MIGRANT & REFUGEE WOMEN'S HEALTH PARTNERSHIP

AMRC Australian Migrant Resource Centre

Outcomes document

Consultations on access to health care for refugee women: Strategies to promote culturally appropriate care and consumer health literacy

Adelaide, May 2017

Background

Migrant and Refugee Women's Health Partnership, in collaboration with the Australian Migrant Resource Centre, held a series of community and stakeholder consultations on refugee women's access to, and experience of, health care. The consultations were overseen by the Partnership's Sub-Working Group on Refugee Women's Health. Two consultations were held with refugee women—with women who arrived in Australia within the last two years and over two years ago, respectively—and a health practitioner roundtable that brought together clinicians and health care services.

The consultations provided the opportunity to better understand the issues refugee women experience when accessing health care services, as well as their health care and health literacy needs and concerns, and to then identify strategies that may address such needs, including enhanced health orientation as part of the settlement program. The health practitioner consultation discussed opportunities for clinicians to work effectively with refugee women in health care settings with regard to the provision of culturally appropriate care.

Key themes discussed in the consultations with refugee women included:

- women's experiences of interaction with health professionals and the health care system;
- impact of the length of time since arrival on confidence in navigating the system;
- key sources of information on health and the health care system; and
- strategies to improve women's knowledge and understanding of health issues and the health care system.

Issues explored at the health practitioner consultation included:

- professional culture and leadership;
- professional cultural capability – minimum standards;
- practice, systems and processes; and
- ongoing improvement and measures of success.

The organisers thank all refugee women and health practitioners who participated in the consultations, and generously shared their insights and experiences.

Key issues

Cultural and gender considerations

The consultations addressed the impact of cultural and gender complexity on women's expectations, including health beliefs and help seeking behaviours.

Both refugee women and health practitioners stressed the relevance of cultural considerations with regard to health literacy and providing information to women. Women who had been in Australia for a number of years recognised that education about women's health was critical, but expressed that it was difficult to address because of the sensitive nature of the topic in some cultures.

Particularly low levels of health literacy are often influenced by cultural factors:

- Mental health may not be addressed in some families, due to the stigma attached to it. This is of particular relevance considering the traumatic backgrounds of many refugee women, and the stresses associated with moving to a new country.
- Mental health needs of young people are often overlooked as they are adjusting to life in Australia—trying to fit into a new culture while staying connected with their family's tradition, and may feel that they do not belong in either.
- In many cultures, women do not talk about women's health issues openly, so they do not know where to start when they first visit a doctor.

Cultural and gender considerations were also noted in the context of receiving care. Refugee women repeatedly noted that they were more likely to feel comfortable around female doctors, particularly when disclosing women's health related health issues. Some women expressed that they would sometimes not trust an answer given by a male GP. This was consistent regardless of how long the women had been in Australia. However, the gender of a health practitioner was considered significantly less of a factor when the situation did not involve a women's health issue, or when there was an emergency and no choice but to see a male doctor.

It was additionally preferred that interpreters be female if the focus of the consultation with a health practitioner was women's health related, due to women being hesitant to give full details to a male interpreter. This tendency was also observed by health practitioners.

Individual context and experiences

Both women and health practitioners reflected on the impact of women's diverse social and personal experiences and determinants, including pre-migration experiences, on health literacy and systems knowledge.

Refugee women participating in the consultations had vastly diverse evaluations of the effectiveness of the Australian health care system, depending on their pre-migration experiences and interactions with health care systems overseas. Overall, they were positive about the fact that the Australian health system provided patients with choices.

> *"If women have a positive experience with a GP or hospital, they are much more likely to be trusting of the Australian medical system." – Refugee woman*

There were significant knowledge gaps, particularly among recently arrived women, with regard to the process involved in seeing a specialist in Australia and related wait times. Women were confused about the need for a GP referral in order to see a specialist, as this is not the case in many other countries. It was a common fear that their health conditions would worsen due to long delays between GP and specialist appointments. The process was particularly negatively perceived when appointments with specialists were further delayed due to an absence of an interpreter.

Women expressed that health practitioners should be better aware of the health systems and medications used in other countries, in order to better support, and work more effectively with, women who are used to different health systems and medication regimes.

Health practitioners agreed that the hierarchy of the health care system in Australia is difficult for refugee women to navigate, and that practitioners should be aware of these complexities in relation to the cultural background of their patient.

Practitioners strongly supported health system literacy education for refugee women to enhance women's understanding of what they can expect when they visit a doctor, a specialist, or a hospital, so that they are not confused and daunted when they arrive. Women also need to be provided with information on other relevant systems and processes, such as child protection.

