

The Unmet Health Needs of New Arrivals in Whittlesea

An Analysis of the Access Barriers Newly Arrived Migrants and Refugees Face Within Health Services

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1. INTRODUCTION

1.1 Background

Whittlesea's diversity is uniquely marked by continual change and rapid population growth, of which migration patterns are contributing factors. While Whittlesea is made up of large older settled communities, new arrival communities and refugees are increasingly becoming an important part of the municipality. How Whittlesea adapts to this change is critical in providing equal access to services, particularly basic services such as health care.

Newly arrived migrants to the City of Whittlesea totalled almost 2000 in the 5 years to 2003. Of this number, humanitarian entrants actually increased by over 100% in numbers from 50 in 2001-2002 to 104 in 2002-2003. Humanitarian entrants now constitute 18% of all new arrivals in Whittlesea.

Many refugees have had damaging life experiences including exposure to torture/ trauma, famine, persecution, forced relocation and separation/ loss of family and friends. This, by no means exhaustive list, necessitates access to a range of supporting services upon arrival, to minimise the potential long-term effects. In particular, basic needs such as health care and access to health services will be fundamental in the recovery process and settlement for the long term. The stress and difficulties associated with the settlement experience, contributes to and exacerbates the ill health of newly arrived migrants. For example, poor English skills may reduce links to the community and access to other services and increase isolation, adversely affecting mental health and general well-being.

As well as a growing humanitarian component, many new arrivals in Whittlesea are from smaller emerging communities. For example, 14 Somali and 8 Sudanese arrived in 2002/03 compared to no entrants from either country the previous year. Further, over 40 smaller emerging communities constitute nearly half (48.3%) of new arrivals in Whittlesea. These communities lack the established support networks, informal and formal, of more settled communities that provide a link within and between communities. Assistance from local services will therefore be required, particularly initially when accessing mainstream services providing improved opportunities for social and economic participation. The largest countries of origin for new arrivals in 2002/03 in Whittlesea were Macedonia and Iraq.

Just over half (57%) of new arrivals to Whittlesea 2002-2003 were females, 57% of all new arrivals were also aged between 19 and 25. Addressing women's health issues, particularly young women's health and issues related to mothers, will be important in meeting the needs of young female new arrivals.

Community participation and access to mainstream services in Whittlesea are further affected by English proficiency. Almost 60% of newly arriving migrants and refugees in 2002-2003 were of low or poor English levels, limiting the ability to identify and link into appropriate resources. The Australian health system presents particular barriers due to unfamiliar systems, which are difficult to navigate, enhancing communication difficulties.

To ensure adequate and accessible health care for everyone, barriers faced by often the most marginalised in the community need to be identified and addressed by multi-dimensional strategies and joint partnerships. Traditional methods of health service provision need to be re-examined to ensure newly arrived migrants and refugees have the right to equal access and opportunity.

1.2 Project Aims

The Community Information Whittlesea health project aims to identify the needs and mechanisms that may help bridge the gaps between barriers newly arrived migrants confront in accessing health services, and the difficulties health services have in providing quality health care to this client group. Health care was approached from a broad perspective, encompassing mental as well as physical health and other issues of well-being. Clients and providers will be targeted to participate in the project through interviews and focus groups, enabling both sides concerned to communicate their experiences.

Exploration of barriers clients and providers face allowed for the development of strategies and identification of priority needs. In particular, where gaps between clients and providers intersected, recommendations for community development work with targeted groups as well as changes aimed at increasing access to the health sector were formulated.

2. PROJECT DESIGN

2.1 Introduction

Community Information Whittlesea conducted a health survey in 2003, and while results were inconclusive they nonetheless indicated that gaps in local health services did exist. In particular, service gaps in relation to women's and maternal child and health issues were prominent. In order to combat risks of reduced health and further isolation of newly arrived female migrants and smaller emerging communities in general, Community Information Whittlesea felt additional work on the issue was required. Further research on the health needs of the newly arrived was undertaken with the aim of developing recommendations and strategies to help break down health care access barriers.

2.2 Definitions: Newly Emerging Communities

According to the Department of Immigration and Multicultural and Indigenous Affairs, 'newly arrived communities' refers to groups arriving in Australia within the last five years. This definition can be problematic for individuals and communities arriving beyond the specified time frame who may still experience settlement challenges. However for this project, if a small community, predominantly comprised of recent arrivals, lacks the support and established networks that other more settled and larger communities have, then the term 'newly arrived' applied.

In Whittlesea for example, the Iraqi population has grown substantially in the last five years, now constituting the second largest country of origin for new arrivals. In 2001/02 Iraqis made up 23% of new arrivals to Whittlesea, increasing to almost 60% in 2002/2003. In comparison Iraq did not even register as a country of origin in the ABS Census of Population and Housing for Whittlesea in 2001. This indicates that the majority of Iraqi migrants and refugees have arrived quite recently in Whittlesea, now representing a major new and emerging community in this municipality. However the Iraqi community in Whittlesea remain largely undeveloped in terms of networks and support.

