Refugee Health Network recommends:

The Commonwealth Department of Health and the Commonwealth Department of Immigration and Border Protection:

- 3.8.3** Develop strategies to address mental health issues experienced by people seeking asylum.

The Commonwealth Department of Social Services and the Department of Immigration and Border Protection:

- 3.8.4** Provide free interpreting services for all Medicare Benefit Scheme funded mental health services to improve access to these services for people from refugee backgrounds.

The Victorian Department of Health and Human Services:

- 3.8.5** Continue to provide priority access for refugees and asylum seekers to community health counselling.
- 3.8.6** Review mental health service models to increase access for communities from refugee backgrounds, including data analysis and meeting with community members.
- 3.8.7** Co-create mental health programs with CALD communities, including those from refugee backgrounds, to improve access.

Services:

- 3.8.8** Pay particular attention to terminology when discussing mental health symptoms and conditions with people from refugee backgrounds.
- 3.8.9** Consider more flexible approaches to mental health and mental health promotion services, including capacity for outreach, group work etc.

3.8.10 Provide culturally appropriate and trauma-informed psycho-education about mental health symptoms, coping strategies, and supports that are available in Australia to communities from refugee backgrounds.

3.8.11 Become more culturally responsive by:

- developing cultural responsiveness plans
- providing staff training in culturally competent mental health care
- consulting with local communities about service design and delivery.

3. Findings from the consultations

3.9 Income and employment

We need full employment to stay healthy and look after ourselves. Provide us full employment so we can have the ability to look our physical and mental health.
(young African man)

What did the community members say?

Income and employment featured strongly in the responses. This supports global understandings of income and employment as social determinants of health (Wilkinson & Marmot, 2003). People described living on low incomes as negatively impacting health in a number of ways – through financial stress and worry, and by creating cost barriers to purchasing healthy food, accessing health services, and accessing exercise and sporting facilities. People identified the cost of accessing health appointments as including both the fee for the service and the cost of transport to get to the service. Some respondents mentioned a desire for volunteering opportunities.

Income and employment were particularly strong concerns for people seeking asylum.

In my view people who came to Australia by boat face a number of barriers that make them unhealthy such as having no secure job, no income and the uncertainty of their visa situation that make them unhealthy through worry. (Iranian woman who is seeking asylum)

What did the Project Advisory Group say?

PAG members reflected that a person's ability to look for work and secure employment is dependent on their physical and mental wellbeing, English language competence, and confidence levels. While the PAG acknowledged that income and employment are outside of the remit of health services, they felt that different service sectors need to work together to support people from refugee backgrounds to secure employment. It was suggested that the Network should share the report from this project with relevant government departments and services outside of the health sector, such as employment services.

PAG members reported that job search requirements can create a lot of stress for people from refugee backgrounds. Jobactives require people to apply for 10 jobs per fortnight, and to report their job search activities to Centrelink, which can be stressful for people who

have low levels of English language proficiency and have difficulty filling in forms and writing resumes.

PAG members suggested that the health sector is in a position to offer volunteer positions to people from refugee backgrounds who have an interest in working in the health field. One PAG member also suggested that while many people with health training and/or work experience from their home countries do not have their qualifications recognised in Australia, they may be well placed to work as peer educators in health programs, or may be able to provide services with valuable information about how health is regarded in their communities.

There are people here with health qualifications and experience working in health in their home countries. Even if their overseas qualifications aren't recognised and they aren't working in health here, there is an opportunity to consult with these people about how health is conceived of in their own home country. (Project Advisory Group member)

CASE STUDY

Australian Karen Organisation job search assistance

A bilingual volunteer from the Australian Karen Organisation (AKO) who speaks Karen, Burmese and English provides assistance to people in the Karen community in Wyndham who are looking for a job. The volunteer provides assistance with job searching, filling out job application forms, and reporting job search activity to Centrelink at the AKO office in Werribee on Wednesday and Sunday evenings.

