CONSULTATION REPORT

African Diaspora Women's Voices in the South East

Women's Health in the South East

GOOD HEALTH DOWN SOUTH

A SEXUAL & REPRODUCTIVE HEALTH STRATEGY FOR THE SOUTHERN METROPOLITAN REGION

Acknowledgement

Women's Health in the South East acknowledges the traditional owners of the land of the Southern Metropolitan Region of Melbourne including the Bunurong People and Wurundjeri People of the Kulin Nation. We pay our respects to elders past, present and emerging. WHISE acknowledges that sovereignty of this land has never been ceded and we are committed to honouring Australian Aboriginal and Torres Strait Islander peoples in our work.

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Who is WHISE?

Women's Health in the South East (WHISE) is the regional women's health service for the Southern Metropolitan Region.

WHISE is a not-for-profit organisation that focuses on empowering women. We work to improve the health and well-being of women in our region by providing health information and education to governments, organisations, education providers, and community groups.

Our team of health promotion professionals work to promote gender equality, sexual and reproductive health and the prevention of violence against women.

Primary prevention
Primary prevention in health promotion is at the very core of what we do. It is a deliberate way of changing the underlying causes of poor health. Rather than treating disease, our work seeks to prevent disease. WHISE work aims to reduce incidence of poor health of women in our community. We train and raise understanding about gender equality because we know that this is the root cause of violence against women. We work in partnership with communities on sexual and reproductive health to support women to take control over their own health and well-being. Health Promotion and Primary Prevention increases community well-being and most importantly for us, empowers women.

Where we work
We work across 10 local government areas. Our area of work is called the South Metropolitan Region and consists of approximately 1.3 million people, representing about one-quarter of the state's total population.

We cover Port Phillip, Bayside, Kingston, Frankston, Stonnington, Glen Eira, Dandenong, Cardinia, Casey and Mornington Peninsula.

Project Background

Women's Health in the South East (WHISE) worked collaboratively with key stakeholders to develop the regional sexual and reproductive health strategy 'Good Health Down South 2018-2021' to promote and celebrate optimal sexual and reproductive health for all in the Southern Metropolitan Region (SMR), by increasing knowledge and access to safe and appropriate services. The strategy has the following objectives:

1. Advocate for sexual and reproductive health to be viewed as a priority in the SMR across targeted settings
2. Influence and inform practices, policies and legislation that promote equity, inclusion and non-discriminatory behaviours
3. Build workforce capacity to meet the diverse sexual and reproductive health needs in the SMR
4. Identify the sexual and reproductive health literacy of community members
5. Improve the coordination of existing sexual and reproductive health services in the SMR
6. Research and monitor sexual and reproductive health trends in the SMR to continually inform and adapt evolution of activities
7. Raise awareness of safe and respectful sexual practices through a number of communication platforms

Objective 4:

To identify culturally and linguistically diverse women's understanding of sexual and reproductive health, and access to information and services.

The purpose of this research was to inform objective four of Good Health Down South (GHDS), to identify culturally and linguistically diverse women's understanding of sexual and reproductive health, and access to information and services. Drawing from the best practice, the consultation was informed by the Multicultural Centre for Women's Health (MCWH) 'Common Threads' project (Hach, 2012).

Consultation Process

A total of 14 women participated in this research in early 2019. Women from the Ethiopian (5), Eritrean (1), South Sudanese (1), Sudanese (2), Somaliland (3) and Somali community (2), were recruited. Demographics were identified, including women's level of formal education and time spent in Australia (figure 1). As can be seen from figure 2, a majority of women have resided in Australia between 11 and 25 years, while a large percentage of women have undertaken some form of formal qualification in Australia (figure 3).

The women participated in two (2) focus group sessions, also, three of the women were individually interviewed on separate occasions. It was found that these women had extensive insights into women's health issues because of their involvement and employment in community health both in Australia and in their home countries.

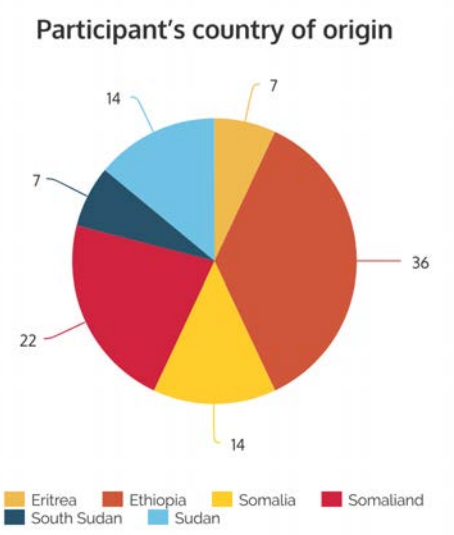

Figure 1

Figure 2

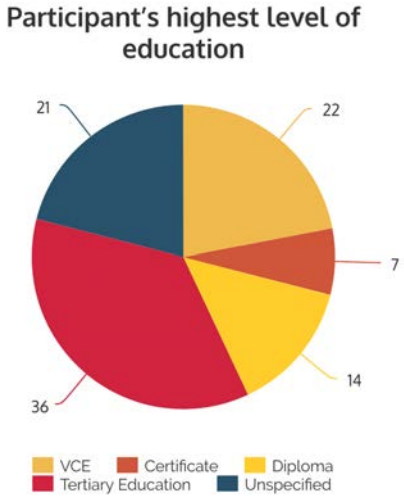

Figure 3

Consultation Process

The focus groups and individual interviews sought to better identify women's understandings of several health concerns, in particular, sexual and reproductive health (SRH). This included what it meant to be healthy and women's views about what health issues affected women. Questions about women's understanding of sexual and reproductive health were also discussed including sexually transmitted infections (STI's), menstruation, birthing and sexuality (see appendices). Women were also asked about their experiences around accessing health services and information as well as some of the barriers they might have come across.

As well as having the facilitator and researcher present throughout the focus groups and interviews, two bi-cultural workers from Monash Health (Female and Reproductive Rights Education Program) were also in attendance. Their presence was significant for a several reasons. They were instrumental in recruiting the participants and played an important role in interpreting from English to specific languages when required. Importantly, the two bi-cultural workers acted as cultural mediators. This provided a level of comfort and reassurance to the women about the nature of the questions and the possible impact the topics raised might entice in some of the women.

Although the presence of the bi-cultural workers was central to enabling women to feel comfortable about the conversations raised, it is important to acknowledge the possibility of bias that could arise from this involvement. Importantly, "the role of the translator or interpreter [can] affect data collection, results, and degree of bias in the results" (Squires, 2009). These issues can significantly impact how, personal information and other details might be interpreted and translated to researchers, particularly when a common language may not be shared. In this research, however, it was found that while the possibility of bias could certainly be a factor in how details might be interpreted, the level of English amongst participants was found to be of an adequate level. In fact, amongst a number of the women, English proficiency was not an issue. As such, the role of the bi-cultural workers within the research became more about providing emotional or peer support and assurance rather than needing to translate any language challenges that might have arisen.

The role of the bi-cultural workers within the research became more about providing emotional or peer support and assurance

Recruitment

Women were recruited through two avenues. Some of the participants were recruited through a cultural and language specific women's group facilitated by one of the workers. Other women were recruited through the FARREP[1] program run through a major public hospital in the SMR. Examining the SRH experiences of culturally and linguistically diverse women raised some ethical considerations when conducting consultations. All participants were provided with a plain language statement in their preferred language (see appendices). Before beginning the consultation a brief about the purpose of the consultations was provided to the women.

