MATER HEALTH SERVICES

# Refugee Women as Health Leaders Project

## *Health Action Plans*

**Paula Peterson – Mater Centre for Primary Care Innovation**

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Mater
Exceptional People. Exceptional Care.

*These Health Action Plans developed by each of the refugee women engaged as Health Development Workers in consultation with women from their respective communities. They are intended to assist and inform health services and policy makers about the health needs of women from refugee backgrounds and contribute to building the skills and capacity of the health sector.*

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1. Afghan community
2. Burundi Community
3. Community from Burma
4. Congolese community
5. Eritrean Community
6. Rwandan Community
7. Sudanese Community
8. Togolese community

**Health Action Plan Brisbane Afghan Community**

*Azada Forotan - Health Development Worker – Refugee Women as Health Leaders Project*

## 1. AFGHAN COMMUNITY IN BRISBANE

The story of Afghanistan is in so many ways a very tragic one. Afghanistan is one of the most impoverished nations of the world. It is one of the most war-torn, most ravaged, and most beleaguered of nations. Afghanistan is a nation that has been beset by invasion, external pressure and internal upheaval. Its people have endured more than most of us can ever imagine. Afghanistan has historically been the link between Central Asia, the Middle East and the India sub-continent. It is therefore a nation made up of many different nationalities – the result of innumerable invasions and migrations. Within its current borders there are at least a dozen major ethnic groups – Baluch, Chahar Aimak, Turkmen, Hazara, Peshtun, Tajik, Uzbek, Nuristani, Arab, Kirghiz, Pashai and Persian.

### Healthcare System in Afghanistan

Beginning in 1979, military conflict destroyed the health system of Afghanistan. According to USAID, infant mortality rate has decreased by 22% and child mortality has dropped by 26% since 2003. It was reported in 2006 that nearly 60% of the population lives within two hours walking distance of the nearest health facility, up from nine percent in 2002. The average life expectancy at birth is reported between 50 years and 64 for both sexes.

## 2. THE HEALTH ISSUES IN THE COMMUNITY

The complex experiences of Afghan refugee women in their countries of origin and in refugee settings have major impacts on their health. Access to basic needs such as adequate food and water, education, and income generating and resettlement opportunities would have been limited. These factors, together with the relative lack of gender specific health care, have had a major impact on their physical and psychological health. At their point of entry in countries of resettlement women, are likely to experience a large number of acute and chronic health problems.

Physical health issues are; Chronic disease including, hypertension and heart disease, nutritional deficiencies such as folate, iron and vitamin D efficiency. There are many clients that are going through pregnancies close together and prolonged breastfeeding.

Psychological effects; post traumatic stress disorder, anxiety, depression, low self esteem, symptoms of fatigue, major headaches (migraine), and general pain over all body. Furthermore the general conditions that includes incomplete immunisation, and dental problems.

The main health related issues in the Afghan community for women in Brisbane include - low English language proficiency, gender issues, stress, distrust of the health system and size of family.

### 2.1. Mental /emotional health

Mental Health Issues; resettlement in a new country produces stress and this is combined with the stress of dealing with pressing needs such as housing, transport, finance, social security and immigration. Adjusting to a new culture brings about change in roles and the dynamic of relationships within family, which can often become strained. As a result many women become more vulnerable to family violence.

Many of the women express their feelings of grief, due to the traumatic separation from their loved ones who are left behind in the country of origin. They fear for their safety, and as a result the memories of past trauma are kept alive.

### 2.2. Language barriers and interpreting

Understanding a new language is definitely a significant stress and impacts on every aspect of life. Every health professional should understand this issue. As one woman said:

> *I don't understand the language here which means I can't gain success in this country. I seek help from my children for basic interpreting and translations of letters. I can't ask them all the time they get annoyed and won't answer me all the time. Then I get cross with them and angry at myself, then the depression starts and I ask why I even came to this strange country.*

Many women suggested that "the interpreters are our voice", "we don't understand the language. We are like blind persons". Bearing in mind the absolute confidentiality to be kept – many clients requested to involve a family member instead. This often presents a cultural challenge.

