



Health Issues Centre
Consumer voices for better healthcare



victorian refugee
health network

WORKING TOGETHER TO IMPROVE HEALTH LITERACY OF WOMEN FROM REFUGEE BACKGROUNDS

FINAL REPORT

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EXECUTIVE SUMMARY

This report was prepared by Health Issues Centre and the Victorian Refugee Health Network for the Victorian Women's Benevolent Trust. Between 2014 and 2015 the Trust funded the first stage of a three stage project on the health information and access needs of refugee communities in Victoria. The report presents the information collected through a series of consultations undertaken in Victoria between June 2014 and July 2015. The participants in the consultations were women of different ages, parenting and employment status from Syrian, Karen, Afghan, Iranian, Sierra Leonean, and Sudanese refugee communities.

Participants told us that staying healthy in Australia depends on many factors including establishing effective communication with health professionals, particularly through interpreter mediated appointments or doctors who speak their language. Understanding how the health system works in Australia (including making general practice appointments, the role of pharmacies and referral systems to specialists) was important to participants and their communities. Also, knowledge about how to take medications and follow regimes correctly, the role of preventative screening and care including healthy eating, and support for raising children were also viewed as areas of need. Engagement in meaningful activity including workforce was viewed as vital for maintaining health. For instance men facing unemployment often experienced deterioration of their mental health and wellbeing. Supporting families and resolving intergenerational conflict was also viewed as important for staying healthy. Shifting power dynamics as children more readily adapt to the new environment, culture and language than their parents results in fractions and misunderstanding between generations. Support with mental health and addressing the issue of stigma and lack of knowledge about the effects of trauma on physical and mental health were also viewed as being pivotal for keeping healthy in Australia.

The women who participated in the consultation told us that information is needed about understanding and accessing health services; healthy eating and physical exercise; the roots and effects of ongoing stress on family violence, divorce and family breakdowns and intergenerational relationships. Information about mental health issues such as stress, depression and anxiety and the roots and risks of engaging in gambling, taking illegal drugs and alcohol consumption are also important for refugee communities in Australia.

We were also told that the best ways to distribute this information was through face to face sessions and group encounters and through the Internet and social media. Other distribution channels suggested included community settings such as churches, schools community groups, sport groups, Neighbourhood Houses, coffee shops, GP clinics, Maternal and Child Care services, councils, refugee and Migrant Resource Centres, Adult Multicultural Education Services (AMES) and women's health organisations.

Based on this information, we recommend continuing with stage two of this project and will be seeking funding to map existing tools/resources/programs and to develop a health literacy program/tool addressing the gaps identified among women from refugee backgrounds. A stage three of the project would see a pilot program/tool on health literacy for women of refugee backgrounds delivered, evaluated and rolled out to communities in Victoria by Refugee Health Nurses, settlement and asylum seeker support workers.

INTRODUCTION

This report presents the findings of the first stage of a three stage project on the health information needs of women from refugee backgrounds, families and communities in Victoria. The consultation was funded by a Victorian Women's Trust Grant and undertaken by Health Issues Centre in collaboration with the Victorian Refugee Health Network between June 2014 and July 2015 in Victoria.

The project responded to the need for information about what refugee communities themselves report as the health information needs of their communities; and about the way that these communities prefer accessing health information.

This project aimed to be the first stage of a three stage project. The overall project aim is to develop and trial an effective and sustainable health literacy program/tool suitable for women from refugee backgrounds living in Victoria. The content of the program will be based on information collected through consultation with refugee community members. The program will be made sustainable through a Train the Trainer program for refugee health nurses and settlement and asylum seeker support workers who could deliver the program on an ongoing basis to their clients in the community.

The objective of this first stage of the project was to conduct qualitative interviews with refugee community members to ascertain what their health information needs are and best ways to access/deliver this information to their communities.

The main feature of this project was the partnership developed between Health Issues Centre and the Victorian Refugee Health Network who facilitated access to women from refugee backgrounds. Through interviews and a consensus workshop the women provided valuable and relevant information about their health information needs, the health topics that are relevant to them and their communities, and the way they would prefer to access this information. The information obtained through the interviews and workshop was also discussed with experts from the Victorian Refugee Health Network for validation and gaps identification.