2.3 Participating Communities

The research focused on 2 new and emerging communities in Whittlesea, the Arabic speaking and Sudanese communities. While many members of the Sudanese community speak Arabic also, experiences negotiating with the Australian health system may be quite different between the two groups. Hence both communities were given the opportunity to explore issues relevant to their individual experiences with health services.

The Arabic speaking community was chosen due to large increases in this population group arriving in Whittlesea in recent years. More than one-fifth (21.2%) of new arrivals in the City of Whittlesea in 2002/03 were Arabic speaking, the most common language spoken by new arrivals.

However despite the Arabic speaking community being a major new arrival group, minimal ethno specific services exist for this community in Whittlesea. Determining how services were providing access to this group and how the Arabic speaking community were approaching services in Whittlesea was an aim underlying this report.

While the Sudanese community are largely of Arabic speaking background, this group is one of the smaller communities with relatively little support in the fringe areas of Whittlesea. Double isolation arising from loss of support networks due to the migration process and Sudanese community members settling elsewhere raises difficulties for

confidently accessing services in the local area. Experiences of the Sudanese community accessing health services in Whittlesea were therefore of interest to this project.

While other small and emerging communities were not directly consulted, discussions regarding barriers faced by newly arrived communities in general were initiated through interviews with health practitioners. Representatives from the health system in Whittlesea included the Northern Hospital, Plenty Valley Community Health Service, the City of Whittlesea and three local General Practitioners. This broad consultation enabled views about various newly emerging communities to be raised.

2.4 Ethical Considerations

Examining barriers for newly arrived migrants in accessing the health system raised some ethical considerations when conducting our research. Firstly, as the research was based on a holistic approach to health care, mental health and issues affecting well-being may have been raised through discussions with clients. Issues such as trauma, stress and relationship breakdown may be important issues affecting the health of the newly arrived, and as such would need to be treated with sensitivity. Secondly, exploring health issues also presents priorities for ensuring confidentiality and privacy.

It was important then for interviewers and focus group facilitators to be aware of the multi-dimensional and long-lasting affects of issues associated with health, particularly when discussions were in an open forum. Anxiety and stress related to past trauma and the settlement process were approached in a proactive manner and focused on what improvements and changes could be made to benefit the community. In this way, individual health problems were not highlighted or stigmatised.

Privacy of clients was further respected by personal health issues not being specifically explored, rather it was the problems accessing health services themselves that provided the main focal points for discussion. Confidentiality was also ensured to clients, and names of participants have been withheld.

2.5 Method

Targeted interviews were conducted with eight health practitioners working in Whittlesea, and included representatives from the Northern Hospital, Plenty Valley Community Health Services, Maternal Child & Health from the City of Whittlesea Council and three local General Practitioners. Three of the eight participants worked within the child and maternal health field and presented barriers in providing appropriate and quality health care for newly arrived mothers and their children.

Interviews with health practitioners opened up general discussions, reflecting experiences health providers had had in providing services to newly arrived migrants and refugees. Discussions were primarily steered by the participant, according to common experiences and perceived difficulties. Questions were also asked about why certain barriers may exist and what strategies could be implemented to address these issues.

Two focus groups with client groups were also held, in collaboration with the Arabic speaking settlement support worker. With an emphasis on the needs of the Arabic speaking community, focus groups allowed for the difficulties faced to be expressed. Clients were similarly asked for strategies they thought would assist in better health access in this municipality for their community and future new arrivals.

Focus group 1 was a women only focus group, creating a more comfortable environment for Arabic speaking women to identify women's health issues and barriers. Eleven women participated ranging from 25 to 55 years old. Questions ranged from difficulties

accessing interpreters and female doctors and accessibility of translated health information or material (refer to Appendix 1).

Focus group 2 consisted of 5 participants, both males and females, ranging from 30 to 55 years old. This focus group used the same question and discussion format as the previous focus group, with the exception of gender specific questions being omitted.

The individual interview participants were two Sudanese male recent arrivals who have been in Australia for no more than one and a half years. The individual interviews explored experiences of the emerging Sudanese community, when accessing health service in Whittlesea. Similar to interviews with health practitioners, these interviews were largely guided by the participant's experiences and knowledge regarding others in the Sudanese community. Open-ended questions were used to initiate and facilitate the interview, in order to determine the needs and gaps in service for the Sudanese community. As feedback from this community was quite small, reflecting the size of the Sudanese community in Whittlesea, two workers from The Victorian Foundation Survivors of Torture working intensively with newly arrived Sudanese clients were also consulted.