### 2.3 Cultural differences including family size and composition

Time has a cultural meaning; time for meeting and greeting can open new paths of generating trust and better communication. This is difficult to build in the health appointment. Many

women experience embarrassment when asked to expose their bodies to health practitioners. This is especially if the practitioner is a male.

Many of the Afghan women have never had family planning, counseling and contraception information. They tend to hold fertility and motherhood in high regard and as a result have short spacing between births and very large families.

## 3. RECOMMENDATIONS

- Build health literacy in the community – especially in regard to how infection is spread, assurance regarding confidentiality, preparedness to deal with the uncovering of trauma and violence, explanation of the Australia healthcare system, and explanation about treatment and counseling regarding stress management, dietary and nutrition advice, provision of immunization.

- Particular strategies need to be developed in relation to women's health – especially discussing contraceptive options in the context needs of the women's general physical state, as well as practical, financial and cultural considerations.

- Build health service capacity by increasing primary care cultural awareness and sensitivity, especially for the front desk staff. They are the first people who clients encounter and colour the approach to the health system.

**Health Action Plan Brisbane Burundi Community**

*Elizabeth Niyokushima - Health Development Worker – Refugee Women as Health Leaders Project*

## 1. BURUNDI COMMUNITY IN BRISBANE

**Burundi** is the smallest country in Africa , officially known as the **Republic of Burundi and it is** a landlocked country in the Great Lakes region of Eastern Africa, bordered by Rwanda to the north, Tanzania to the east and south and the Democratic Republic of the Congo to the west.

The Twa, Hutu and Tutsi peoples have lived in Burundi for at least five hundred years and, for over two hundred years, Burundi was ruled as a kingdom. At the beginning of the twentieth century, however, Germany and Belgium occupied the region and Burundi and Rwanda became a European colony known as Ruanda-Urundi. Social differences between the Tutsi and Hutu have since contributed to political unrest in the region, leading to civil war in the middle of the twentieth century.

Burundi is one of the five poorest countries in the world. The country has suffered from warfare, corruption, poor access to education and the effects of HIV/AIDS. Burundi is densely populated and experiences substantial emigration.

There are approximately 1500 Burundians in Brisbane. Most Burundian people who are living in Brisbane came from refugee camps where most of them spent their whole life struggling to survive there. Most of Burundian people are mainly living in areas such Logan, Woodridge, and Goodna due to accommodation affordability and job access.

The main language spoken by Burundian people is “Kirundi”.

The things that make Burundian community unique are - drumming, culture, beliefs and solidarity. Most of Burundian people believe that God heals as well as sorcerers and that they are better than any doctor in the World. Burundian people, especially women, gather together to talk about issues in our community such as wellbeing, development, education, dances, peace in their family, and much more. Many Burundian live in Brisbane have seen many horrible things due to the civil war in our country and refugee camps like, massacre, violence, torture, rape. This legacy has had an impact on the health of the community.

### Health beliefs and practices

Many Burundians use traditional remedies to treat illnesses and have a profound belief in God as the source of healing.

Many Burundians do not like to practice prevention of illness and don't take illness seriously unless it becomes really bad. Tea and herbal tea are used to treat illnesses.

## 2. THE HEALTH ISSUES IN THE COMMUNITY

Some of the main health issues in Burundian community are:

- Mental health and the legacy of trauma
- Language barriers
- Systemic issues - lack of trust between healthcare professionals and clients
- Poor health literacy.

### 2.1 Mental Health and the legacy of trauma

Mental health is one of the main heath issues in Burundian community. As we all know, Burundian people have experienced a hard time in life such as war, trauma and life threatening including witnessing killings, extortion, kidnap, torture and beatings, rape, see loved ones dying in their hands or by fire, starvation, amputation and many more atrocities. Most of Burundian woman are left with grief, trauma, stress, depression and anxiety. As result of all these issues, Burundian women are suffering from mental health problems.