Participation was entirely voluntary, informed consent was sought from participants in writing and they were aware that at any stage they could leave or disengage from the discussion (see appendices).

A note about terminology

Throughout this report there is reference made to the practice of female genital cutting (FGC). Several terms have been used to describe this practice. While the precise meaning and description of these terms, including 'FGC' and 'female genital mutilation' (FGM) have been greatly debated there is widespread consensus that these terms can be used to describe "the cutting and removal of tissues of genitalia of young girls to conform to social expectations" (Gruenbaum, 2001). Although the term 'female genital mutilation' (FGM) has been used widely and at times interchangeably with the term 'FGC', it has also come under fire. For some authors, the use of the word 'mutilation' is inaccurate as it "implies intentional harm and is tantamount to an accusation of evil intent" (Gruenbaum, 2001). On the other hand, to describe a practice that removes healthy tissue as mere 'circumcision' is seen by other writers as trivialising the scale of the practice and its consequences for the woman and her wellbeing. Given the complexity of the practice, therefore, any practices referring to or dealing with any cutting or sewing of female genitalia will be referred to in this report as FGC.

The importance of representing women in an ethical manner

In any research, particularly feminist research, the way women are represented is significant. Not only is it important to "represent the views and experiences of women in order to challenge their marginalised status", but also because women's voices need to be heard. To challenge perceived stereotypes, women's voices at the margins cannot remain silent or muted, particularly if any research aims to reflect wider society and not just those in the mainstream.

In this same way, this document aims to prioritise the views and perspectives of the women who participated in the focus groups and interviews. Through their conversations, it was possible to gain an insight into their experiences and understandings of sexual and reproductive health, so that an authentic and accurate representation could be given.

As the women explained, their experiences of racism and discrimination in the wider community as well as from specific health professionals, had caused many of them to feel weary about how they might be represented. In this light, they sought more accurate depictions of their understandings and encounters highlighting the diverse range of experiences as well as some of the common themes that arose in our interactions.

To challenge perceived stereotypes, women's voices at the margins cannot remain silent or muted

Cultural Norms

Health and the notion of community

When women spoke about what it meant to be healthy, several significant issues were revealed. In particular, women stressed the importance of connectedness in relation to one's ability to feel well and happy. For many women, 'being healthy' was a concept that was reliant on one's connections to family and the community. Without these connections, women talked about feeling unwell and lost. Additionally, women expressed how their identities were viewed as being intrinsically tied to family members either in Australia or back at home, whether that be Eritrea, Ethiopia or Somalia. As one woman revealed "we cannot enjoy life when conflict is happening back home or when someone is in pain".For many women, the notion of 'being healthy', centered on being well in terms of the whole being/body. As one woman explained, "healthy is about the full body: mentally, physically, financially and being able to work and enjoy life". Being healthy was understood to be not just about being free from disease or physical pain, but about having access to secure housing; employment; support from family and friends; being part of a happy family; having connections with one's community.

Women recalled with fondness the many aspects of a communal way of life from home countries. They remembered how they met with children in tow at each other's homes for afternoon tea and where children could play together. They recalled the sense of connectedness they felt with others in their community and how that made them feel well. In contrast, many revealed how they struggled to feel that same sense of connectedness here in Australia and how this impacted on their feelings of health and well-being. As several women revealed, meeting neighbours in Australia was described as being difficult. Very few had been able to make friends with neighbours even when they had made attempts to. As one woman explained, "in Australia, people are scared of Africans".

The role of religion

While women's conversations around the notion of health and being healthy reinforced the importance of connectedness and community, within these understanding the importance of religion and religious beliefs was highlighted. For many of the women, religious beliefs and ideals were intrinsically tied to women's everyday lives. These beliefs, as the women explained, provided a sense of wholeness to women's experiences, providing meaning and acceptance about what might come their way.

Women related to us how "one's relationship with God" could provide a sense of acceptance when someone fell ill or had an accident. Often women explained events in their lives as "God's will". Such an understanding was highlighted in experiences of infertility or the loss of a child. Conversely, this sense of acceptance was seen in the way women accepted the birthing of numerous children and could explain women's reluctance to take contraception as they did not want to interfere with what they believed to be their destiny. This was also seen in the way many women accepted any symptoms that might arise from the onset of menopause, for example. As one woman explained, "menopause is part of life – we accept this".

Intimate relationships & sexuality

For many of the women, talking about intimate relationships and sexuality was at times challenging. Many revealed that they often did not find out about sexual intercourse for example until their wedding night. As devout Muslim women, it was revealed that for women, intimacy and sex were strictly reserved for when one married. Women explained, therefore, how little was known about sexuality or aspects of intimacy prior to marrying and how few of them felt comfortable to openly speak about sex or intimacy, particularly before marrying. Married women were also hesitant about speaking about their sexual lives or revealing any intimate details. In addition, women explained that they did not feel comfortable talking to their husbands about sex. Nor were they comfortable speaking to daughters or sons about this very sensitive topic.

It became clear that for the majority of the women interviewed, the concept of virginity was of great significance. Being a virgin when marrying was considered to be an integral part of a woman's life. Several of the women revealed the importance of breaking the hymen on the wedding night, for example, as this practice was seen as confirming a woman's virginity. Despite the significance of this tradition, women also understood that a woman's hymen could break in other ways even when she might still be a virgin.

The notion of remaining a virgin until marriage is not new, particularly due to religious or cultural conceptions about women's virtue and acceptability. Even in countries like Australia, virginity has been viewed (until quite recently) as something women should aspire to. There also remains a slight ambivalence still about what society often describes as 'promiscuous' women. Nevertheless, many societies throughout the world are still "guided by norms and values that proscribe sex before marriage and thus, adolescent girls (and young women) are expected to be virgins at marriage" (Gyan, 2018).

From our interactions with the women, it was evident that the prescriptions around a woman's sexuality continued to be adhered to in Australia. Moreover, such views revealed specific beliefs about what constitutes gender appropriate norms and behaviour. The reluctance with which women spoke about sexuality and/or intimacy perhaps alludes to gender appropriate norms and behaviour. While this will be discussed in more detail later in the report, it may useful to discuss some relevant elements here. As well as expressing the value and significance of virginity, the women's discussions often drew attention to another equally important component of a woman's identity: the importance and expectation that women will fall pregnant and have children soon after marriage. The women further explained that when a woman failed to fall pregnant quickly enough, women might be stigmatised and/or conflict may arise between families. Being able to bear children, the women explained, was highly valued. This view might also reinforce the notion that a woman's role and identity is that of a mother and nurturer and not as sexual beings. Such a view may explain the negation (of sorts) about a woman's sexuality and the autonomy she may or may not hold in relation to her sexual and reproductive health.

Being able to bear children, the women explained, was highly valued

While women's sexuality was felt to be something to be guarded, at least until marriage, men's sexual lives were understood to be vastly different from that of women. In contrast to women, men were seen as being able to more freely explore their sexuality, with many of them being encouraged to have sex before marriage often with sex workers. Notions of masculinity were expressed as men being seen as 'strong'; 'free' and 'sexual'. The concept of virginity does not apply to men in the same way it was for women.

Sexual & Reproductive Health Literacy

Puberty and Menstruation

In the same way women found it challenging to openly speak about sexuality and intimacy, several women also revealed the challenges they faced learning about and talking about their experiences of puberty and menstruation.

Many of the women spoke about not being given much information or details about menarche from mothers or extended family, with many only finding out about it when they began menstruating. Even then, women recall being given little information about what menstruation meant and how this related to their reproductive life. One woman explained, "I didn't know anything about this until it appeared one day!" Other women revealed how older cousins might explain menstruation or how the topic might be brought up at a science class where the human body was being studied. Another woman recalled an encounter with a friend during puberty and how she had commented and 'teased' her about the commencement of her menses. She believed that menstruation was linked to becoming sexually active and it was only later that she realised that menstruation was not a sign of sexual activity but rather a normal part of growing up.