2.6 Limitations

As the research had a strong maternal child and health focus, an attempt was made to gain a broader perspective of the health issues affecting newly arrived migrants and refugees in general. To do this, General Practitioners working in Whittlesea were approached to participate in the study. However due largely to time constraints of GPs, many were unwilling or unable to commit to an interview. As a result, only three GPs were consulted, a much lower response rate than was expected.

3. FINDINGS

3.1 Health Services Perspective

Targeted interviews with health service providers were conducted with an Anti-Natal Care Social Worker from the Northern Hospital, a Mid-Wife from Plenty Valley Community Health Service and a maternal child and health nurse from the City of Whittlesea. To gain a broader view of factors affecting health provision for newly arrived communities apart from maternal child and health issues, the Manager of Social Work and a Social Worker from the Emergency Department at the Northern Hospital and three local General Practitioners were also interviewed.

The summary of findings from the interviews are detailed are as follows:

Interpreters

- There is a lack of access to interpreters overall, particularly female interpreters and interpreters of smaller emerging community languages.
- Doctors reportedly used family members as interpreters, sometimes even using children. When asked how young the children were, the response was 'sometimes too young.' This was not consistent amongst all doctors however.
- Services including the Northern Hospital use on-call interpreters, which means clients cannot always see the same interpreter, reducing levels of trust and effective communication. This has resulted in some clients choosing not to use interpreters, or being very cautious about what they say with interpreters.
- Some health practitioners have had experiences where interpreters advocated on behalf of the client, leading the discussion rather than interpreting. This affects what information can be given to the client.
- Cases were also cited where interpreters personally became involved in the client's story, reducing their ability to detach themselves from the client and reducing professional performance levels.
- Less respectful attitudes towards clients from some interpreters were also highlighted as affecting the quality of interviews in several cases.
- While requests for interpreters are increasing in this municipality, and the Northern Hospital in particular, appropriate referrals are often difficult to locate due to the lack of language specific trained counsellors locally.

Doctors

- It is perceived within the health sector that doctors do not access interpreters as widely as other health practitioners due to lack of training, direction from above to do so and pressure to assist increasing client numbers. Use of interpreters is largely dependent on individual approach and is not consistent throughout the health sector. This was verified by GPs who rarely used interpreters due to the impractical and awkward nature of the process. Time constraints and perceptions that interpreters were too costly were also discouraging factors for doctors to use interpreters. Further, it is sometimes inappropriate for doctors to use phone interpreters, particularly when dealing with complex cases or mental illness.
- Doctors sometimes performed medicals without explanation causing distress for some women about appropriateness of the procedure. Different cultural and religious backgrounds also affect what can be discussed with clients, particularly male doctors assisting female clients. GPs also referred to the time it takes to learn about cultural differences, and how this learning period could be difficult and uncomfortable for clients.
- Women have accessed other health practitioners for information about how to take medication etc. due to lack of understanding of doctors' instructions. Similarly, the

advice given by doctors may be culturally inappropriate, for example diet requirements prescribed by doctors may not correlate with cultural and or religious requirements.

- It is difficult to access female doctors in this area (there is only one female obstetrician at the Northern Hospital) and many clients travel to Royal Women's Hospital to see a female doctor.
- While it is difficult to have language specific doctors for each language in one municipality, cross- cultural skills within health practices are needed. Further, as the government does not provide funding to people of CALD backgrounds who cannot access health services, encouraging practices to employ appropriate service staff that can assist with access to other health services would be advantageous.

Family & Child Services

- Maternal Child and Health Clinics (MC&HC) are not flexible enough to meet diverse cultural needs. For example, the '40- day stay at home' rule means that new mothers cannot go to a MC&HC and they receive only one home visit. Women who rely on working husbands for transport cannot access clinics that operate within business hours either. Failure to attend appointments is not followed up and considered to be fault of the client.
- Shorter hospital stays mean new mothers are not always confident with breast-feeding upon discharge. There is only one Breast Feeding Centre in Whittlesea with an expectation that women access the service themselves as no outreach services are provided. Many women therefore miss out and may relate to the low breast-feeding rates in Whittlesea compared to the rest of Victoria.
- There is a lack of language specific family support and social workers in this municipality. Cross-cultural training is at least needed to increase client confidence to access these services.
- Child- care is not provided at the Northern Hospital and many other health centres. Women with small children cannot wait for long periods and sometimes do not show up to appointments for this reason.
- Due to the lack of accessible child- care, some women are forced to take their children into consultations with doctors, limiting the opportunity for mothers to address sensitive issues in these consultations.
- Differences in child development practices are leading to child communication and behavioural problems later on. For example, concepts of play and its role in child development may be viewed differently in some resulting in instances of children not being enrolled in playgroups and or kindergarten. Opportunities to learn about social interaction are limited and problems with child development, eg) need for speech therapy, are therefore not identified until school years.
- Low levels of awareness exist within new and emerging communities regarding available children's services, resulting in some children not accessing essential support, particularly children with disabilities.
- There is a lack of support for women from small and emerging communities experiencing domestic violence. GPs have reported cases where women have nowhere to go due to the smallness of their community fearing disclosure would lead to discovery by the whole community, causing the victim a great deal of shame. Unestablished links with the mainstream community further complicates the available practical support, and has in some cases, caused a level of dependency being placed on GPs for family issues.