Health Issues Centre and the Victorian Refugee Health Network will seek further funding from the Victorian Women's Benevolent Trust to continue with stage two of the project. This will consist on developing a health literacy program/tool for refugee communities based on the information collected through this initial stage of the project. It is envisaged the women who participated in the first stage of the project would also participate in the development of this second stage of the project.

In the future, we expect to be able to obtain further funding to deliver and evaluate a pilot program/tool on health literacy for refugee communities and to use the evaluation of the pilot to develop a program that could be rolled out to refugee communities in Victoria by Refugee Health Nurses, settlement and asylum seeker support workers.

This report presents firstly the findings from the consultations and finally a series of recommendations emerging from the analysis of the information.

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We thank especially the refugee community women and the experts who provided valuable information and were so generous with their time.

BACKGROUND

The need to develop this project emerged from literature and existing work in Australia in the fields of health literacy in general, and among refugee communities in particular, and consumer participation.

Consumer participation is about individuals and communities involved not only in decision making about their own health care and treatment, but also about how the health services and programs are planned, delivered and evaluated. (Victorian Department of Health, 2006, p. 3)

Health literacy is an enabler for effective participation

Health literacy has been defined as the "knowledge, motivation and competencies of a consumer to access, understand, appraise and apply health information to make effective decisions about health and health care and take appropriate action." For example, knowing what foods are required for healthy eating, how to get referrals to specialist health services, how to access rehabilitation and support programs and services, how to make an appointment at an antenatal clinic, etc. (ACSQHC, 2012, p.12)

Surveys undertaken in Australia show that around 60 percent of adults have low health literacy. The literature indicates that low literacy is linked with poorer health outcomes, lack of effective participation in health decision making, poorer health status, higher levels of chronic disease, and higher hospital admissions. (ACSQHC, 2012)

Limited research has been undertaken with migrant and refugee communities around health literacy. (Paterson et al, 2011, p. 11) Nevertheless, a few studies have suggested that health literacy among refugee communities is low. For example, one study showed that "women from some cultural backgrounds are likely to have low levels of literacy and low health literacy in particular" (Foundation House, 2004, p.18) Another study, identified low levels of health literacy and health system literacy among refugee communities posing a significant barrier to access to healthcare for these communities. (Russell et al, 2013, p. 18)

A study undertaken in Queensland showed a "high degree of reliance on relatives and friends from the refugee communities for health information including assessment of the quality of care". This fact "suggests merit in developing programmes that effectively enhance the functional, interactive and critical health literacy of individual members and refugee communities as a whole" (Paterson et al, 2011, p.13).

Russell et al (2013, p. 30) state that improving refugee health and health system literacy is "crucial to empowering refugee individuals and communities to successfully engage with the health system and to make important decisions about their health". These authors argue that "while initial health and health system education is provided immediately before or after arrival in Australia, it needs to be reinforced by further education once the refugee is more settled."

METHODOLOGY

Information about the health information needs of, and the way of accessing this information by, refugee communities in Victoria was provided by women from refugee backgrounds from six refugee communities: Syria, Karen, Afghanistan, Iranian, Sierra Leone, and Sudan. These women work closely with their communities and hold valuable information about their health information needs and the way that these communities access information.

The recruitment of the participants was facilitated by the Victorian Refugee Health Network. A key feature of this project was giving a platform to voices not regularly heard. To improve access for participants, Health Issues Centre was available to conduct face-to-face interviews at times and locations most suitable to the participants; funding was available for childcare; and all participants were reimbursed for their participation. Reimbursement was provided as an acknowledgement of the participants' expertise and the fact that they are often under-employed and/or undertake unpaid work.

Face-to-face interviews were held at diverse locations in Victoria including Dandenong, Melbourne CBD and Footscray. The interviews were digitally recorded and extensive notes were taken. The interview notes underwent content analysis and the digital recordings were used to extract verbatim statements for the report.

A consensus workshop with the women from refugee backgrounds was held to present the first analysis of the information. This workshop provided an overall confirmation and validation of the data collected through the individual interviews. Participants in the workshop also offered new insights on issues that were only tangentially covered during the interviews.