CASE STUDY

Monash Health Volunteer Concierge Program

Volunteers perform a concierge role at Monash Health Community in Dandenong, welcoming visitors to the service and guiding clients to their appointments. The team comprises people from a diverse range of cultural and linguistic backgrounds, the majority of whom arrived in Australia seeking asylum, with many still awaiting determination of their asylum claims. The volunteers help to improve the patient experience and contribute significantly to

the cultural competency and responsiveness of the Monash Health community health service. Monash Health provides volunteers with induction, orientation, and regular ongoing training and support to fulfil these roles.

Evaluation of the program has identified enhanced social capital and sense of belonging, reduced loneliness, increased confidence and mental health, and development of workplace experience and skills. Many of the volunteers have found employment in the community and consider their volunteering experience as having contributed to their success.

Find further information about [Monash Health's volunteer program](#)

Recommendations

Based on the advice of community members surveyed, the Project Advisory Group, and previous experience of the Network:

The Victorian Refugee Health Network will:

- 3.9.1** Share this report with relevant government departments and services outside the health sector.

The Victorian Refugee Health Network recommends:

The Commonwealth Department of Immigration and Border Protection:

- 3.9.2** Address risks to employment pathways and continuity of employment for people seeking asylum, such as gaps in work rights, and continuity of visas.

The Commonwealth Department of Employment:

- 3.9.3** Further develop Jobactive and other employment services that respond effectively to the needs of job seekers from refugee backgrounds particularly those who are newly arrived, by:
 - providing training and development for staff
 - employing bilingual staff to assist clients with low English proficiency.

The Victorian Government:

- 3.9.4** Provide work experience and employment pathways in public sector employment for people from refugee backgrounds.
- 3.9.5** Continue to provide incentives to businesses that employ people from refugee backgrounds, including people seeking asylum, such as in the Back to Work scheme.

Local government:

- 3.9.6** Provide work experience and employment pathways in public sector employment for people from refugee backgrounds.

Services:

- 3.9.7** Provide skill development for clients from refugee backgrounds in areas, such as preparing resumes, interviews, and work health and safety.
- 3.9.8** Provide volunteer opportunities and work experience for people from refugee backgrounds that include pathways to paid employment, to assist in the development of culturally diverse workforces.

3. Findings from the consultations

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Appendices

Appendix 1: Project Advisory Group Terms of Reference



Access & Equity Project Advisory Group Terms of Reference

The Victorian Refugee Health Network (the Network) aims to:

- build the capacity of the Victorian health sector to respond to health concerns experienced by people of refugee backgrounds,
- support services to be more accessible to people from refugee backgrounds, and
- improve service coordination for recent arrivals and those with more complex needs.

Project purpose

To inform the work of the Network through consulting with refugee background communities and help ensure that we are responsive to refugee community concerns.

To create opportunities for people from refugee backgrounds to provide advice about their health priorities and experiences of using health services.

To document the process and findings from the project into a publicly available report to share with Victorian health services and policy-makers.

Purpose of the Project Advisory Group (PAG)

To reflect on and discuss issues related to consultation with communities from refugee backgrounds.

To provide technical advice about:

- the development, implementation and evaluation of the Access & Equity Project consultation framework
- strategies for engaging with under-represented refugee background communities.

Structure of the Project Advisory Group

It is anticipated that the PAG will meet three times during the six-month period of the project (ending April 2016) at the Centre for Culture, Ethnicity and Health, 23 Lennox Street Richmond.

Membership of the Project Advisory Group

Chair

Principles for selecting the chair:

- The chair was directly appointed by the Executive of the Network Reference Group who recognised the role of the Centre for Culture, Ethnicity and Health in identifying and promoting good-practice strategies for cultural competence and meaningful engagement with culturally diverse communities.

Expectations of the chair:

- Assist in identifying PAG members
- Assist in developing agendas for PAG meetings
- Facilitate discussion during PAG meetings
- Identify actions for follow-up
- Provide strategic and content advice about the development of the project

PAG members:

Principles for selecting PAG members:

- Directly appointed based on their experience of working with refugee background communities as bicultural, community liaison, or community access workers. They do not represent a community however have expertise in community engagement.
- PAG members should between them have experience working with diverse groups including a range of ages, genders, geographical regions in Victoria and ethnic communities.