Those who are survivors of torture, violence and trauma live with their memories for years, even for the rest of their life. They remember all events happened to them through nightmares and daydreams. They experience emotional and strong physical reactions of stress, despair, grief and terror.

For instance, one young lady, I talked to during my consultation, mentioned that:

> *Most of the nights I often sees my loved ones who passed away during war, calling me and dragging me. Even if I try to avoid the voices they don't go away. I decided to stay on my own. I don't want any friends and I don't want to tell anybody what happened to me. I only believe that God will rescue me. I don't want to see a counsellor or join some social group activities*.

If nothing is done, survivors of torture and trauma can develop problem such as severe depression, problem caused by drug and alcohol consumption, anxiety disorder, not able to trust anyone and lose focus and control of their life.

### 2.2 Language and cultural barriers

Language barrier is another important issue in many Burundian women which lead to stress and other mental health problems. Research shows that only 19% of Burundian females speak English well and 49% of Burundian women do not speak English well. This is a big issue and a very stressful situation for Burundian women. To be able to access health services in Australia, you need to speak and understand English so that you can explain or express the way you feel. So for Burundian women it is still big problem for them. For example one woman told me how she feels when she receives letters from hospitals, Centrelink, or other department.

> *She said she feels sick, terrible, all because she can't read and understand them, even if she tries to ring someone to help her, most of time they do not come when she needs them or not even come at all .The worst thing is when she gets sick, she can't call medical centre to make an appointment that's when she starts thinking so deeply and remembers what happened to her, she sees the world so differently to the point she thinks about taking her own life.*

The community knows that hospitals provide Interpreters, but they still meet some problems like unqualified interpreters. Confidentiality between interpreters and clients is not trusted as Burundian people believe that secret is between two people only. If any different from that - there is no secret or confidentiality at all. On top of that, Burundian women have the lack of availability of interpreters, lack of affordability of houses, lack of ability to get the jobs due to limited English, lower levels of education and literacy, lack of health information and a poor understanding of how to access health services. Financial circumstances in many Burundian families exaggerate the differences between family members, and misunderstandings between father and mother or one of the parents and kids.

### 2.3 Systemic issues

The other main health needs in Burundian community is the difficulty making sense of the health care system, being able to understand it, and having confidence that they are heard by healthcare professionals when they are explaining their health problems. They also need more time to understand the differences between Australian healthcare system and back in refugee camp and being able to access it.

For instance, a warm welcome from a healthcare professional means something great to Burundian people. They feel more cared, heard, and valued. This influences them to explain in much detail their problems, and helps them to trust a health professional. That is why many Burundian people have the same GP.

One woman said:

*I trusted my GP so much because, he treated me nicely starting with few jokes as conversation starter which has made me to forget that I was sick and I felt more confident with my poor English, he listened to me carefully by using simple English when he asked me how I feel. What upset me is when he left, things changed to the point I don't want to see any other GP except him but I do not know which medical centre he moved to and I don't have his contact so that I can talk to him .*

This woman is very desperate for losing the GP she trusted. this GP showed care about her. And that's why Burundian women stick on one GP once they find out those GPs cared them with dignity, respect no matter where they come from or language barriers.

Many women spoke of the length of time it takes waiting to see specialists and feared the conditions get worse before treatment. Many Burundian women have no idea why they have to wait for treatment and they develop an idea that it is because they do not have enough money to see specialists.