The information gathered through the interviews and the consensus workshop was then presented to an expert advice panel formed by four members of the Victorian Refugee Health Network. These staff members work with refugee communities across Victoria and have first-hand knowledge of these communities' health information needs. Their views on the raw data were invaluable for validation and clarification on some aspects of the data collected through the interviews and workshop.

Limitations of the project

This was not an academic research project rather a consultation about community needs to inform next steps of the project. Therefore it was not reviewed by a Human Ethics Committee. Due to the limited findings, the number of interviews was small and limited to participants who spoke English.

FINDINGS

The findings of the consultations are presented below according to the main themes of the project. Selected verbatim transcripts are used to illustrate some of the information. Names and countries of the interviewees have been avoided to respect the confidentiality and privacy of the participants.

The themes are:

- What do refugee families and communities need to stay healthy in Australia?
- What health information content would be useful for refugee communities to stay healthy
- How would refugee communities like to receive/access health information?
- Where would refugee communities prefer to find health information?

What do refugee families and communities need to stay healthy in Australia?

The women who participated in the project nominated a series of factors that would contribute to them, their families and the community staying healthy in Australia. These included:

1. Effective communication with health professionals
2. Health literacy
3. Meaningful activity
4. Support for families
5. Support with mental health

These factors are explained in detail below. Verbatim quotes have been used to illustrate some of the points made by the women during the interviews, but their names and countries have not been used to respect the confidentiality of the information.

1. Effective communication with health professionals: interpreting services and language concordant health professionals

The women who participated in the consultation referred to the importance of accessing quality interpreting services and health professionals that speak their language. The women referred to the need to access interpreters when they have doctors' (GPs and specialists) appointments or during hospital stays. According to the women, using family members to act as interpreters is a common practice (at times this is promoted by health services providers too) - but considered not good practice.

The women referred to several reasons for community members not requesting and using professional interpreting services. For example, the particular dialect may not be known well by the interpreters; the interpreter may know the family members and this impacts on the confidentiality of the information disclosed (this is especially important in relation to diagnosis and treatment of mental illness); the alternative use of telephone interpreting services may not be appropriate due to the fact that some people find it difficult to speak and understand information provided over the phone.

When they go to doctors they need interpreters and not all health providers want to use interpreters because it comes back to cost, because it's very expensive for them to use interpreters, so they are trying to save money and not provide on-site interpreters and prefer to use phone interpreters. But when you speak on the phone some patients find it very difficult to speak and to understand on the phone because they [the interpreters] don't explain everything they [the patients] need [to know].

When they have quick appointments, they [the doctors] don't want to use interpreters; they prefer someone to bring their family members or friends who can speak a little bit of English, which I don't think is right because they are not supposed to use family members to interpret for their patients. For example, for ultrasounds or X-rays they ask them to bring someone who speaks their language.

Some doctors don't call interpreters because it takes time to call the interpreters; they talk to the clients through their relatives...[]... in our culture if a person has a serious health issues, the doctor won't say straight to the patient about what is their condition or about how long they are going to live; they always go through their relatives. But here because the doctor says face-to-face to the patient that you have this kind of issue; but because the interpreter for that particular patient is the family member, this does not translate very well for the patient because their relative don't feel good to tell their relative because it will be distressing for the patient... []. Mostly the family members are young people because they learn to speak at school and the young people are not really focussing on the specific instructions.

Accessing health professionals that speak their own language was highly valued and the participants in the consultation reported that there are general practitioners and specialists from their own communities in Victoria. The participants argued that these health professional understand better the patients and their culture and sometimes people ask their GP to refer them to another GP or specialist who speaks their language.

Sometime they push their doctor to send them to a doctor who is from their own country. They think that this doctor can support them to get what they want because they speak the same language.

There are lots of doctors out there but they don't know how to deal with refugees or what refugees need.

The established community that came here many years ago... they can speak English clearly and they go to Australian doctors, no problem. On the other hand, the new arrivals or if they have been here for a few years but still don't speak English they prefer to go to a doctor who can speak their language.

2. Health literacy: understanding the health system and how to stay well

Most participants in the consultation said that to stay healthy in Australia, refugee communities need to understand the health system, how treatments work and how to look after themselves and their families. For example:

- communities would benefit from understanding how the health system works in Australia; GPs appointments; how to access female or male doctors; the role of pharmacies and referral systems to specialists.