Lack of English Skills

- It is common for women to use their husband or family member/s with higher levels of English as interpreters. This is not appropriate and reduces quality of care as misunderstanding often occurs. For example, a new mother using her husband as an interpreter was unable to fully understand how to breast- feed her child and through frustration eventually gave up.

- Lack of English and misuse or non- use of interpreters means people are not getting the right information and services at the right time. Preventative measures are therefore not fully explored and illnesses are treated with more severe medication and procedures at later stages.
- Some people travel long distances to access language specific health practitioners, which is still common within the Vietnamese community. Culturally appropriate health services in the local area are needed to enable all members of the community to receive the same quality health care.
- Available English classes are not practical or accessible for many women with children, and as it is more common for women to have lower English skills, this further alienates women within the community.
- Newly arrived migrants, particularly those with lower levels of English skills and fragmented families, are socially isolated and not accessing mainstream services as well as other members of the community. This affects their overall wellbeing and exacerbates any existing health problems. One doctor indicated that social isolation was the highest risk factor in developing emotional illness for members of newly arrived communities.

Prevention

- Many newly arrived migrants and refugees lack understanding regarding the concept of prevention as they come from a needs based system and therefore use GPs as required. This may be due to a variety of reasons including the chaotic lifestyle settlement presents, and preventative measures may just be too much to deal with.
- Prevention has been particularly difficult to stress with Horn of Africa clients who generally only access health services when they are really sick. Low levels of awareness about preventative health measures has also led to severely neglected health, increasing rates of hospitalisation and recovery periods. It has also led to an expectation that doctors can provide a cure at such a late stage when one may not exist, causing patients to become anxious and stressed.
- Health services need to encourage preventative approaches and provide education about the health system locally. This can be achieved through recurrent exposure and increasing confidence to use the system. People from the Horn of Africa also have a high level of respect for professions, which can be used to disseminate such information.

Mental Health

- It was reported by one health practitioner, that newly arrived female migrants and refugees are not turning up at GPs for psychological problems at the same rate as men. A further barrier is that men from the Horn of Africa tend to bring their children to doctor appointments rather than women, and an opportunity to inadvertently promote women's health becomes lost.
- Whether or not women with mental illness is under-reported, actual figures are estimated to be high by one GP interviewed, particularly as women are more likely to face isolation within the community. Difficulties to learn new languages are exacerbated by lack of opportunity and low confidence levels.
- It is difficult for doctors to discuss issues around mental health due to language barriers, particularly as interpreters are rarely used, preventing patients from disclosure and accessing appropriate supporting services.
- Illnesses such as post-natal depression may not exist or be highly stigmatised in some cultures, and are therefore not identified and treated. Community education is needed to reduce the stigma attached to certain health problems, particularly regarding mental health.

Understanding the Australian Health System

- Newly arrived migrants do not fully understand the Australian health system and navigating the system can be difficult and daunting. This can result in lack of awareness of available services and rights and responsibilities.
- The difference between doctors and hospitals and health practitioners' roles is unclear leading to problems with access to services and programs such as Shared Care.
- Women lack culturally sensitive and translated information and advice about contraception and family planning.

Transport

- There is a lack of accessible transport in Whittlesea generally, and particularly to the Northern Hospital. Bus times to the Northern Hospital for example are infrequent meaning people have to wait for long periods to match bus and hospital appointment times.
- There are also issues of safety, familiarity with the transport system and difficulties with taking children on public transport that need to be addressed.

3.2 Clients' Perspective

Arabic Speaking Community

Focus Group 1

7 of the 11 participants visit the doctor accompanied by a family member or friend due to mainly language and transport difficulties. Most participants (8) request an interpreter when independently accessing health services, however only three indicated this was the case when attending a health service with someone else. This suggests that many Arabic speaking women with low levels of English are using non-professionals to act as interpreters for them.

The majority of those (7) not accessing an interpreter within the health system do not feel the best or right information and service is being received. Problems that have occurred as a result include, lack of understanding about the problem and what options are available; one respondent was unable to correctly take the prescribed medication.

When asked about the ability to access a female doctor within health services, 3 found it very hard and 7 found it hard. Only one respondent was able to consult with a female doctor easily. When unable to see a female doctor, 4 respondents indicated they cancelled their appointment and went home, 2 saw a male doctor, but only because they felt it was urgent. Only 1 participant felt comfortable seeing an Australian male doctor.