### 2.4 Health literacy

The process of consultation with Burundian women revealed that there is misinformation and fear on the community because of their lack of knowledge and poor health literacy. For example there is

- Fear of "internal" cancer and most of Burundian women believe that all cancers are caused by sun exposure.
- Distrust of contraception and a belief that contraception causes obesity which contribute to cancer
- Unfamiliarity with cancer screening and prevention such as Pap smears and breast screening
- Poor understanding of Hepatitis A, B and C as well as HIV in spite of those diseases having a relatively high prevalence.
- Poor health literacy in regard to
    i. healthy eating and the relationship to prevention of diabetes
    ii. allergies caused by some foods medication and chemicals
    iii. correct use of prescription medications

## 3. RECOMMENDATIONS

- Build health service capacity by increasing primary care cultural awareness and sensitivity, especially for doctors and medical centre staff.

- Build health literacy in promoting health life style in the community especially on prevention of some diseases before and follow medical advice.
- Establish good relationships and rapport between healthcare professionals and clients as they help the client to trust the health care professionals who provide some relevant information regarding clients' health and the undertaken procedures. This may include why patients' need to sign consent form before the procedure and have the knowledge about it.
- Improve the use of professional interpreters in all health care system and increase the knowledge about the interpreters and explain to clients, the use of professional interpreters.
- Organise some programs on TV, Radio, School(TAFE) regarding refugee women's health, how to access health services in Australia, and so on
- Increase hours for English learners to learn English rather than to push them to find Job while English for them is limited as we know communication is important thing when you are looking for job ,seek medical assistance, interviews, see healthcare practitioners, and many more
- Translate in Kirundi anything risky so that people can understand it before they do , use, or sign it

**Health Action Plan Community from Burma in Brisbane**

*Evelyn Pe – Health Development Worker – Refugee Women as Health Leaders Project*

## 1. COMMUNITY FROM BURMA

Myanmar, formerly known as Burma, is the largest country in mainland Southeast Asia. The country is bordered on the northwest by India and Bangladesh, on the northeast by Tibet and China, by Laos and Thailand to the southeast, and by the Bay of Bengal and Andaman Sea to the south.

In 1948, Myanmar formally gained its independence from Britain. As with most third-world countries, Burma experienced a fair share of political instability in the years between independence and the present. Its current state is one of the most repressive military dictatorships in the world. The name of the country was officially changed to the Union of Myanmar in 1989. In addition, Myanmar is a vital part of the so-called Golden Triangle that includes Laos and Thailand.

The official language of Myanmar is Burmese. The government also officially recognizes several minority languages: Jingpho, Mon, Karen, and Shan.

The government of Myanmar officially recognizes 135 ethnic groups. By far the largest is the Burmese, at about 68%. Significant minorities include the Shan (10%), Kayin (7%), Rakhine (4%), ethnic Chinese (3%), Mon (2%), and ethnic Indians (2%). There are also small numbers of Kachin, Anglo-Indians, and Chin.

Now more than 3000 people from Myanmar lived in Queensland. Karen and Karenni people come from Thai refugee camps and most Chin and Kachin people come from India and Malaysia. They all have their own languages.

### Health beliefs and practices

Most people from Myanmar health beliefs include a belief in karma – that is good and bad events can be attributed to actions committed in the past. Aspects of mental illness are also attributed to one's past and current life actions. It is also a belief that the health of a person is controlled by the four elements of fire, water, air and earth and any imbalance in these elements causes illness and disease. Certain foods and medicines are classified as hot or cold and they can adversely or positively affect health conditions and emotions. The classification of foods as hot or cold is unrelated to temperature. States of health seen as hot or cold are seen to require treatment with the opposite in medicine or foods.

Buddhist verses are important in curing illnesses, either being blown over the patient or recited over water for the patient to drink.

Many Karen and Karenni believe that a person possesses a number of souls called kla which might flee for various reasons (e.g. in connection with a mental breakdown). It is seen as vitally important to retain the kla and losing klaputs a person in danger of illness. One way of keeping kla is by an elder or religious shaman tying sacred string around the wrist. The kla are said to leave the body at death and reappear in the form of the kla of a newly born child.