Some people think that to get Paracetamol you need to go to the doctor and get a script. They don't know if you have a stomach ache you can go to the pharmacy and ask and some people wait for months to get appointments. They don't know that they can go to another doctor; they think that it would offend their doctor if they do that.

They are informed about community doctors but not about going to see a specialist. For normal things they know that they don't have to pay, and they are aware that there are certain things that they have to pay, but don't know how to pay them. Some people are sent invoices and they don't understand where these are from... []... and when you don't speak English, it's a bit scary, that you have to pay this amount of money but who do you pay to and where is it from.

Some of them are confused, they think that they can go directly to a specialist.

Women prefer to see a lady doctor and they may not go to the same clinic again because they couldn't see a lady doctor last time.

If the patient has some health issues that require a specialist, the doctors just write the letter and give it to them to go to this address to see this doctor but they don't actually explain what this doctor does. Also the blood test results...[]...women in the community who don't speak English cannot ask to understand what the doctor says to them. The doctors don't usually explain; they just say: it's normal or it's not normal. Some clients we see here [at the refugee support centre] say: "the doctor gave me Vitamin D and took it for a week and stopped it"; they don't understand that this is something that you need to take regularly.

When they have to make an appointment to a specialist by themselves, because of the language barrier it's difficult. Sometime they have the electronic message to press 1 and press 2 and it's very hard and there is not interpreter. And usually the appointments made for a specialist take a couple of months and it's a long wait. ...[]... also, the patients going to see a specialist think that's bulkbilled and it is not bulkbilled. Most people here receive Centrelink money and if they have to pay \$80 or \$100 dollars, it's a big chunk of money.

- how to take medications and medication regimes and doses

Another issue is with the prescriptions. The doctor doesn't explain the medication very well to the client because the doctor is reliant on the pharmacist to say this to the patient, and the pharmacist does not. Again this is translated through the family members and mostly the family members are young people and they are really not focussing on the details; they just say take the medication and you will feel better. Sometimes they come [to the refugee support centre]and say: "I have been taking this medication for a while and don't feel better" and you check and it's because in the box it says: take one table twice a day... it has been translated to the patient that it is one table a day, so the patient only takes one tablet a day and that's why the dose is not correct; and it also says: for one week; so they are taking the one tablet a day for a week, but they are not actually taking the full dose.

Doctors don't take the time to explain their patients the difference between mental health issues and physical and how the depression tablets work. For example, anti-depressants you don't take like antibiotics and you feel better in a week; it may take a few weeks to adjust to it and some antidepressants don't work for a particular person and they may have to be changed.

- understanding preventative care and screening. For example, physical activity, oral hygiene, blood tests and using sunscreen and sun protection products

They don't know what to do. For example, the doctor recommends that they join a gym. But to go there they will need to buy the appropriate clothes to wear and get the membership, so there are lots of things they have to do that they are not able to do. They do little somethings, like they go for walks – 30 minutes and reduce the amount of food they eat; they do what they can but it's not what a westerner or an Australian would do.

With dentists; they don't understand about oral hygiene; they can't afford toothpaste or toothbrushes. Why they chew betel nut? It's to release the stress; it's the only thing instead of drinking and why they have bad teeth? It's because they have never been to a dentist before in the camps. And some people don't even know how to sit in the dentist chair, to sit down, to lie down, how to get on.

If they have to go for a blood test, they don't want to go because they don't want to know what's wrong with their body. For example if they have high cholesterol or high blood pressure and need to stop eating something; they don't want to lose that. For example, many women don't cook for the children or husband; because they eat out, take away because it's cheap; electricity, gas it's expensive.

One thing you have to advise them it's the sun in Australia because most people don't use the hat for children to go outside. They think that's funny and ask: "what's going to happen?" And also the sunscreen is expensive.

- information about healthy eating and how to raise children

The women need information how to raise their children, when to feed and start with solids and what type of milk...[] I visited a lady who has a seven month baby and she doesn't speak English and she relies on her husband to take her to the doctor and nurse, but the husband is obviously working so he does not have time. She is doing what she thinks is good. Just last week I visited her and she told me that she has just found that she is pregnant again and has stopped breast feeding the baby and started giving the little baby long-life milk that was open and sitting on the kitchen bench.