As women discussed their experiences of menarche and menstruation it became clear that these topics were viewed as taboo.

Women recall being given little information about what menstruation meant and how this related to their reproductive life.

Menopause

The topic of menopause revealed the challenges women encountered in regards to fertility and ageing. As has been alluded to in this report, the importance of fertility across the cultures outlined in this report is undeniable. For the women in this project, the social and cultural norms that the women have grown up with have reinforced the value of being able to have numerous children. The ability to have children, therefore, can be said to have been imbued with notions of 'youthfulness', 'vitality' and 'vigor'. Consequently, women explained how the ending of a woman's fertility through the onset of menopause was seldom welcomed, but instead seen negatively and detrimentally, particularly because of women's concerns about being viewed as undesirable and 'spent'. It was revealed how older women were often seen as 'cold' and 'not useful' when menopause appeared. Women revealed that it was widely known that women who were seen to be no longer fertile could be replaced by younger and more 'vital' wives. It was explained to us how some husbands had been known to do this, especially where polygamy was practiced and sanctioned. In addition to these experiences, women explained how they also seldom revealed their age. For them, being identified as being older than 40 years was seen as risky as they did not want to be branded as not been able to have children. They did not want to be labelled as 'old' and 'infertile'.

They did not want to be labelled as 'old' and 'infertile'

Given these realities, it makes sense that women rarely spoke about menopause or what this entailed, at least in an open manner. Such concerns meant that women did not openly discuss symptoms of menopause, for example. Indeed, many wondered if these symptoms were known about at all given the level of secrecy found amongst so many communities. Despite the restrictions and notions of shame expressed about menopause, women explained that, at times, grandmothers and other older women like aunts did understand some aspects of what transpired during menopause. Women spoke about having hot flushes and experiencing fatigue. Others secretly spoke about some of these symptoms to one another.

Contraception

For many of the women interviewed, contraception and the use of it, was a topic that they felt more comfortable to talk about. It was found that this topic was more readily accessible to the women and was not viewed as being taboo.

In speaking about contraception, women expressed several concerns. In particular, women talked about the impact of long term use of contraceptives such as 'the pill' or 'long acting reversible contraception' (LARC). Women expressed concern about whether contraceptives might negatively impact their fertility; whether contraceptives might lead to other health issues such as cancer; and the impact on their overall health including the fear that these might cause irregular bleeding or cause women to put on weight.

Women's concerns about contraception reveal several significant issues. For many of the women, becoming a mother and having children is extremely important and clearly defined their roles and identity in society. As such, anything that appeared to jeopardise these notions was seen as something to be avoided or at the very least viewed with some caution. As Watts et al explain, "Motherhood is an important part of many women's lives, particularly in societies where traditional gender roles persist. In many African societies, motherhood is central to the social and cultural system" (Watts, et al., 2015). Moreover, "motherhood is seen as an essential role, with family and social life orientated towards children with early onset of childbearing and large families preferred" (Watts, et al., 2015).

Given these realities, women's concerns about using (or not using) contraception are valid and well founded, particularly with their concerns about limiting fertility. In addition to women's misgivings about the efficacy of contraception, lies another important aspect to women's appraisal of contraception use. That is the role of the bio-medical model of health and how contraception is imbedded in this model of care and the misgivings they shared about that. This will be explored later in the report.

Sexually Transmitted Infections

When the topic of sexually transmitted infection's (STI's) was brought up, women revealed a hesitation to speak about the topic. Women expressed a limited understanding of STI's, but in particular about how STI's could impact men's and women's health, how they may be transmitted and how they can be prevented or treated.

To better understand women's limited understanding or knowledge of STI's, it became clear that the role of culture and notions of gender needed to be explored. As was revealed above, women in the focus groups and interviews found it difficult to speak about sexuality and aspects of their reproductive health such as menstruation. It makes sense that the women would also find it challenging to speak about the prevalence of STI's and their experiences of it. As many of the women revealed, these topics were seen as being taboo – something that women should or could not speak about.

It became evident that the clearly defined gender norms that framed women's reproductive experiences and understanding, including aspects of women's sexuality, was closely mediated by social, religious and cultural conventions. This can be seen in several examples, including the way virginity was/is valued amongst women and views about STI's. For example, one woman explained that STI's "did not apply to married couples". Women felt that married couples were more likely to be exclusive to one another, while single people were more likely to have multiple partners particularly if they engaged in premarital sex. There was also a belief that STI's was a woman's problem rather than being something men should guard against.

These views highlight the clearly defined gender roles that many of the women subscribed to. Rather than viewing STI's as being something that could potentially impact both men and women, there was a view that women were somehow more vulnerable and closer to nature and thus more likely to develop an STI. In contrast, men were seen to embody the characteristics of strength, vigor and energy.

While the role of culture and religion and its impact on gender roles is significant, the inability to openly speak about STI's has serious ramifications for health outcomes. A "lack of openness and mixed messages regarding sexuality create obstacles to STI prevention for the entire population and contribute to the hidden nature of the STIs" (Institute of Medicine (US), 1997). This was visible in how women spoke about condom use. While some women understood the role that condoms played in stemming the spread of STI's, it was also evident that a level of stigma existed in purchasing condoms or asking partners to wear one. A participant who had worked in Sudan as a health professional recalled how men were reluctant to attend a health clinic she had worked at to get condoms, preferring instead to purchase them from a chemist. The men feared being recognised there and have rumours spread about them. Buying from a chemist was seen to be less conspicuous.

The role of stigma associated with purchasing condoms however, highlight the dire consequences when condoms are not sought or bought. Even though women in the focus groups had limited understanding of STI's there was an awareness that sometimes individuals only found out about having an STI or human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) when it might be too late or when visible symptoms appeared. Women were also aware that men and women who developed HIV/AIDS, for example, were very often ostracized and shunned from their families or community.

While women were reluctant to speak about STI's generally, it was interesting to note that the topic of HIV/AIDS was brought up on several occasions. Women had a wider understanding of HIV/AIDS and spoke about its transmission more openly as well as the social stigma associated with contracting the disease. The increased openness and greater understanding of HIV/AIDS amongst the women might be explained due to the large numbers of individuals affected by HIV/AIDS throughout Africa. As the World Health Organisation (WHO) reveals, in 2017, 19.6 million adults and children were affected by HIV throughout Eastern and Southern Africa (UNAIDS, 2019). By contrast, Australia had 26,000 adults and children living with HIV/AIDS in 2017 (UNAIDS, 2019).

The enormity of the epidemic may explain the high level of awareness about the incidence of HIV/AIDS amongst the women interviewed. The work of organisations such as the United Nations have been instrumental throughout the world, including Africa, in reducing the incidence of HIV/AIDS and are "leading the global effort to end AIDS as a public health threat by 2030 as part of the Sustainable Development Goals" (UNAIDS, 2019). Their efforts have been acknowledged both in grassroots education programs and in influencing health policy across many regions.

Women's experiences of pregnancy, birthing and female genital cutting

While our conversations with the women centered on sexual and reproductive health, we sought not to be too prescriptive about what the women might want to speak about. It was important to create a safe space where women felt comfortable to speak about the issues that they saw as significant – even when others might differ in what these issues might be. As a result of this approach, the topic of pregnancy care, birth and FGC did not readily avail itself in our interviews. Indeed, it was only when we spoke to some of the women individually that discussions about these topics arose.