Almost all of the respondents (9) did not feel confident accessing the hospital due to long waiting periods because of family commitments, lack of female doctors, transport issues, child-care needs and low English skills. The inability to get the right information was also a problem.

Related to this is the fact that 10 respondents felt they did not understand the Australian health system and all respondents indicated the need for more information about how the health system here operates. Apart from structural information, it was felt that greater understanding about children and women's health was also required.

Other problems participants highlighted were difficulties accessing specialists due to higher costs and reluctance by specialists to use interpreters. Cost of medication was also too high for some respondents.

Participants' perspective on why they thought such problems existed focused on language and communication problems (5) and lack of information about the Australian health system (5). Clash of cultures was also mentioned, for example, some cultures do not allow treatment by a male doctor, particularly for intrusive procedures such as having an ultrasound, and women therefore do not feel comfortable with a male doctor.

In order to improve the health system and increase access for Arabic speaking women, participants recommended having access to interpreters at all times, increasing the ratio of female doctors in Whittlesea, displaying/ supplying health information in Arabic and providing community information sessions. It was noted that provision of information on the health system was particularly important for new arrivals.

Focus Group 2

Focus group 2 also explored language barriers the Arabic speaking community have when accessing health services. It appeared that age was a factor in communication difficulties, as the older people in the group were more inclined to take someone with them when seeing a doctor to act as interpreters. The younger and more educated however preferred to go on their own.

It was noted that interpreters were requested when accessing services alone, to assist with greater clarification, particularly when going through processes which may have on-going effects, for example, filling out work cover forms.

Interpreters were not always accessed however due to the lack of understanding of how to do so, and also a lack of trust regarding interpreters. Respondents felt people from their community were reluctant to use interpreters, fearing the disclosed information would spread to other members of their community. However there was an acceptance that everyone had the right to an interpreter from the same cultural and linguistic background, and that interpreters needed additional training in hospitals to deliver better client focused services to increase client confidence.

Instead of accessing interpreters some respondents used family and friends, which can be inappropriate, ineffective and even harmful. For example, some mothers have used their children as interpreters, which not only prevents certain issues from being discussed and proper information disseminated, but also puts children at risk. Using children as interpreters raises other ethical issues, and may cause undue stress and anxiety.

However language was not the only barrier faced by the Arabic speaking community, difference in cultures also presented difficulties. The focus group agreed that they preferred seeing Arabic doctors due to a common understanding about their culture and background, and would not have to explain certain issues as they would to a non-Arabic doctor.

Moreover, some respondents did not feel confident accessing hospital services as they felt they could or would not be treated equally due to their colour, religion or even the way they dressed. It was felt that the health system clearly needed a change in attitude and cross-cultural training to understand and respect the diverse cultures accessing the health system.

Respondents indicated that lack of knowledge about clients' rights and responsibilities also caused problems when accessing the health system. While most understood how the Medicare process worked, any further information was clearly lacking, particularly in community languages.

Lastly, little understanding about preventative health meant health practitioners were accessed only when the problem had already presented itself or progressed, sometimes quite severely. Doctors also need to provide information about individual health in a simple manner and be able to easily discuss this information with clients.

Sudanese Community

While many Sudanese speak Arabic, the two individual interviews with members of the Sudanese community highlighted additional problems this emerging community faces in terms of health needs. The Victorian Foundation for Survivors of Torture (Foundation House) was also consulted to confirm whether other Sudanese were also experiencing similar problems accessing health services.

The nature of the Sudanese conflict has created an environment where trauma, torture and instability are common experiences, leaving many Sudanese refugees to carry complex psychological injuries with them into re-settlement. However a Foundation House worker supporting many Sudanese new arrivals similarly indicated that while some are keen to tell their story of survival, the Sudanese community rarely seek help to explore personal issues related to their traumatic past. This is reflected in the low number of self-referrals for psychological support, as Sudanese clients are more inclined to indicate they are managing well despite displaying symptoms of anxiety and stress.

Major barriers for accessing support services for mental health include higher priorities being placed on security, particularly housing and income, and the shame attached to mental illness, which is similar to many other cultures. The Sudanese community need a way to understand mental illness and erode negative perceptions about its' causes and effects in the community. Community education strategies need to be established and sustained for the long-term and by the community itself, highlighting the importance of addressing emotional health.

When referring to the Sudanese community, it is necessary to be aware of the diversity within this one but very different community, most importantly the division between the north and south. Traumatic experiences of forced family separation and loss of children were common for the south Sudanese population. It may be the case therefore that the Sudanese from the north may have fewer issues related to mental health and, that differences in opinion as to the causes of the past and present Sudanese conflict may exist. This may be something to consider when developing and implementing community development projects.

In terms of language barriers, most Sudanese feel unable to fully explain their and or their children's health problems to doctors and there is little knowledge regarding names of illnesses and other medical terms. The shame of not knowing causes some people in the community not to access doctors, or access them at later stages. Information sessions and translated written material is therefore needed to not only increase understanding but remove fear about accessing doctors who they might not understand. Doctors also need to communicate in simpler terms.