Some pregnant women say that they cannot stay away from sweets and cannot be without rice and bread and potatoes. Some say that sweets are cravings because they are pregnant...[]... they take a litre of full cream milk a day, they say that skinny milk does not taste good, they go for the taste not for the benefits.

You would have thought that it's the older people who would tell you this is good to eat or not, but it's the opposite, it's the younger people who tell the older people what to eat. For example, after I have my little boy, some community members came to visit and brought me foods that had oil on top of it. They say it was good for me because after birth it gives you strength.

Back at home because the diet was different, the climate was different...[] back home everything is seasonal, fruit, vegetables and everything is in moderation. Snacks and things like that did not exist, like cookies and cakes and different kind of chocolates. They are in the shops but they are very expensive. So the only thing for a health snack was fruit for example. But here everything is all year around and probably have chemicals. And the first thing they experience when they come to Australia is the food and they are not used to it. They were used to less amount of food and natural food.

This is one of the big problems, I try to teach them... this is not about going out and eating but how to eat the healthy food; how to eat vegetables and fruit. They want to eat pizza; I teach them how to make pizza at home for the children. And some did not want to accept this advice. The food affects their high cholesterol. They also sit and eat in front of the TV and then don't sleep very well.

My main concern for my community is the overconsumption of unhealthy food which leads to a lot of health problems...[]...over there was survival, it was not about being healthy; it was about finding food each day and trying to survive each day and preserving the food. Here it is completely different. People say: when I was there I couldn't eat this type of food, now I can eat it! They say: I never want my children to be starved as I did. My mum tells me that when she was a child it was all about rationing food.

3. Meaningful activity

Most of the women in the consultation also referred to the importance of meaningful activity and engaging in the workforce as a factor to staying healthy in Australia. With regards to participating in the workforce, many participants believe that refugee men facing unemployment results in deterioration of their mental health and wellbeing.

All members of the community have depression, anxiety, stress because of what happened back home with the war and boys being killed. Most of them left things behind, their houses are full of their stuff, everything, they just left. For the men, when they come here to Australia and they can't speak the language and most of them may have had a job there and when they come here – no job and of course no money.

My husband told me once: "it's hard not to have a job and to see that your wife is working and you are just sitting at home and eating what she brings because I'm the man. It's supposed to be the opposite". He makes himself busy by looking at things in the internet and applying for jobs but I noticed that he was unwell only when his blood pressure was high. I have a blood pressure machine at home which I used for my father and I noticed that his blood pressure was high and I took him to the doctor and then in front of the doctor he said: "I'm stressed for not having a job".

Some of the women referred to the impact of lack of connectedness and social integration affecting people's health and wellbeing. For example, women who cannot speak English well stay at home, don't work or engage in social activities and depend on their husbands for all decisions; other communities are socially isolated due to their own experiences in their countries of origin.

When people just arrive, everything is new and they get bombarded with information and for some time they say they can't focus on things, can't sleep or things like that...[] everything is structured here...[]. The problems in my community is that the women rely on their husbands like its's the same as back home. Everything men are supposed to do. For example: "take me to the doctor, to the shops". If you ask a woman about something they say: "I don't know, ask my husband".

Some people say that they are sick and don't engage in anything; they don't cook, don't clean. I tell them: "This not good for you". If they can get into bilingual language classes....[]...One woman from my group got employed and others are waiting now. But all of them used to say that they can't do anything, can't study. I tell them: "yes, you can study". They need encouragement. The environment of the study is important for them.

My community is very isolated, they don't really do activities, participate with other organisations; they don't know what's out there. This is because they are shy and perhaps they think that other people are better than them. Because they have been oppressed for so many generations, they don't have self-confidence or self-esteem.

4. Support for families

The participants in the consultation argued that another important factor in keeping healthy in Australia was related to the need of support for the families in their communities. This includes the need to develop skills for negotiating with children and address miscommunication between parents and children – mainly because the children speak English and their parents do not. Some women also raised the importance of raising children and staying at home with small children to teach them their traditional culture and language.