Women's reluctance to openly speak about birthing was revealing. As the women spoke about their experiences it became clear that part of this reluctance was in part due to women's experiences of FGC. There was also the view that birthing was/is seen as being a natural part of life that did not require intervention. As such, women did not naturally view their experiences of pregnancy and birthing as something that was necessarily relevant to sexual and reproductive health.

Birthing

While very little was said about pregnancy care as such, that is in relation to prenatal care for example, women did speak about some elements of their birthing experiences. In particular, women revealed how they often felt misjudged or not heard during the birthing process. Women remember not being believed that they might be close to giving birth because, as some of them explained, they did not voice or express much pain or verbalise like other women during contractions. At times, women's insistence that they may be close to giving birth were dismissed. Women explained how they were sometimes told to return home only to reappear soon after to give birth. Another woman explained how she had begun to give birth alone as the midwife or nurse were not in attendance.

Women also disclosed how husbands were rarely involved in the birthing process. While some participants were aware of some husbands playing a more active role, the women in these focus groups had not directly experienced active involvement from partners. In addition to feeling unheard or doubted, women also commented on their apprehension about caesarean sections performed. From the women's conversations, it appeared that women preferred a natural birth, once more explaining that birthing was understood to be a natural part of life that did not require medical intervention. Where cesarean sections had been performed, some of the women wondered whether their female circumcision had influenced this decision as they expressed some misgivings about health professionals' skills and training around deinfibulation (the process of 'undoing' female circumcision) or re-infibulation (repairing the vaginal area following the birth).

Female genital cutting

A lack of clarity around the rules governing FGC were expressed whilst discussing this issue. Some of the women felt uncomfortable and dissatisfied with the type of care received prior to and following birth. In particular, women expressed concerns about the lack of 'repair' following birth and the limited options women had access to in regards to 're–infibulation' after birth.

It is important to remember that a large percentage of women born in Somalia, Ethiopia, Eritrea and Sudan have undergone some form of FGC. According to the United Nations Population Fund, "Female genital mutilation (FGC) is a practice that involves altering or injuring the female genitalia for non-medical reasons, and it is internationally recognised as a human rights violation. Globally, it is estimated that 200 million girls and women alive

today have undergone some form of FGC" (United Nations Population Fund, 2019). Data from specific countries reveals that in Somalia 98% of female aged 15-49 have undergone some form of FGC; 89% of females in Eritrea; 88% of females in Sudan and 74% of females in Ethiopia (United Nations Population Fund, 2019). With such a large number of women having experienced FGC in these countries, it is not surprising that this issue is significant during women's experiences of pregnancy and birthing, both in their home countries but also in the numerous host countries where women have resettled in either as migrants or refugees.

Within the Australian context, the existence and prevalence of FGC amongst a number of refugees and migrants, has meant that specific laws and practices have been introduced to deal with the practice. In most states in Australia, 'female genital mutilation', has been legislated against and is covered by differing Children's Protection Acts as well as Criminal law. In Victoria for example, The Children, Youth and Families Act 2005 is the principal Act covering aspects relating to FGC. Other relevant acts and legislation in Victoria include The Charter of Human Rights and Responsibilities Act 2006 and the Child Wellbeing and Safety Act 2005. Beyond the specific laws governing the practice of FGC, however, lies the very real experience of the women themselves and the type of care they might seek.

As the women's conversations around pregnancy, birthing and FGC developed, women's concerns revealed dissatisfaction about the type and level of care women received. As mentioned above, women revealed concerns about not being believed during a birth because of women's differences in relation to their expression of pain and urgency. In addition to these concerns, women also spoke about aspects of care related to their female circumcision specifically. One woman, for example spoke vividly about a friend who had been unhappy about the level of repair work (re-infibulation) undertaken in Australia following the birth of her daughter. She explained how her friend's sense of bodily integrity had been challenged to such an extent that she often described herself as 'ugly' because of how her FGC had been dealt with. The woman's level of distress had been so great and had impacted her sense of self-worth and the relationship with her husband to such an extent, that she had been compelled to return to Sudan to seek further 'repair' work. Only then had she been able to feel well about herself.

Such an example highlights how FGC continues to impact women's experiences, long after the practice of FGC has been undertaken. Significantly, this example reveals women's perceptions around the inadequate nature of care they receive from health professionals at occasions. It appears that from the women's experiences, health professionals fail to fully understand the impact of FGC on women's bodily experiences and their sense of self, which may be leading to the women receiving less than appropriate care. There also appears to be a lack of acknowledgement about the practice's significance even when the practice is no longer viewed as acceptable or condoned. It is important to remember that the practice of FGC in the various countries where it is found has been viewed as an "essential part of a girl's

identity" (Harnkness, 2011). Moreover, as Kaplan et al explain, FGC is often viewed in practicing communities as "critical to preserve ethnic and gender identity, protect femininity, ensure purity and virginity, guarantee's the "family's honor", assure marriageability, and maintain cleanliness and health" (Kaplan, et al., 2013). Given the significance of the practice and despite many women later objecting to the practice of FGC in principle, women's experiences of FGC remain present and should be better considered following a birth.

Traditionally, the process of re-infibulation following a birth, as sought by the woman in the example above, concerns how women's genital area is re-stitched or sutured once more. Traditionally, this procedure is repeated as needed whenever a birth takes place. In a study of Eritrean women in Sweden, Lundberg and Gerezgihir (2008) reveal that "most of the women in this study had gone through re-infibulation after childbirth once or twice in their home country or Sudan. They described that, in their own country, they were sutured after delivery. According to their tradition and culture, no one neglected to have this done" (Lundberg & Gerezgiher, 2008).

The question of re-infibulation raises complex issues around human rights and their relationship to cultural rights. Moreover, the illegal nature of FGC in Australia leaves little scope for how best to manage women's wishes around re-infibulation or the type of 'repair' work women might seek. Health professionals may fear encouraging the practice if 'too much' re-infibulation is undertaken. For some women, however, the level of repair work done in Australia may be seen inadequate and may lead some women, like the woman in the example above, to travel to Africa to receive the type of re-infibulation sought.

Barriers Accessing Sexual and Reproductive Health Services

Role of migration and resettlement

Approximately half of the women who participated in the focus groups indicated they had arrived in Australia as refugees. The remainder arrived either under the family reunion program or as migrants. While the manner of the women's arrival in Australia is important

to identify, it is equally important to acknowledge that the resettlement process and the adjustment that naturally comes with arriving in a new country, can often be traumatic and challenging, particularly when individuals have been forced to flee due to civil unrest, war or other environmental factors. Moreover, the experiences of women will be different from that of men.

The impact of resettlement is multifaceted. Individuals may experiences social marginalisation, grieve the loss of social networks and experience adverse health consequences such as depression or post-traumatic stress disorder (PTSD) due to the process of migration. Others may also struggle to find employment and study options or understand what, are at times, vastly different cultural and social norms. In addition to these factors, many may still be coming to terms with "events that precipitated their departure, and the ongoing relationships with friends and relatives in their home countries" (Shishehgar, et al., 2015). For example, for many of the women, the need to continually send money back home in the form of remittances was often a source of great anxiety that could not be ignored even when they may not have the means to do so.

It is equally important to acknowledge that the resettlement process and the adjustment that naturally comes with arriving in a new country, can often be traumatic and challenging

The role of resettlement, therefore, for both migrants and/or refugees, can play a significant role in the way in which individuals can access any type of service in a new country. As mentioned, factors including language differences, cultural differences and how individuals are perceived in terms of their appearance, for example, can all impact on how safe and comfortable individuals might feel to seek out specific services. Such factors may be especially influential when accessing sexual and reproductive health services. The highly sensitive and personal nature of SRH may be especially challenging for those newly arrived.