Many ascribe some conditions that cannot be cured by Australian health care practices to human evil spirit that dwells within humans. Belief in spells and black magic is thought to be widespread in Burma. When a person has an illness that cannot be cured by any kind of medicine, black magic is usually suspected, and a cure is sought from a healer experienced in dealing with illnesses.

## 2. THE HEALTH ISSUES IN THE COMMUNITY

Some of the main health issues in community from Burma include:

- Mental health
- Language barriers
- Systemic Issues
- Poor health literacy
- Infectious and preventable diseases

### 2.1. Mental /emotional health

The women from Burma report that women coming from Thai-Burmese border camps have high rates of depression, anxiety symptoms and post-traumatic stress disorder. Depression is common in the Burmese community. But most women don't have professional health care and they do not know about counseling service. They do not believe that depression is a mental health issue and counseling is one of the treatments.

Mental health is very important for these refugee women because most of these women suffer from stress and depression.

*When I got my visa to come to Australia, I felt like I was top of the world. When I lived in camp I am independent but I arrived in Australia, I had to depend on other people start day one till now. Every day I need to worry about everything. I couldn't sleep for most nights. I asked by myself, why I came to Australia….. May be I should go back to my camp but I have no house over there."*

**2.2 Language barriers**

The most important issue is depression related to stress because most women can't communicate with Australian people without their children or interpreters help. Most women come from refugee camp can't read and write even their own language. That is why most women got too much stress and depression associated with previous trauma as well as when they got bills or any letters from post.

**2.3. Systemic issues**

Western health care practices and services are complicated and expensive and discrimination and racism is not uncommon. A woman with a history of suicidal ideation reported that:

*I never have letters and bills when I was living on the camp. In Australia, I get so many letters from Centrelink, bills for the telephone and electricity and now I get bills for blood tests. I don't understand why I need to pay for blood tests. I can't read and some people read them for me. I was so upset and depressed and I fought with my husband …. I didn't want to live in this situation…….anymore so I took a lot of ….tablets with other tablets. Next time I do not want to go to [hospital]because the staff from hospital looked down to me when I woke up. I was more upset than before. I feel like I am useless and a trouble maker."*

Most refugee women from Burmese ethnic groups believe that western health care practices and services are complicated and expensive. Cultural and language barriers complicate the situation. Western medicine has developed into a subculture with its own history, language, codes of conduct, expectations, methods, technologies, and concerns about the science which support it.

There are many difficulties accessing health care. Unfortunately, most refugee women cannot afford treatment because of high rates of unemployment and dependence on social security payments. So they use natural traditional remedies that can mean the condition worsens and

this places a burden on the health system. Lack of transportation or not knowing how to get there makes access difficult.

Refugee background Burmese ethnic women are afraid of many things. Some believe if they have some disease, the Australian government will deport them while they are seeking treatment and they do not speak English language.

### 2.4 Health literacy

Refugee women from Myanmar don't seek medical advice because they do not understand the processes, they believe in alternative treatment procedures. For example, Burmese ethnic background women after conducting a medical assessment expect to receive medical treatment in the form of an injection. However the medical protocol in Australia does not always require that medical treatment (injection) be necessary or done directly after a doctor's appointment. Therefore, women from Myanmar community members are not always happy when they receive only tests or tablet medication after a doctor's appointment.

### 2.5 Preventable and Infectious diseases

People from Burma settling in Australia have been shown to have high rates of treatable infectious diseases including Helicobacter pylori infection, latent tuberculosis, vitamin D deficiency and strongyloidiasis. However refugee women come from Myanmar have identified the major health issues with Hepatitis B & C.

A significant number of women (age between 40 and 60) reported suffering back pain, abdominal pain, stiffness, headache, migraine, anemia, type 2 diabetes, high blood pressure, gynecological problems, vitamin and iron deficiency, and toothache.