In terms of staying at home with your kids or getting a job, I think that for the first few years it is important. Because, especially our culture is dying; a lot of our kids speak English from very young. This is an issue with their parents, an issue of communication. The child speaks in English, the parents speak their native language....[]... it is important for at least one year to stay at home with the child to teach them your language.

For example, in my country children are not allowed to scream or shout to their parents; here they do what they want and that creates conflict.

The issue in here is because the children go to school and they learn English and their parents don' know English, they often use them as interpreters then the children start to think: "we are superior because we can control because we know the language". That's where the conflict starts between the children and the parents.

Some of the participants also referred to the need of support in terms of husband-wife relationships, divorce, domestic violence and how to raise children and adolescents so they respect Australian values. One of the participants referred to a session on domestic violence offered in her community and one of the men participants approached her and said: "you are trying to turn our wives against us. [The men] were not happy about that".

There is a problem of divorce in my community because of misunderstanding about how to work together and that is not healthy. Because there is freedom and that if they start having problems they go to court and get the divorce....[]... the

children suffer in that situation. It is not good talking in front of the children... they are fighting, beat each other or any problem they have they talk in front of the children and they get mental health problems. This is not healthy.

Lots of us came to Australia through our husbands and our husbands back home are the oppressors: "you are not allowed to do this; you are not allowed to do that", and you just stay home and when we come here we realised: "oh, we can be free here"...[]... then the family gets separated. The women think that Australia is a women country; the women have a lot of rights and they will make the decisions and even keeping the man from seeing the kids, not knowing that they are affecting the health of the child. Because the child needs both parents. So we need to know that even though we are going separate ways, you still need to have a good relationship with each other for the sake of the child.[] The kids start disrespecting their parents because of what happened between the two of them....[] they are dropping from school and if you do a check-up, you will see that there's problems in the home.

5. Support with mental health

One of the main issues referred to by the participants in the consultation was the widespread presence and negative effects that mental illness has in the community;. Addressing these issues are paramount to staying healthy in Australia. Most women said that the origins of mental illness amongst refugee communities are related to previous trauma and that there is prevalent stigma associated with mental illness in their communities. Most community languages do not have a term to refer to mental illness hence people are categorised as "crazy" or "normal" and these labels make it hard for people affected by mental illness to seek and receive treatment.

Depression is the biggest issue in my community and a lot of people have psychosomatic issues that they are suffering and the pain in their bodies is because they don't understand that the physical can be caused by stress and depression. This is because back at home if somebody is suffering from depression is considered that the person is crazy, so it's a very hidden thing. [] Back home counselling is not well known in the community.

There is also mental health but people don't talk about it in the community; they don't want to acknowledge it. It is because the things that they experienced and went through. There is no word in our language for mental health; it's just crazy – you're crazy or you're not crazy. If you have a mental illness, people say that you're crazy. There's no understanding about the link between being a refugee or being tortured or what comes with being oppressed, having to fear for your life and coming to Australia and having those flash backs coming to you. But they don't know what it is because depression is a new word for them. When I translate there is not a word that means depression, anxiety, stress; these are new health words introduced into my community language.

Only if you acknowledge yourself that you have a mental illness, you seek help. But what's wrong with that is that some family members don't have the opportunity to do that. For example, the parents say: "no, don't do that, people would know that's something wrong with us"; and that stops people from seeking help. [] This leads to gambling problems in the community, marriage break downs, divorce, family violence, drinking – especially with men because they don't know how to deal with their problem...[] young kids turning to drugs or some people get married very early; it leads to other problems and it's all connected.

There's the issue of depression... there was only when we came here that we heard that there was something called depression. We're scared of accessing the medication because they think that once you start taking the medication, you will go crazy. Some people who are going for a difficult time and they go to a GP and the GP prescribes antidepressants ... but when they came back a lot of people [family and community members] said: "oh, no, no, no you cannot go down that way; it's bad for you; they are not helping you". We don't know about depression, we only know about the mental state of mind of a person and once you go mental it's like a bad thing for the family and the family is ashamed.