This was certainly the experience for a majority of the women interviewed. Many spoke about the difficulties they encountered in understanding what was required in a new country. Who should they ask for assistance? Where did one go to seek out medical help?

The process of resettlement and the ongoing negotiations between one's own cultural understanding and those found in Australia were also spoken about. In particular, it was found that people varied in how comfortable they felt in Australia or how they felt a sense of belonging. While some could more easily integrate into a new community, others were less able to do so for various reasons including age, language challenges, and gender. Such a disparity in experience can mean that members of the same community can have very distinct understandings of resettlement and integration. As the women explained to us, these differences had led some to feel that others were forsaking their own cultures or homelands for that of a new community. This was certainly something that the women felt strongly about, particularly as some of them were viewed as being less 'Somali' or less 'Ethiopian' because they were perceived to have stronger allegiances and a sense of belonging here in Australia.

In one example, it was revealed how the term 'African black white people' had become popular across the African communities here in the South East. This term had been coined by specific African communities to describe those African migrants and refugees who were seen to be behaving or acting too much like 'white' people. Similarly, others were seen to be less authentic because their children did not learn their parent's language or dressed in an overtly 'western' or 'Australian' manner. Others, particularly women, were seen to have forsaken specific cultural and social rules regarding gender norms especially when women were seen to behave in less traditional ways. For example, in many African communities, the interaction of females with unknown or unfamiliar males is viewed negatively. These interactions are seen to violate established norms regarding how men and women should interact.

While the cultural basis of these interactions can be understood, for many in the focus group, these understandings were also found to be problematic. They explained how even very innocentencounters such as allowing a plumber or other handy-person to enter the home could be construed in a negative light (for example the woman might be thought to be having an affair) given the very restrictive social norms in place, particularly for women.

These occurrences had led some within the specific African communities, whether Somali or Ethiopian or Sudanese, to question loyalties and notions of identity. Women spoke about having to negotiate two very different worlds and identities to ensure they continued to be supported and respected in their own communities. Others expressed frustration about others' apparent inability to integrate new ideas about for example, how men and women interact in a new country.

The experience of racism

In addition to these practical challenges, women highlighted the varying attitudes and views they encountered when meeting people in specific settings. They revealed how the wider community at times assumed certain characteristics about them based on the way they looked or spoke. Women spoke about being brandished with the general label of 'African' not realising that they could be 'Somali' or 'Ethiopian' or 'Eritrean'. The women spoke about feeling unwelcomed or marginalised because of these assumptions. They did not feel people understood their experiences or the factors that had forced many of them to resettle in Australia. Amidst such experiences of 'othering', women recalled the implicit racism they often felt. They spoke about the generalisations accorded to them based on their 'African-ness' and how this often resulted in them being viewed as 'uninformed', 'illiterate', 'uneducated', and so on. As the women recalled such experiences, it was revealed that this sense of racism did not just come from the general public, but also health professionals including GP's. It became clear that when women encountered such views or felt vilified in such ways, particularly by professionals such as GP's, they were less likely to re-visit that doctor or professional again. Moreover, they were less likely to fully trust a professional's suggestions or advice given particularly if they felt unheard or trivialised.

In another example, women revealed how certain schools with large numbers of African students were often bypassed by Australian parents or non-African parents (at least this was the perception of the women). Parents instead enrolled their children at schools where fewer students from African backgrounds were enrolled in. For the women, this was seen to be discriminatory and highlighted the negative manner Africans were still been viewed through.

Parenting

In speaking about some of the challenges women encountered in Australia, parenting was particularly poignant for them. In particular, the topic of parenting arose in relation to the opposing and contrasting parenting styles found in Australia, different models of discipline and sexual freedom, particularly in reference how this could potentially influence daughters.

For many of the women, having children was an important aspect of their identity. Women spoke about 'being closer to children' because they had a natural biological connection in terms of having given birth to them. This was not the case for fathers and as such, fathers were not seen as needing to be as involved in the rearing of

children. Conversely, women explained that this natural and biological connection to their children often meant that a child's behaviour, even when older, was often reflected onto them. This was even when mothers had little control over how their children might behave including any criminal behaviour they might undertake later in life.

While a woman's identity was viewed as been intimately tied to their role as mothers, the opposing and at times conflicting notions around discipline found in Australia left many women unsure about their place and how best to deal with specific situations. As one woman explained, "in Australia, the emphasis seems to be about negotiating with your kids rather than disciplining them".

In addition to these conflicting notions around discipline, women expressed a several concerns about the level of sexual freedom found in Australia amongst teenagers. Women spoke about their daughters being influenced by new ideas particularly concerning sexual intercourse. They spoke about their unease for example when their daughters' high schools participated in 'sex education'. They worried about how this might influence their daughter's views about their bodily integrity. As revealed in the women's conversations, traditionally, women have not previously openly spoken about sexuality or intimacy. Having not experienced this level of awareness and openness, the women expressed alarm at how information about contraception, consent and personal freedoms might cause their daughters to abandon more traditional ideas around virginity and the importance of marriage before entering into a sexual relationship. Women also expressed concern about information given to teenagers about the Human papillomavirus (HPV) vaccination. For some of the women, such information was viewed as encouraging teenagers to have sex. As a result, some of the women spoke about not wanting their daughters to have the HPV vaccination. While women expressed concerns around opposing beliefs and views around sexuality and intimacy, it also became clear that such fears and unease could have negative consequences. Some of the women revealed the prevalence of teenage pregnancy amongst Sudanese young women, causing some community members to perhaps rethink people's apprehension against more open discussions about sexual health.

It is interesting to note that while teenage pregnancy amongst Sudanese young women was felt to be common in Australia, the experience of teenage pregnancy was not new nor was it specific to Australia. Women recounted stories about young women falling pregnant out of wedlock in Sudan for example. They explained how young pregnant women might be forced to marry quickly in order to maintain a family's honour. It was explained that when a marriage could not be arranged, not only was the young woman seen as dishonourable and shameful, but that her family too would be tainted by this transgression. In extreme cases, some families might consider killing their pregnant daughters, hide the pregnancy or shun the girl. The father of the unborn child might also be injured or killed if this was found out. Sometimes the young infant might be killed or was threatened by aggrieved family members.

Contesting gender norms/roles

The sense of shame that might befall a pregnancy out of wedlock highlights how gender norms are enacted in everyday experiences, as well as the ramifications for individuals when these are transgressed. In all societies, "gendered norms are embedded in the social structures" found (Keleher & Franklin, 2008). However these gendered norms, can not only limit specific opportunities or modes of behavior but can also encourage or endorse others. Moreover, such attitudes and beliefs, especially about what constitutes male or female roles can impact markedly on people's own identity as well as the relationships forged within these norms. Challenges around gender norms and roles, however, become more apparent in new environments, especially through the seeking of asylum or migration. In these new environments and contexts, established ideas about what might be constituted as men's or women's work or roles can be contested particularly when these are seen to differ from what is considered the 'norm'. As highlighted throughout this report, women's conversations revealed the presence of strongly defined gender norms amongst many of the women's communities. For women, these gender norms have highlighted the significance of becoming a mother and having children; the importance of virginity and how men and women can interact and under what circumstances.