## 3. RECOMMENDATIONS

- Work with clients and communities to identify their needs and prioritizing which of those needs, need to be addressed first.
- Provide relevant existing resources and education.
- Mobilize additional resources if needed and refer clients to relevant service providers (housing, employment, education, legal, etc.).
- Provide interpreters and translators for the needs of the clients as required
- Advocate for the needs of the clients as required and provide translated information in the appropriate language.

**Health Action Plan Brisbane Congolese Community**

*Esperance Kalonji - Health Development Worker – Refugee Women as Health Leaders Project*

## 1. CONGOLESE COMMUNITY IN BRISBANE

The Democratic Republic of the Congo, is a country located in Central Africa. It is the largest country in Sub-Saharan Africa by area and the eleventh largest in the world. With a population of over 75 million, the Democratic Republic of the Congo is the nineteenth most populous nation in the world. It has the second-highest total Christian population in Africa. French is the official language of the Democratic Republic of the Congo. Approximately 242 languages are spoken in the country, but only four have the status of national languages: Kikongo (Kituba), Lingala, Tshiluba and Swahili. The Congolese community in Australia is very small - the 2001 census identified around 270 residents of Australia who were born in DRC. Over the years 2000-2005, the department's Settlement Database (SDB) has recorded around 640 entrants to Australia who were born in DRC2, 95% of whom were humanitarian entrants.

Health problems have been a long standing issue limiting development in the Democratic Republic of the Congo (DR Congo). These health problems include HIV/Aids, Malaria, outbreaks of polio, cholera, typhoid, yellow fever, the Ebola virus, and hemorrhagic fever. Tuberculosis is an increasingly serious health concern in the DR Congo. Many insect-borne illnesses are present as well. The culture of the Democratic Republic of Congo is extremely diverse, reflecting the great diversity and different customs which exist in the country.

## 2. THE HEALTH ISSUES IN THE COMMUNITY

Some of the main health issues in the Congolese community include:

- Mental health
- Language barriers
- Poor health literacy
- Infectious and preventable diseases

### 2.1 Mental health

Most Congolese refugee women living in Brisbane have seen their relatives being killed and also have been victims of different kinds of violence during the civil war. Some suffer from mental illness and depression due to being separated with their children/husbands in the refugee

camps. Families have been split apart during the refugee process. Children who are not considered "dependent" are not able to be included in the family visa. There is depression especially in women, separated from adult children in refugee camp. They spent many years in camp, the children grew up and then could not come to Australia with family. They married there and can't be reunified now.

The prevalence of HIV in the community has meant that family members have been left behind in refugee camps causing heartbreak. The separation of families has a significant impact on mental health.

The community stated that mental health is the most important issue in the Congolese community, and people want to learn how to prevent it.

As a woman in the consultation meeting said:

> *I am stressed because the same small amount of money I'm receiving from Centrelink has to be budgeted in order to send my daughter some money in the refugee camp for assistance. I have to do this because it's hard for me to stay calm and free when I know my daughter's suffering in the refugee camp with no one to assist her but me.*

### 2.2 Language barriers

The language barriers is also a big issue that's preventing newly arrived Congolese women from accessing appropriately the health care services and getting to wellbeing. Most women have English difficulties and it is worse when required to understand the health recommendations from doctors and pharmacists.

### 2.3 Health literacy

Another important health issue in my community is internal cancer, which has left many people worried.

As a woman in the consultation meeting said:

> *I witnessed a woman die with cancer because of the long waiting period to see a specialist Doctor. The lady was suffering from really bad stomach cramps so she went to see a General Practitioner (GP) and was referred to a Gynecologist. When it was finally her turn to see the specialist doctor for a check-up, she undertook a*

*few tests and later on found out during her consultation that she had cancer and it was now too late to seek any treatment because the cancer had already spread around her whole body. A few days later she passed away.*

From hearing that story, many women in my community are now very scared if they have pain in the abdominal area and are unsure if they'll see a specialist doctor in time in case if the pain was caused by internal cancer. They fear that due to long waiting lists it might also be too late for them to seek any treatment before having a consultation with a specialist doctor.