SUMMARY: staying healthy in Australia depends on many factors and the women in the consultation referred to some of the most important factors contributing to the health of their communities. These included establishing effective communication with health professionals, especially through accessing interpreters, avoiding use of family members as interpreters and having access to doctors who speak their language. Health literacy was also considered essential to keeping healthy in Australia. It is important for refugee communities to understand how the health system works in Australia including how GPs appointments work, what the role of pharmacies is and how the referral systems to specialists work. It is also important to know how to take medications and follow medication regimes correctly; understand and practice preventative care and screening; and learn about healthy eating and how to raise children. Important to maintaining health is engaging in meaningful activity and engaging in the workforce; men facing unemployment results in deterioration of their mental health and wellbeing. Supporting families and integrational issues are also important for staying healthy. Miscommunication between parents and children, particularly when children speak English and parents do not, results in fractions and misunderstanding between generations. Support with mental health and addressing the issue of stigma and lack of knowledge about the effects of trauma on physical and mental health are pivotal for keeping healthy.

What health information content would be useful for the community to stay healthy?

The participants named a series of topics that their communities would need information about. Participants recommended improving access to information about the health system in Australian and how to access services, understanding treatments, healthy eating and how to raise children, and information about mental health. Below is a list of information content areas recommended by participant in the consultation.

Practical assistance in understanding and accessing health services

Information about:

- health and community services available in Australia
- appointments system and referrals to specialist
- Medicare, bulk billing and healthcare card
- difference between public and private health services and methods of payment
- transport or explanation of how to use public transport
- how to access subsidised services (e.g. exercises, dietician, counselling)
- healthcare rights

Health literacy

Information about:

- medical treatment and use of pharmacies
- how to read prescriptions and follow medicines instructions and dosage
- use of herbal and natural medicines and interaction with Western medicine
- healthy eating and physical exercise including reading food packaging labels

- prevention of spread of disease
- immunisation
- sexual health and reproduction

Support for families

Information about:

- the roots and effects of ongoing stress on family violence, divorce and family breakdowns
- teenagehood and intergenerational relationships
- respect to parents and respect to children

Mental health

Information about:

- mental health issues such as stress, depression and anxiety
- the roots and risks of engaging in gambling, taking illegal drugs and alcohol consumption
- the interaction between physical and mental health

How would the community like to receive/access health information?

The participants in the consultation provided information about the best ways for their communities to access and receive this information. The participants recommended caution in terms of using written information – both in English and community language and encouraged methods such as information sessions and face to face opportunities. This is due to the lack of English proficiency in the community and some levels of illiteracy in their own community languages.

Among the methods for distributing information were:

- In own language, video clips, diagrams, pictures
- Verbally from teachers, nurses, elders, priests, community leaders
- People training others; this requires training community leaders
- Information sessions at hospital (for women)
- Information session for the whole family, at schools for example
- Work in collaboration with other organisations. For example police, settlement services
- Information nights
- How to stay health classes combined with practical activities such as cooking classes
- Newsletters, websites, own country newspapers and web sites
- Brochures with simple messages

Where would the community prefer to find health information?

Women from refugee background provided valuable information also about where the community would find this information, these included:

- Churches
- Schools, play groups and kindergartens
- Community groups
- Sport groups and fitness clubs/classes
- Community Health Services
- Neighbourhood Houses
- Maternal and Child Care services
- Coffee shops
- Ethnic radio, TV and newspapers
- GP clinics
- Councils
- Refugee and Migrant Resource Centres
- Adult Multicultural Education Services (AMES)
- Women's health organisations
- Skype learning
- Internet

RECOMMENDATIONS

In light of the information collected through the interviews, workshop with women from refugee backgrounds and experts in the field of refugee health, Health Issues Centre and the Victorian Refugee Health Network make the following recommendations.

It is expected that these recommendations would be undertaken as a process of building the capacity of the refugee health nurses and others in the health sector working with refugee communities, as well as settlement support case workers.

We recommend undertaking the following stages of the project:

Stage 2

- Map existing health literacy tools/resources/programs against needs articulated by the participants of the consultation
- To develop a health literacy program/tool for women from refugee backgrounds based on the information collected through this initial stage of the project and the above gap analysis
- Establish a community advisory group to oversee the project

Stage 3

- To deliver a pilot program/tool on health literacy for women from refugee backgrounds
- To evaluate the pilot program/tool
- To use the evaluation of the pilot to develop a program that could be rolled out to refugee communities in Victoria by Refugee Health Nurses, settlement and asylum seeker support workers.

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