Such notions or beliefs about women's place in the world, however, may be at odds with a host country such as Australia. In this context, differing views about women's sexuality, marital status and who they can interact with could be said to be quite distinct from what many refugees and migrants, both men and women, might see as acceptable. Such divergence may create a sense of conflict and may cause some to hold steadfastly to more traditional customs and beliefs. Others may seek to reassess the relevance of established norms in the context of a new environment.

In this project, women's experiences of sexual and reproductive health have clearly shown the continuing impact of established gender norms. This can be seen in the way contraception is viewed and understood. It can also be seen in the women's understanding around who might take responsibility for STI's and the importance of virginity. Moreover, the significance of fertility, as a marker of a woman's 'value' and identity is visible particularly when the topic of menopause and the importance of having children is discussed. Women's concerns about been labelled 'old' and 'useless' once menopause has begun to highlight the role and value of youthfulness and vitality.

Challenges around gender norms and roles, however, become more apparent in new environments, especially through the seeking of asylum or migration

Women's conversations also emphasised how gender norms can affect how others in a community view family and friends who are seen to diverge from more traditional gender roles. As was discussed earlier, this may cause some to feel that allegiances to a home country are compromised. Others may question the authentic nature of someone's identity to a specific community when children do not learn a native language or when they may be seen to be behaving in a manner that is perceived to be "too white" or "too western".

Bodily autonomy

The role of gender norms and how these impact on individual behavior provides important insights about the factors that help or hinder women make decisions about their lives and bodies. Recently, the work of feminist writers and advocates have stressed the importance of women being able to make autonomous decisions about their bodies. As the UN explains in a working paper, "the right of a woman or girl to make autonomous decisions about her own body and reproductive functions is at the very core of her fundamental right to equality and privacy, concerning intimate matters of physical and psychological integrity" (UN Human Rights, 2017).

While these sentiments are significant, it is important to remember that gender norms and roles found within specific contexts cannot be easily discarded nor ignored. This was certainly something that the women in the focus groups grappled with. For example, on one hand many expressed a view that having numerous children was tiring and caused women to prematurely age and become tired. Many understood the risks that giving birth to numerous children could have on one's body and how this could be detrimental to women's well-being. At the same time, however, such understanding did not necessarily stop women from having more children, often explaining this as 'God's will' or that as a woman bearing children was a vital aspect of their identity.

Equally insightful was women's comments about the level of responsibility placed on them by husbands and extended family to bear more children. As some women explained, at times husbands might refuse or challenge women about them taking contraception as this was felt to be going against their 'natural' roles as mothers and wives.

Decisions about their bodies or how they should proceed in relation to taking contraception or having an STI was something that they felt they had little say in, particularly before coming to Australia. Women explained how they had been brought up to view their role as needing to 'serve men' and 'look after men'. They had not necessarily viewed themselves as autonomous women, able to make decisions about their bodies, especially in the same way women might do so in Australia. It is important to state, that while women may be unable to exercise bodily autonomy in certain contexts, this does not mean they have no agency. Individuals, whether male or female, can and do exercise agency despite the restrictions and norms the may need to consider and live under. The constraints of patriarchy, socio-economic status and gender may certainly hinder a person's ability to make autonomous decisions. These factors do not completely erase women's ability to exercise agency in other aspects of their lives.

Cultural concepts of health and health care

As explained above, women in the focus groups and interviews, clearly explained what being healthy meant to them. For the women, being healthy was not just a concept where you were free from disease. Being healthy included other aspects including having good relationships between family and friends; housing security; employment; and feeling safe. As one woman explained, being healthy is about being well in terms of the whole being or whole body. In addition, the role of religion and religious beliefs was also seen to be vital in ensuring a healthy life.

Such a view of what it means to be healthy does not easily fit into more western notions of health. As Keleher and McDougal state, "Health is a dynamic concept with multiple meanings that are dependent on the context in which the term is used and the people who use it. People see health as essential to well-being, but how people define their health varies according to their own social experience, particularly in relation to their age, personal knowledge, and social and illness experiences." (Keleher & McDougall, n.d.). Moreover, there are the cultural experiences of health and illness that also influence how people view health.

For many of the women, the notion of health and healthcare as found in Australia was, at times, viewed in a negative light. While many of the women acknowledged the importance of being able to access free, and to an extent, universal health care in Australia, the focus here on preventing disease and the treatment of illnesses, caused them distress. Rather than alleviating worry around potential health risks, the women explained how the biomedical model of care found in Australia,

The role of religion and religious beliefs was also seen to be vital in ensuring a healthy life

heightened women's concerns. They explained how the process of preventative care found in Australia, as well as the persistent provision of wide ranging information about possible risks and illnesses, caused women to feel fear and alarm even when they may have no reason to be concerned.

As the women explained, women were not used to attending a doctor in their home countries in the same way as they might do so here in Australia. They remembered going to a doctor only when symptoms were strong or they felt great pain. The notion of preventative health was new to many of the women interviewed and as such, they did not find solace, as others might, in knowing that they could prevent the development of breast cancer or ovarian cancer through specific interventions such as a mammogram or cervical scan. For many of the women, such options did not allay fears. Rather it created greater angst and anxiety.

In addition to these concerns, it became clear that medical doctors were often viewed in a very different way in the women's home countries. Women explained how individuals seeking assistance from a doctor may not necessarily believe or accept a diagnosis or course of treatment. People's expectations about what type of medicine should be prescribed were at times at odds with what was actually given. A health practitioner from Sudan now living in Australia explained how clients might ask for "real" medicine when they were prescribed what they saw as in-effective or "weak" medication. It was explained to us how some clients, feeling dissatisfied with certain treatment options, would instead seek advice from a pharmacist as they felt more at ease to speak to them. It was also cheaper to visit a pharmacist. Visiting a doctor could be extremely expensive and as such individuals sought appropriate care given the expense.

Given the level of distress, many of the women felt as a result of the type of care found in Australia, it was interesting to note the types of concerns the women had regarding their health. When asked about the types of issues affecting women in their community they revealed several topics. These include:

- Breast cancer
- Cancer in general
- Thyroid problems
- Cervical cancer
- Autism and its impact on children
- Diabetes
- Blood pressure
- Cholesterol

Equally significant is the notion that for many of the women, their relationship with God and religious beliefs could at times prevent women from seeking medical care. As was explained above, religious beliefs often explained ill health or enabled women to accept health issues such as cancer and other illnesses. But while the notion of accepting 'God's will' in terms of women's health experiences might provide solace and comfort, such a view could conflict with what might be found in a new country such as Australia. Women's views might be seen to be at odds with more mainstream ideas about health and wellbeing.

This notion of fatalism in the context of health care is complex and beyond the scope of this report to delve into substantially. Nevertheless, it is worthwhile to explore some elements for context. Fatalism "refers to a wide variety of beliefs, ideas, and concepts that appear to have significant impact upon the health behaviors of individuals from a diversity of backgrounds. Fatalism in the context of health generally refers to the belief that health issues are beyond human control" (Nageed, et al., 2018). Equally important is the way "religious fatalism related to God's control of disease and cure are reported to significantly impact attitudes towards preventive health as well as choices about therapy" (Nageed, et al., 2018).

As explained earlier, women's encounters with the biomedical model of health in Australia was seen to be challenging for a few reasons. Significantly, the notion of preventative health in Australia seemed to create more angst and anxiety for the women instead of providing a sense of relief or better care. Moreover, such a view of health was seen to be interfering with 'God's will' concerning one's destiny and how one should proceed with individual health and wellbeing. For some women in this project, "poor health might reflect a reprimand from God" and thus may be seen to conflict with religious beliefs. As some women explained, ill health could be interpreted as God providing a sign that they may not be on the right track or that more religious devotion was required.