Arabic speaking doctors also need to be aware that newly arriving communities lack the knowledge to effectively navigate the health system. Experiences of Foundation House workers suggest that even without language barriers, Sudanese clients remain confused about certain procedures and processes, such as how referrals work. GPs need to take the time to provide basic explanations about follow- up procedures for their patients.

Language barriers affect more Sudanese women than men and it is often difficult for women to learn a new language, lacking equal opportunities. While men are expected to participate in employment and other social activities, women are mainly responsible for caring for children and are not exposed to the broader community as often and as widely. This is supported by doctor's comments that men tend to bring their children to the doctor rather than women. Foundation House similarly indicate that male networks are far more advanced than their female counterparts. As a result women experience and are more at risk of being affected by social isolation.

Cultural barriers are also apparent when Sudanese women in particular access the health system. Discussing female health issues with male doctors can be inappropriate and women often try and find a female doctor. Due to the lack of female Arabic speaking doctors in Whittlesea, many of the Whittlesea Sudanese community access health services in surrounding areas.

Sudanese women and men with lower English skills also visit doctors accompanied by another person to help with interpreting and translating. Interpreting services in health clinics are therefore essential to providing quality health care to people of non-English speaking backgrounds.

The first few months of settlement can often be the hardest and most stressful period of settlement. To combat this, there is a lot of help available for newly arrived refugees in particular social workers at hospitals were mentioned as being very helpful. However it was felt that not much help was available after the initial 3-4 month period, and many health issues the Sudanese community face require long-term care, particularly mental well being. Lack of knowledge about other services and the health system here are essential. For example, family doctors in Australia who are able to follow individual case histories are not something most Sudanese would have had access to previously. Knowledge about such services, including rights and responsibilities is therefore needed.

3.3 Discussion of Findings

The consultations with both health practitioners and clients indicate that the major barriers newly arrived migrants and refugees face in accessing services relate to language and cultural barriers, and that these barriers affect how well clients understand their health options, and indeed outcomes. Lack of understanding regarding the health system in Australia as a whole as well as other health issues was further evident.

Constrained by low English skills some newly arrived men and women rely on family and friends to act as interpreters and translators. This raises a few issues; that this process may result in reduced quality of client care due certain sensitive health issues not being openly discussed, or not discussed at all. Information may also be missed or not translated properly. Finally, ethical issues must also be raised, particularly when children are used as interpreters. Greater awareness also needs to be raised with health practitioners about the negative implications of using children to interpret for their parents or other family members.

When interpreters are utilized, problems with the system still exist, acting as a disincentive for clients to use interpreters. There is the problem of access linked to the lack of funding for health services to provide interpreting services. Demand for interpreters of certain smaller community languages and for female interpreters continues to be unmet. Limited access to interpreters adds to already long waiting times at health services, discouraging women with children in particular to not request interpreters. Knowing how to ask for interpreters is also missing for some clients.

There is also an issue of negative client perceptions about using interpreters. Some community members fear that disclosure to an interpreter will risk the whole community finding out, and lack of trust is further undermined by use of on-call interpreters removing opportunities to establish more trusting and open dialogue. Less than professional experiences with interpreters, such as advocating on behalf of clients rather than just interpreting, have also affected interpreters' standing not only with clients but with health practitioners also. Re-establishing confidence in interpreting and translating services is necessary for both the local community and health services, increasing access and providing easily understood information and leading to improved health.

A further problem is that GPs are reluctant to use interpreters for many other reasons including time constraints, inappropriateness, unfamiliarity with the process and

willingness and convenience of family members to act as interpreters. Doctors may also be misinformed about the costs involved with using interpreting services. Greater effort needs to be undertaken to highlight the fact that GPs and specialists in private practice can book an on-site interpreter for Medicare-related services free of charge, and training provided to minimise perceived complexities in using this additional service.

Lack of English skills and problems with the image of interpreters require short and long-term strategies. Short-term strategies include encouraging greater use of interpreters to clients and health practitioners, providing training on how to use interpreters for health practitioners and clients, and encouraging ethical use of interpreters to create greater confidence in the system. Providing information about relevant health issues in community languages, and in written and verbal form through information sessions are also necessary. Long-term strategies include establishing more flexible English classes that allow women with child-care responsibilities to participate in education.

Language difficulties appear to be related to many access difficulties, limiting access to mainstream services or increasing use of ethno-specific services outside the municipality. This is particularly the case for newly arrived women. Due to previous education and greater opportunities for men to participate in the community, enhancing English communication skills, newly arrived women have on average lower English levels than newly arrived men.