Expectations of the members:

- attend a majority of meetings
- be responsive to email correspondence
- complete action items that they agree to follow up
- promote the work of the group within their organisation.

Appendix 2: Letter to services



[Date]
[Name]
[Service]
[Address]
[Suburb] [VIC] [Postcode]

Dear [Name],

Invitation for bicultural workers to participate in Victorian Refugee Health Network project

In 2015 the Victorian Refugee Health Network (the Network) established an Access & Equity Project, supported by the Centre for Culture, Ethnicity and Health. The project aims to consult with refugee background communities across Victoria about their health priorities and experiences of using health services. The information collected through the consultation process will be collated into a public report and used to inform the agenda of the Network.

To accomplish this task we are inviting people employed in bicultural roles to nominate to participate in the project, and we are seeking support from managers to endorse their participation. All participants and their organisations will be acknowledged in the final report. To participate in the project bicultural workers need to:

- ATTEND a full-day networking and skills building forum at Foundation House in Brunswick on Tuesday 22 March 2016
- CONSULT with five people or groups from the refugee background communities they work with over a five-week period
- SUBMIT de-identified data from the consultations to the Victorian Refugee Health Network by Friday 29 April 2016.

The Project Advisory Group, chaired by Michal Morris, comprises of bicultural workers employed in eight Victorian health services. The group has advised that consultation with refugee background communities requires facilitators skilled in language, culture, health and communication. Bicultural workers possess strong skills across each of these domains and bicultural roles provide a 'bridge' between communities and services. People employed in bicultural worker roles in health, settlement and community agencies across Victoria are ideally placed to conduct consultations with refugee background communities.

Bicultural workers from your service who work with people from refugee backgrounds are invited to participate in this project. The forum will provide an opportunity for bicultural workers to:

- Network with other people employed in bicultural roles.
- Share case studies where bicultural workers were integral in improving access to health services.
- Create greater understanding of the context of health issues facing people from refugee backgrounds.
- Develop skills to undertake consultations.

Expressions of interest to participate in the project may be submitted in a number of ways, see the enclosed form for further details.

You can contact Lauren Tyrrell at the Victorian Refugee Health Network on 9389 8996 or tyrrelll@foundationhouse.org.au if you have any questions about the project.

Sincerely,

Paris Aristotle, CEO
Victorian Foundation for Survivors of Torture

Michal Morris, General Manager
Centre for Culture, Ethnicity and Health

Appendix 3: Bicultural Workers Forum Agenda



victorian refugee
health network



centre for
culture,
ethnicity
& health

Bicultural Workers Forum

Tuesday 22 March 2016

Foundation House, 4 Gardiner Street, Brunswick

9.45am	Arrival and registration	
10.00am	Welcome and house-keeping	Michal Morris General Manager, Centre for Culture, Ethnicity and Health
10.10am	Opening keynote presentation	Sonia Vignjevic Commissioner, Victorian Multicultural Commission
10.30am	Interactive panel discussion <i>Chair: Lindy Marlow,</i> <i>Statewide Facilitator Refugee Health Program</i> <i>Deputy Chair, Victorian Refugee Health Network</i>	Mental Health <i>Chitlu Wyn (Community Liaison Worker, Foundation House)</i> Physical Health <i>Dr Mark Timlin (GP & Refugee Health Fellow, Monash Health Refugee Health & Wellbeing Service)</i> Access issues <i>Jamad Hersi (Refugee & Asylum Seeker Health Coordination Support Worker, cohealth)</i> Sexual Health Education & Prevention <i>Phuong Nguyen (Peer Education Officer, Centre for Culture, Ethnicity and Health)</i> Maternal & Child Health <i>Dr Elisha Riggs (Researcher, Murdoch Children's Research Institute)</i>
11.30am	Case study: Travancore & Foundation House Children's Health & Wellbeing Project	<i>Dina Korkees, Community Liaison Worker, Foundation House</i>
11.45am	Case study: Asylum Seeker Resource Centre Health Promotion & Needs Assessment	<i>Michael Kinyua, Social & Community Development Manager, Asylum Seeker Resource Centre</i>
12.00pm	Lunch and networking	
12.45pm	Workshop: Consultation skills development	<i>Sara Brocchi & Michal Morris</i> <i>Centre for Culture, Ethnicity and Health</i>
2.15pm	Case study: VICSEG New Futures Playgroups & Refugee Family Mentoring Program	<i>Sayanti Bhatta and Ruby Ayoubi, VICSEG New Futures</i>
2.30pm	Case study: Woman-to-woman approach to bilingual health education	<i>Christina George, Bilingual Health Educator, Multicultural Centre for Women's Health</i>
2.45pm	Afternoon tea	
3.00pm	Workshop: Self-care	<i>Susannah Tipping, Clinical Psychologist & Facilitator, Professional & Organisational Development Team, Foundation House</i>
4.00pm	Wrap up and evaluation	<i>Michal Morris</i>
4.15pm	Finish	