### 2.4 Infectious and preventable disease

The consultation with women from Congo revealed a high prevalence of diseases which are preventable. Therese include

- Diabetes
- High blood pressure
- Edema in feet
- Arthritis
- Worms
- Sinusitis
- Flu in children
- Allergies
- Nutrition related illnesses

## 3. RECOMMENDATIONS

- Build the community's health literacy around particular illnesses including cancer and cancer prevention,
- Build the community's health literacy around chronic disease, and disease prevention including healthy lifestyle and exercise, and health eating and nutrition
- Build the community's capacity to understand mental health issues and prevention of mental concerns

**Health Action Plan Brisbane Eritrean Community**

*Samira Ali – Health Development Worker – Refugee Women as Health Leaders Project*

## 1. ERITREAN COMMUNITY IN BRISBANE

Eritrea is located in the horn of Africa, a country that has experienced war for decades. This has forced thousands of Eritreans to flee and seek refuge in other countries. Eritrea was formerly the northern most province of Ethiopia. Eritrea is bordered by the Sudan on the north and west, the Red Sea on the north and east, and Ethiopia and Djibouti on the south.

The Italians captured the coastal area in 1885 and ruled there until World War II. The British captured Eritrea in 1941 and later administered it as a UN Trust Territory until it become federated with Ethiopia on September 15, 1952. Eritrea was made an Ethiopian province on Nov 14 1962. A civil war then broke out against the Ethiopian government, led by rebel group who opposed the union and wanted independence for Eritrea. Fighting continued over the next 32 years. In 1991 the fighters gained control of Asmara, the Eritrean capital, and formed a provisional government. From 1998-2000, Eritrea and Ethiopia fought a war that killed more than 70,000 people and displaced more than 600,000 people from areas near the border.

There are currently about 500 Eritreans living around Brisbane, with most of them arrived as humanitarian refugees since 1990 till the present due to political unrest their homeland. Most of Eritrean refugees have lived in refugee camps for many years. The majority lived in Sudan prior to coming to Australia and some have children born in Sudan. Other places of transition are Egypt, Ethiopia, Kenya and Uganda. The current 'no war and no peace' situation in Eritrea causes a lot of trouble for many Eritreans and because of that, there are many Eritreans still living in refugee camps.

Eritrea's population comprises nine ethnic groups, each with its own language and cultural tradition. The working languages are Tigrinya, Arabic and English. 80% of Eritreans speak Tigrinya which is the national language in Eritrea, but most of the Kunama ethnic group does not speak Tigrinya. The Kunama are the smallest group in Eritrea and are a distinctive people with their own language that is unrelated to the major language. Here in Brisbane they have a big problem in finding a Kunama interpreter. The Kunama are more vulnerable than the other Tigrinya speaking Eritreans because they have less education than other Eritreans and are less familiar with modern services because they are not used to city life.

The two main Eritrean religions are Coptic Christian Orthodox and Islam. There are many Orthodox, some Catholic, protestant and Muslim Eritreans in Brisbane.

**Health beliefs and practice**

The use of prayer for spiritual healing is an important part of treatment for illness for many Eritreans. However, here in Brisbane they also access health care services for treatment. Boys' circumcision is a common practice in all religions, traditionally Eritrean people like to circumcise their sons as young as 7 days old. However, in Australia they are facing difficulties to do that because not many doctors are doing circumcision and if they do it is very expensive. Female circumcision is not as common as it used to be because the Australian government banned female genital mutilation and has warned that anyone taking part in or promoting the practice faces a fine of several hundred dollars or a jail sentence.

In many families, although the men and women work or study, it is the woman who comes home and cooks the meal as well as cares for the family. Eritrean women in Brisbane seek prenatal care from community clinics or hospitals. In Eritrea, many had home deliveries performed by traditional birth assistants. They don't dare to do it here though. Despite their belief that doctors know more and do good job, they feel strongly that Australian doctors do too many unnecessary Caesarean sections and they would prefer that the doctor wait for the baby to come naturally as they do back home.