Lack of confidence and inability to communicate exacerbates feelings of isolation experienced during the settlement period, and can cause further health problems affecting mental and physical well-being. This is particularly concerning for women experiencing family and domestic violence who find it difficult to find support both within their community and beyond. Lack of support almost leaves some women with little choice but to continue living in unsafe situations.

The stigma also attached to mental illness prevents many newly arrived migrants and refugees from accessing the appropriate health care, people sometimes live with these problems for years before asking for help. Some mental illnesses do not formally exist in some cultures and are treated with alternative medicines, or not at all.

Education around prevention is also needed, as many newly arrived clients are not accessing health services until the problem presents itself or is well advanced. Preventing illness can be difficult due to the stress already experienced upon arrival and the fact that many new arrivals come from needs based health systems with less of a focus on prevention. However not stressing the importance of prevention could lead to serious health problems later on, particularly as many new arrivals may already have multiple unaddressed health needs due to limited access to health services in their country of origin. This would be especially true for refugees and humanitarian entrants.

The focus groups also indicated that greater understanding regarding the Australian health system and user rights and responsibilities were something clients felt were lacking within their communities. Easy to understand and translated materials were not readily available. Information about maternal and child health issues and a greater understanding about other health problems were also identified to be lacking. There is also a need for developing a 'common' language between patients and practitioners, the absence of which is a real barrier to health service access.

Most concerning was that some focus group participants did not feel confident presenting at the hospital for the less than equal treatment they had received there in the past. Addressing any discrimination based on race, ethnic background and religion needs to be a priority for the community as a whole, but particularly for essential service providers such as the Hospital.

Lack of cultural understanding by health services is also a major access barrier for newly arrived migrants and refugees. Services that continue to work within rigid frameworks are

not able to meet the needs of a culturally and linguistically diverse community. For example, a health service that operates between business hours, offers no outreach services and is reluctant to utilize interpreters is not providing accessible and adequate health care to many communities in this municipality. Failure to attend health consultations may be considered by such services as a reflection of the client's lack of interest or need, rather than an inability to overcome barriers imposed by services. There needs to be a rethink about how local health services can be flexible enough to meet health care needs that exist outside the traditional boundaries of service provision.

The focus groups and interviews with health practitioners reveal that many barriers exist for newly arrived migrants accessing health services. Greater understanding about the health system for clients, and greater cross-cultural understanding for health practitioners to remove discriminatory perceptions and practices need to guide future strategy development for community agencies and the health sector.

4. RECOMMENDATIONS

Interpreters

- Advocate for greater access to interpreting services, particularly as population growth, and growth in the CALD population, continues to increase in Whittlesea.
- Provide information and instructions for clients to request interpreters and be aware of the process when using interpreters. Addressing perceptions about interpreters is also needed.
- Circulate findings to interpreting/translating services and follow up on their response.

Health Practitioners

- Provide cross-cultural training to doctors and training regarding access and using interpreting services. Cross-cultural training to other staff is also needed to erode discriminatory perceptions about diverse cultures and their practices
- Doctors or anyone providing medical advice need to provide written and verbal instructions about medication to patients as well as other procedures such as the referral process.
- Advocate for more female health practitioners practising locally to reduce health risks for women.

Family & Child Services

- Circulate findings to Maternal Child and Health Clinics to increase flexibility of services; including provision of more outreach services, greater use of interpreters and supplying translated information to newly arrived mothers.
- Identify gaps in language specific services in the municipality.
- Provision of child- care arrangements should be made available at the Northern Hospital where waiting periods can be long and in situations where consultations are not appropriate for children to be present.

Lack of English Skills

- Increased use of interpreting services should be encouraged by providing translated interpreter access information in all medical clinics.
- More flexible English classes for women should be established, taking into account child- care and transport issues.
- Informal support/ social groups should be formed for specific community groups to overcome the social isolation resulting from lack of English.

Cultural Issues

- Educate newly emerging communities about health issues not traditionally seen a medical 'problem' to raise awareness and increase access to mainstream services.
- The importance of play for children's developmental skills needs to be highlighted within communities, and language specific groups established to meet cultural group's needs.

Preventative Health

- Increasing understanding about preventative health measures is necessary to prevent serious health problems occurring in newly arrived communities.

Mental Health

- Community education is needed to remove any stigma or shame attached to mental illness.

Understanding the Australian Health System

- An easy to understand overview of the Australian health system in several key community languages is needed, as well as translated information on specific health topics.
- Information about rights and responsibilities are needed.
- Information sessions about maternal child and health issues and medical procedures and terminology should also be established.

Transport

- Address issues of safety and familiarity with the transport system with newly arriving smaller communities through education/ information sessions.
- Advocate for increased transport services and better links between systems.

SERVICE PROVIDERS

Community Information Whittlesea

Community Information Whittlesea is a not-for-profit organisation that promotes community harmony, equity and well-being. Services offered include:

Settlement support for newly arrived migrants and refugees, providing assistance with information, advice and referrals for local services and support, immigration advice, volunteer placement, casework and advocacy.