Practitioners also expressed the importance of working to understand the priorities of their patient, as many migrant and refugee women will be focussing on other issues in their lives relating to the care of their family and adjusting to Australia, and therefore failing to prioritise their own health. They also emphasised the significance of not separating the emotional and psychological issues from physical issues. Settlement is an overwhelming process that involves a multiplicity of issues to contend with, and women's health issues are often overlooked.

Communication

Significant focus in the consultations was placed on the capacity of health practitioners to communicate effectively with women who lack English proficiency or health literacy, and to provide them with relevant information.

Refugee women noted overall lack of literacy with regard to general sexual and reproductive health check-ups, as well as maintaining health post-pregnancy, and pointed out the challenges in communicating such information.

> *"It is very difficult to explain issues of female health, such as pelvic floor and exercises, to women who had never received any information on them before." – Refugee woman and community worker*

Women also had limited knowledge of preventative health concepts, such as 'healthy eating'—the women consulted felt that healthy eating was a big issue, but one on which they received little or no information. For example:

- It was common for women to experience weight gains upon settlement in Australia.
- Despite the overall agreement about the importance of healthy eating, women did not feel they could maintain a balanced diet within their budgets.

Identified health system knowledge and information gaps largely related to women knowing and understanding their rights in the health care system. For example:

- When choosing a GP, women relied on information from the Internet, word of mouth, their caseworker or a friend. Some did not feel informed about the possibility of changing a GP.
- There was confusion, particularly among more recently settled women, about the right to an interpreter when seeing a health practitioner, and whose responsibility it was to organise interpreting services.
- As noted above, women from countries with vastly different health care systems were particularly confused about the process involved in being referred to specialists and associated wait times.
- Women often did not know of their rights as health care consumers. They also did not have the confidence to be active participants in their health care, for example, by enquiring about their treatment or care plan, requesting a chaperone or a female interpreter for a women's health related consultation.
- Women who had been in Australia for several years were more likely to know about their right to an interpreter. However, it is for women who are recently settled and experience major language barriers that an interpreter's presence and appropriateness are critically important.

Refugee women reflected on their capacity to obtain and understand basic information regarding health and health care, and their ability to use this information to make decisions about their health. There was an overall agreement that young women were a particularly vulnerable group requiring information and awareness support.

There was noted disparity in the amount and quality of information on women's health issues provided to women. For example:

- While some women received information on women's health issues, such as breast cancer and mammograms, there was little consistency in how and when they received this information.
- Some women received this information upon settlement, through their settlement services provider, while others received it later—from a specialist refugee health services or from their GP. Some women in the recent settlement group had never received or heard of the information.
- Health-related information as part of the settlement orientation was often provided on a single occasion, not allowing for it to be properly understood and remembered by women.

Refugee women, particularly those who settled recently, were eager for health and health system knowledge, but felt they had limited opportunities to gain it. The following strategies, and combinations thereof, were identified as potentially effective ways to deliver information:

- Information sessions provided exclusively to women by a sexual health specialist with the support of appropriate interpreting services.
- Community education, as women find it difficult to trust a medical professional they perceive as a stranger.
- Visual information, supplementing often complicated verbal and written information.
- Provision of written information translated into common migrant languages may address some of the difficulties experienced by women with low English proficiency when trying to understand the information they are able to obtain.

- Mobile apps can be highly effective in providing health information, particularly when translated into the relevant language/s. However, many apps are confusing.
- Enhanced orientation sessions on the Australian health system, including the provision of adequate level of information at appropriate times throughout the initial settlement period.

Engagement

A key theme throughout the consultations was the importance of developing trust- and collaboration-based relationships between health practitioners and women, and a range of considerations were identified as critical enablers.

It was very important for refugee women to build a relationship of trust with health practitioners, particularly GPs, in order to assist their health literacy. A number of strategies were suggested as facilitating an enabling environment for trust-based engagement, described by women as an environment in which they felt comfortable and encouraged to ask questions.

Health practitioners' perspectives on developing a relationship of trust and effective communication focused on creating rapport between patient and practitioner, finding things that both individuals have in common, and ensuring continuity of care.

> *"We need to be curious, kind and communicate." – Health practitioner*

The importance of practitioners working to understand their patient through compassion and communication was consistently noted. Practitioners should be appropriately curious and accessible, being understanding of their patients and particularly of refugees. They should be careful not to become opinionated and assume a position of power; such a power imbalance prevents women from being empowered and feeling comfortable in a medical environment, and can therefore lead to misdiagnosis.