While such beliefs may seem counter intuitive regarding good health outcomes, it is important to understand how and why these interpretations come about. Women's beliefs cannot simply be discarded. Moreover, "understanding how Islamic fatalism impacts health education, health promotion, and treatment adherence would allow researchers and health educators to better develop protocols to provide more culturally competent care and design interventions to improve outcomes" (Nageed, et al., 2018).

Conclusion

The notion of health and wellbeing is fundamental to people's lives. Moreover, how these concepts are understood and interpreted is highly dependent on one's experience of the world, including people's social, cultural and religious views and beliefs and the way these are seen to create meaning for individuals and their experiences.

Such an understanding becomes even more significant when individuals migrate or seek asylum in countries that may hold different or conflicting notions of health and well-being. In these exchanges and interactions, challenges may arise particularly when seeking support or assistance. Misunderstandings and a lack of acknowledgement may create suspicion or barriers that may prevent individuals from accessing appropriate care.

This research has sought to provide a lens into how women from diverse backgrounds, living in the South East of Melbourne, understand and view specific sexual and reproductive issues as well as their experiences in accessing services and support. Through these conversations, women revealed some of the challenges they encountered and the role that culture and religion play in women's ability to access specific health services. Significantly, the role of migration and the experience of resettlement was found to intersect profoundly with women's experience of the wider Australian community. The loss of family, the grief of leaving their homelands and the adjustment to new and different social and cultural ideas were highlighted as having a considerable impact on women's lives.

Importantly, women revealed the role that racism and stereotyping played in their ability to access certain services including assistance sought from health practitioners such as GP's. Moreover, it was found that women's interactions with aspects of the Australian health care system were at times discriminatory and assumed a lack of education or understanding amongst women. As this research has revealed, however, women's views and experiences do not highlight a lack of understanding, but rather points to some concerning and limiting views held by some health professionals and aspects of the wider Australian community. In light of these conclusions, this report provides several recommendations. In particular, we urge health practitioners to become better informed about the role that culture and religion can play in people's understanding. Moreover, this report acknowledges the important role that health professionals and practitioners can play in being able to provide a safe and welcoming space to clients from diverse backgrounds, thus enabling individuals to seek out care rather than avoid it.

Recommendations

The collaborative nature of this project has meant that women's involvement has been sought beyond their participation in focus groups and interviews. It has been important to also explore with them what outcomes and recommendations they might see as useful to help better engage African women with SRH services. It was also important to facilitate a discussion about some of the more significant issues relevant to them and what they might like to see more of in respect to how they are treated, both from a health perspective and in terms of respecting individual needs and ideas.

African Liaison Officer

One of the key points that arose from these conversations was the possibility of engaging an African liaison officer at local hospitals. Women frequently expressed the way how health practitioners, particularly at public hospitals had little time to fully explain treatment options, medications or symptoms. One woman explained how a friend had not followed the instructions for a test because she had been too shy to ask the doctor about it. Moreover, women did not always feel comfortable to discuss sensitive topics such as sexual and reproductive health with specific health professionals. Another woman explained the barrier of language and how some women were unable to ask for an interpreter even when they may be able to access one. Some women may speak English but not be able to understand more medical terms. Others did not know what types of questions could be asked during consultations whether because of having a lack of experience dealing with medical staff or simply because of a lack of confidence.

These shortcomings had led some of the women to consider the efficacy of having someone like an African liaison officer to help them navigate these challenges and provide a much needed service where women (and men) could seek more information from or seek advocacy from. The role of the Aboriginal liaison officer was cited as an example that could be followed if an African liaison officer could be advocated for.

Recommendations

YouTube videos

Concerning receiving useful and up to date information about health issues, women revealed how the usefulness of videos such as YouTube could enhance people's engagement and understanding. For many of the women, written material was acknowledged as being ineffective. Many of them were not used to reading or could not read in their language so a written pamphlet was seen as unhelpful. Moreover, women often found it hard to attend meetings or information sessions as they had very busy lives. At times they may not fully understand the relevance or have a good understanding of the significance of a specific session or pamphlet.

Better cultural training for health professionals

As has been revealed in this document, women's experiences of the health system in Australia has often been unsatisfactory. Women's experiences of racism and stereotyping have limited their engagement and at times has caused women to stop seeing or attending altogether a specific clinic, GP or health professional. This was particularly the case regarding SRH.

These experiences highlighted to the women the importance of more cultural training for health professionals. They revealed how such training could assist practitioners better understand the cultural and social context of the women they may be assisting or treating as well as help them better understand some of the barriers they may be experiencing in accessing health care. The women felt that rather than just attributing women's decisions to 'ignorance' or 'ill judgment', a more comprehensive understanding about drivers and barriers could assist in engendering a more respectful and beneficial outcome for the women.

Recommendations

Additional resources for health professionals

Women's experiences of health services revealed a lack of understanding from health professionals about the role that culture and religion can play in women's experiences and decisions about health issues and the seeking of support or assistance. Moreover, women highlighted the challenges many of them encountered in adjusting to life in Australia, especially when they encountered different and distinctive views that conflicted or challenged established views.

In light of these experiences, we recommend the formulation of additional resources for health professionals. Such resources could simply and briefly outline some of the challenges and issues that individuals may be experiencing and how these may be impacting on people's health or well-being. We believe the formulation of either a one or two page information sheet or similar, specifically designed for health professionals, could enhance interactions between health professionals and clients. In turn, this could better inform specific practices undertaken by health professionals.

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Appendix one: Consultation questions for women

THEME 1: MEANINGS, BELIEFS, PERSONAL VALUES

Discussion about women's health:

- Discuss personal meanings and interpretations
- What does it mean to be healthy?
- What are some of the factors that enable women to be/feel healthy?
- Main health issues affecting women?
- What do you do when you are not feeling well?
- What do you do in order to stay healthy?

Sexual and reproductive health:

- Discuss personal meanings and interpretations
- Prompts: sexually transmitted infection, pregnancy care - after you have the baby, breast screening, pap tests, rights, culture, contraception, family planning, violence, sexuality, traditional cutting
- Who do you speak to/ where do you go if there is an issue with your sexual/ reproductive health?
- In what ways do you maintain health in this area?

THEME 2: ACCESS TO INFORMATION

- Health information - where/ what/ how
- Prompts: where do you go?
- What kind of health information?
- How is it presented? Clear and sufficient?
- Country of origin and Australia - same kind of information? Same experiences? Problems? Challenges? Successes?
- Could you find what you wanted? What information needs to be provided for immigrant and refugee women?

Appendix one: Consultation questions for women

THEME 3: ACCESS TO SERVICES

• Health Services - where/ what/ how
· Prompts: what kinds of services?
· Talk about experiences - good practice, draw out positive examples
· Talk about feelings and experiences around difficulties and challenges
· Country of origin and Australia – same experiences? Problems? Challenges? Successes?

THEME 4: FEEDBACK AND SUGGESTIONS

Suggestions about how to make services better for immigrant and refugee women - from this, discuss what might encourage women to participate in health promotion activities?

Appendix two: Plain Language Statement

Translations: Amharic, Arabic, Harari and Oromo

Plain Language Statement

Project: Sexual and Reproductive Health Literacy in Culturally and Linguistically Diverse Communities

1. Your consent

Thank you for your interest in participating in this research project. The following few pages will provide you with further information about the research project, so that you can decide if you would like to take part.

Please take the time to read this information carefully. You may ask questions about anything you don't understand or want to know more about.

Your participation is voluntary. If you do not wish to take part, you don't have to. If you begin participating, you can also stop at any time.