The Whittlesea Legal Service.

Emergency Relief for people in financial crisis and needing assistance to overcome immediate financial difficulties.

Whittlesea Volunteer Resource Service for people who want to volunteer within the community and develop new skills, enhance employment prospects and connect with the local community.

Contact: (ph) 9410 6666.

Action on Disability within Ethnic Communities

ADEC is a community-based organisation which represents the rights and needs of people of non-English speaking backgrounds with a disability and their carers. ADEC provides advocacy, information, referral, education, training and consultancy.

Contact: (ph) 9383 5566.

Asylum Seeker Resource Centre

The Northern Asylum Seeker Resource Centre (ASRC) is a non-profit organization that provides a safe and supportive place for asylum seekers and people on Temporary Protection Visas. Access to a range of free services promoting their human rights and well-being such as material aid, legal advice and representation, counselling, recreational programs English tutoring, employment assistance and advocacy are also available.

Contact: Thornbury Centre (ph) 9484 9655
Footscray Centre (ph) 9689 5075

Australian Red Cross

Australian Red Cross assists in locating missing people and supporting people in war-torn countries. Its services include the Asylum Seekers Assistance Service, family tracing and reunion, and support for the health and welfare of asylum seekers living in Australia.

Contact: (ph) 9685 9883.

Immigrant Women's Domestic Violence Service

IWDVS is a state- wide service that works for the safety of all immigrant and refugee women and children from culturally and linguistically diverse backgrounds escaping family violence.

Contact: (ph) 9898 3145.

Maternal and Child Health Centres

The City of Whittlesea operates 13 Maternal and Child Health Service centres. The centres provide health and development check-ups for children up to the age of three and half years and helps new mothers with health, feeding and parenting issues. Other services include Home Visiting and Baby Capsules Hire Scheme.

Contact: Service Development Officer on 9217 2193.

North East Alliance for the Mentally Ill (Neami)

Neami provides holistic and direct services to help people recover from mental illness. Linkages with other mental health care providers and reducing the stigma of mental illness through community education are also coordinated through Neami

Contact: Neami Whittlesea (ph) 9464 6455.

Northern Division of GPs

The Northern Division of GPs advocates on behalf of GPs, and in support of the objectives of GPs to assist in improving the health status of the north. The Division is also a good contact for consumers to find out more about patient rights, fees and ethno-specific doctors practising in the local area.

Contact: (ph) 9416 7689.

Northern Migrant Resource Centre

The Northern Migrant Resource Centre (NMRC), located in Preston, caters for the immediate and long-term settlement needs of migrants and refugees. Settlement needs incorporates immigration advice, assistance finding accommodation, training and employment and other essential services.

Contact: (ph) 9484 7944.

Northern Hospital

The Northern Hospital provides a wide range of services including a 24 Hour Emergency Department, Intensive Care Unit, Maternity Unit and Allied Health.

Contact: (ph) 9219 8000.

Plenty Valley Community Health Services (PVCHS)

PVCHS operates from two sites, Epping (Northern Hospital) and Whittlesea. Allied health, counselling and support, dental services, and disability and adult support services are all provided by PVCHS.

Contact: Epping Centre (ph) 9409 8787
Whittlesea Centre (ph) 9716 9444.

The Victorian Foundation for Survivors of Torture

Foundation House is a non-profit community organisation, providing services and support for children and adults, who have fled persecution, torture and war-related trauma to find safety in Australia. Foundation House provides the opportunity to talk about concerns and difficulties, explore solutions and assists in healing from the trauma.

Contact: (ph) 9388 0022.

Appendix 1

Arabic Speaking Focus Group Questionnaire

1. Do you visit a doctor/ health service on your own or do you take someone with you?
If you go with somebody else, whom do you usually go with?
Why do you prefer to take someone else? (eg transport, low English level etc.)
2. Do you ask for an interpreter when you are alone with a doctor/ health practitioner?
What about when you go with someone else?
If not why? (eg do not know how to ask for one etc.)
If yes, what was your experience with using an interpreter?
3. How many of you use the person you take to the doctor/ health practitioner as an interpreter?
Do you think that you are getting the right information? Do you experience any other problems with this system?
4. If you do not use an interpreter (and you feel you need one), do you feel you are getting the best/ right information and service? Has it caused any other problems?
5. How hard is it to find a female doctor? (Rate from very hard to very easy)
If you were not able to find one what do you do?
6. Do you feel confident accessing the hospital?
If not, what is least accessible to you?
7. Do you feel that you understand the Australian health system or do you require further information?
What is least understood about the health system in Australia and what would you like further information about?
8. What other problems do you find when using the health system? (This is open to general discussion)
9. Why do you think you are experiencing these problems?
10. What would you like to see happen to overcome some of these issues?
11. Are there any other comments/ suggestions?