> *"Imbalanced relationship might be fixed by training health practitioners to be more compassionate, caring about women's health which is of primary importance… Giving women voices, bringing their priorities to the fore might fix imbalance." – Health practitioner*

<u>Cultural humility</u>

> *"Listen to hear… Make them talk… Make them feel safe." – Health practitioner*

Refugee women would often come to a doctor with one issue, but wish to discuss more than one problem. They are then confused when they are asked to book a follow-up appointment to discuss these further problems. Responding to the needs of women with multiple concerns requires taking special care to identify their needs and aspirations and allowing time to listen.

> *"How can you engage if you don't listen and don't give time to a patient?" – Health practitioner*

However, the importance of dedicating time to patients and exercising cultural humility often competed with the bureaucracy and efficiency pressures of the system.

<u>Cultural competency</u>

Refugee women strongly supported the development of cultural competency among health practitioners, as well as non-clinical health services staff, to better understand and support women from culturally and linguistically diverse backgrounds.

Minimum mandatory standards in cultural competency—at least with regard to a patient's language proficiency and need for an interpreter—are required as part of duty of care, similar to the three-point mandatory identification of patients when providing care, whereby failure to exercise such minimum standards would place the practitioner's registration at risk.

> *"Women should be able to access health care, and doctors should be able to respond… The issue goes both ways." – Health practitioner*

> *"In some cases, equity rather than equality is needed for refugee women to receive the same health care as other women." – Health practitioner*

It is important that programs aimed at improving cultural competency set outcomes, as well as standards. A system of measuring and assessing the impact of cultural competency in practice should also be implemented. Potential strategies include obtaining feedback from patients and their families about health and interpreting services, and ensuring effective and respectful mechanisms for providing feedback. Clients should be given the opportunity to engage with services and not feel intimidated.

> *"It is about sharing the power and creating trust." – Health practitioner*

The health practitioner consultation strongly emphasised that an accountability framework, with regard to migrant and refugee women's access to health care, requires a human rights based approach.

Privacy

Women need to be assured of the confidentiality between the health practitioner and the patient, as well as the interpreter when one is required. Confidence in this confidentiality and the right to privacy is particularly important to prevent women fearing that the head of their family could intervene in their health decisions. Both refugee women and health practitioners noted that issues would be likely to arise if a woman and an interpreter are from the same community and know each other.

Language

Women felt most confident in communicating their needs and understanding the information they were provided with in the presence of a trusted and qualified interpreter, and were reluctant to discuss their health issues, particularly women's health related issues, with assistance from an interpreter they did not trust. The importance of a trusted interpreter was echoed by health practitioners noting, however, that it could be difficult for a woman to request a particular interpreter.

Some women found telephone interpreters difficult to engage with. Previous poor experiences with interpreters could lead to a woman failing to attend an appointment. When an interpreter is not engaged, appointments are cancelled and often delayed by significant periods of time, with women being reluctant to reschedule appointments due to the difficulties they experienced.

Health practitioners believed that interpreters must take the same care as clinicians to not be overly assertive and instead build a relationship of trust with the patient. This can help avoid incorrect diagnosis as a result of ineffective communication.

Health workforce diversity

Women expressed that they would feel more encouraged to engage with a health practitioner from the same ethnic background as it would improve communication, or even with health practitioners from different ethnic minority backgrounds, as they felt such practitioners would be more understanding of refugee women's experiences.

Practitioners criticised the level of bureaucracy in the Australian health system. It was stressed that skilled migrants need to be treated equally in the health practitioner accreditation system. Many professionally qualified practitioners from non-English speaking backgrounds, who may be able to more easily build connections with migrant and refugee women, have no or very limited opportunities to have their qualifications recognised in Australia.

Concluding observations

Key messages from refugee women with regard to strategies included: tapping into valuable touch points for health literacy education in the settlement process, opportunities to improve how health and health system information is provided, as well as assistance in transitioning to routine health care. Women noted specific health literacy gaps in relation to healthy lifestyle, including healthy eating and exercise; and mental health, particularly mental health young people as they adjust to their new home.

In the consultation with health practitioners, there was a broad recognition of the need to improve education and training in cultural humility in the provision of care for refugees and migrants. Suggested strategies included developing an educational framework and employing a methodology that would not be too onerous on health practitioners, including professional development opportunities in easily accessible online formats. Health practitioners in the consultation discussed extensively the need to assess and evaluate the impact of culturally competent practice on health care outcomes, particularly around patient experience.

The outcomes of the consultations will further inform the Partnership's work on developing a good practice minimum standard framework for working effectively with migrant and refugee women in health care settings, and on enhancing strategies for the provision of credible and authoritative health literacy guidance to migrant and refugee women.

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