Appendix 4: Plain Language Statement



Victorian Refugee Health Network Access & Equity Project

Plain Language Statement

This project aims to understand the health needs and experiences of people from refugee backgrounds, including people seeking asylum, when using the Victorian health system.

What am I being asked to do?

You will be asked to answer some questions about the health of people you know in your community, and their experiences of using health services.

Why am I being invited to participate?

The Network is very keen to hear the voices of people from refugee backgrounds, to help inform their work.

Do I have to take part?

No, you don't have to be part of this project. If you do decide to take part, but then change your mind, you can withdraw your participation at any time by telling the person who is interviewing you.

What will I get out of taking part?

If you decide to take part, you will be helping Victorian health services to understand the needs of your community so they can improve their services.

Will the information I provide be private and confidential?

Your stories and opinions will be used, but we will not record your name or any other identifying information about you.

What will you do with my information?

The information will be collected into a public report and used to inform the work of the Victorian Refugee Health Network. A copy of the report will be sent to Victorian services, the Victorian Multicultural Commission, and other relevant government departments.

Further information

If you would like more information about the project please contact Lauren Tyrrell on 03 9389 8996 or tyrrelll@foundationhouse.org.au.

Appendix 5: Bicultural Workers Forum Evaluation



Bicultural Workers Forum – Evaluation

Tuesday 22 March 2016

Foundation House, 4 Gardiner Street Brunswick

1. How would you rate your knowledge of the following?

1 = poor, 2 = satisfactory, 3 = good, 4 = very good

Barriers to accessing health services for people from refugee backgrounds, including people seeking asylum

Approaches to engage people from refugee backgrounds in health

Approaches to conducting community consultations with people from refugee backgrounds

Activities to look after yourself to prevent stress and burnout

Before the forum After the forum

_____	_____
_____	_____
_____	_____
_____	_____

2. How do you rate the forum overall?

Poor

Satisfactory

Good

Very Good

3. What did you find most useful? Why?

4. What did you find least useful? Why?

5. What will you do differently in your job as a result of attending this forum?

6. Do you have any other comments or suggestions?

Appendix 6: Consultation Questions



Access and Equity Project Consultation Questions

Please think of a particular group of people from your community and then answer the follow questions keeping in mind this group.

Define the group: *(by age, gender, and cultural or ethnic background – for example, young Afghan women, elderly Bhutanese men, Karen new mothers)*

The questions I am going to ask you today will be specifically about the health of people in the group that you chose, and their experience of using health services.

1. What do people in this group need to stay healthy?

2. a) What are the things that are making them unhealthy?

b) Where do people from this group go for help with these problems?

I'll now ask you to think about a specific health service.

1. What kind of service is it?

- Community Health Centre
- General Practice
- Hospital
- Dentist
- Mental Health Service
- Maternal & Child Health
- Other (please specify)

2. What makes it easy for people in the group you named earlier to go to this service?

3. What makes it hard for people to go to this service?

4. What advice would you give health services to work better with this group?

5. If we want to improve the health of people in this group what is the **most important** thing to do?