2. Purpose and Background

The purpose of the research is to identify culturally and linguistically diverse women's understanding of sexual and reproductive health, and access to information and services.

A total of 24 women will participate in this project. You are invited to participate in this research because we are interested in hearing from women from culturally and linguistically diverse backgrounds who live in the Southern Metropolitan Region. The results from the research may be used to help inform future work to increase the sexual and reproductive health literacy of culturally and linguistically diverse women.

3. Funding

This consultation is funded by the Department of Health and Human Services.

Appendix two: Plain Language Statement

Translations: Amharic, Arabic, Harari and Oromo

4. What will I be asked to do?

If you agree to participate in the research you will be asked to participate in a focus group about your understanding of sexual and reproductive health and how you access information and services. Questions include: "What does sexual health mean to you?" and "Where do you get your health information from?"

Participation of these questions in a focus group should take approximately 2 hours.

In recognition of your time, after you have completed the focus group, each participant is eligible to receive a $20 Coles Myer voucher, lunch will be provided to participants at the end of the focus group. To participate in the consultation, you must be over 18 years of age.

5. What are the Possible Benefits?

Possible benefits of the consultation include the opportunity to reflect and develop insight into your knowledge and experiences of sexual and reproductive health. More specifically, the consultation will assist in understanding what is required to improve sexual and reproductive health.

6. What are Possible Risks?

It is not expected that you will be exposed to any physical risk or psychological distress by participating in this project, beyond the feelings that may be raised to consciously evaluating experiences of sexual and reproductive health. However, participants are directed to contact appropriate services, Lifeline on 13 11 14, 1800 MyOptions on 1800 696 784 and South East Centre Against Sexual Assault (SECASA) on 9594 2289, if you experience any emotional discomfort.

Should anxiety or distress occur at any stage, participants are advised to withdraw from participating in the project.

Appendix two: Plain Language Statement

Translations: Amharic, Arabic, Harari and Oromo

7. Privacy, Confidentiality, and Disclosure of Information

Data collected as part of the project will not be associated with any identifying information. All information gathered from participants will be kept securely. Electronic data will be password protected and stored on a secure server. Only the research staff directly linked to the project will have access to the data. After completion of the project, the data collected will be securely stored for seven years at Women's Health in the South East, as set out by Health Records Act 2001.

In any publication, information will be provided in such a way that you cannot be identified.

8. Do I have to take part?

Participation in any research project is voluntary. IF YOU DO NOT WISH TO TAKE PART YOU ARE NOT OBLIGED TO. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

9. Results of the Consultation

Upon completion of the consultation, a report will be made available to participants.

10. Further Information, Queries, or Any Problems

If you require further information or have any problems, please see contacts below:

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Monash Health
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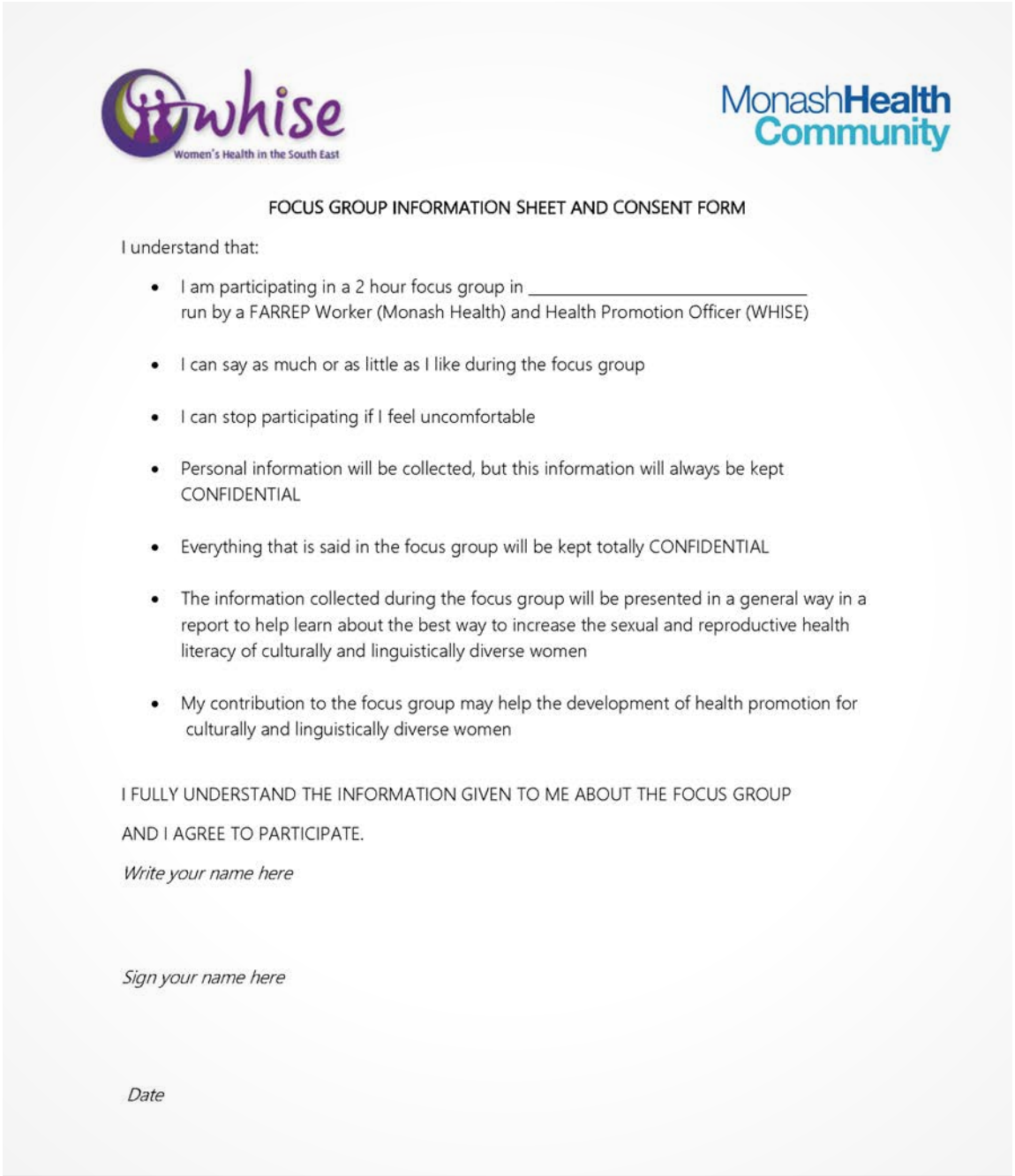
Jess Elsworth
Women's Health in the South East
Phone: 9794 8677
Email: jelsworth@whise.org.au

Appendix Three: Consent Form



whise
Women's Health in the South East

MonashHealth Community

FOCUS GROUP INFORMATION SHEET AND CONSENT FORM

I understand that:

- I am participating in a 2 hour focus group in _____ run by a FARREP Worker (Monash Health) and Health Promotion Officer (WHISE)
- I can say as much or as little as I like during the focus group
- I can stop participating if I feel uncomfortable
- Personal information will be collected, but this information will always be kept CONFIDENTIAL
- Everything that is said in the focus group will be kept totally CONFIDENTIAL
- The information collected during the focus group will be presented in a general way in a report to help learn about the best way to increase the sexual and reproductive health literacy of culturally and linguistically diverse women
- My contribution to the focus group may help the development of health promotion for culturally and linguistically diverse women

I FULLY UNDERSTAND THE INFORMATION GIVEN TO ME ABOUT THE FOCUS GROUP

AND I AGREE TO PARTICIPATE.

Write your name here

Sign your name here

Date