Most Eritreans see a general practitioner when they get sick. They turn to Western medicine first for treatment and believe that doctors in this country are able to help them. However, there are some things they don't like much. First, they feel that often too much blood is taken for testing and would prefer this is not performed unless absolutely necessary. They do not understand why blood is drawn on pregnant women, since they believe pregnant women need all the blood they have.

## 2. THE HEALTH ISSUES IN ERITREAN COMMUNITY

Eritrean women reported a range of health issues impacting on the community - dental disease, vitamin D due to less sun exposure (women usually avoid the sun as they do not want their skin to be darker and have no knowledge about the use of vitamin D).

However the major issue identified was mental health.

### 2.1. Mental /emotional health

The major health issue identified is mental health and understanding mental health. For most of the women the word 'mental health' means not being able to look after yourself or your family or needing to be locked up as a crazy person. Depression is not considered a mental health problem. A woman who suffered from depression due to separation, adjustment in a new country and financial hardship was told by her friends from community not to take any

medication if the doctor suggested doing so. They say those medication are for people who are mentally ill and believe that taking medication will make her sick. Although some women say that they have difficulty falling, or staying, asleep for long time, they prefer to say I have worries or stress and that will go away when I get a solution for the practical problems I have.

Eritreans use less mental health care services from health care professionals, they are more likely to try to fix the problem they think they have for mental health problems. Many Eritrean women do not understand the word 'counseling' and even after explanation they don't believe that talking about the problems you have will do some good to you. One of the Kunama women said

> *People come to my home twice and ask me all sort of question about my whole life. I cannot see what help that could bring for me. What is the point talking about my husband who died years ago? She says for us, past is past, we want our present problem to be fixed. I want my son to come here to help me live my life. I am not capable of doing anything and at the moment there is not much help out there to assist me. I ask the professional not to come again because talking about the past is wasting time for me and doesn't do any good to me. It also doesn't solve my problems.*

Women who have recently arrived in Australia are preoccupied with the immediate challenges of settlement; besides that they are unfamiliar with counseling and its purpose. The stress of resettlement including financial stress can lead to depression. However depression is not recognized as a mental health problem and that makes it difficult to treat.

Most of Eritrean refugees have been through, or exposed to, traumatic events prior to coming to Australia which can lead to post-traumatic stress disorder.

### 2.2. Language barriers, interpreting and the unfamiliarity with the Queensland Health System

All of the Kunama women say that they have difficulties in finding a Kunama interpreter and it has impacted negatively in how they access the health services and other services. A young mother from this Kunama group said*:*

> *When I got sick I don't usually go to the doctor because I know it is too difficult for me to communicate in English. I try to rest and get better. When my children got sick though I always take them to the doctor and hope the doctor understand what my child has got and give the right treatment. I feel sad because I can't tell what symptoms my child has.*

A significant problem in the community is understanding how the public health system works. People have different expectations about the services they can get in public hospitals. Long waiting lists for operations are not expected, making appointments to see a doctor and also waiting too long to see the doctor or the specialist is not what they thought it would be in Australia. As one woman said

> *We see too many doctors at the hospital. Every new doctor asks the same question so we need to explain all over again. We sometimes think what is the use of telling my story to this doctor we won't see him again anyway. The doctors at the hospital they always say 'Let me talk to my boss and I will be back" - , that makes us doubt whether we get the right treatment or not. Back home you see just one doctor and he decide what to do.*

There is a belief that operations are done by students at the public hospital and for that reason many believe that you will be safe if you can afford to pay private hospital. If they don't have the expected result after an operation there a common reaction 'Oh the student was learning on me'.

The third issue is around prescription medications. Refugees have doubt whether they need to take some medications, for example to lower cholesterol, to control the blood sugar or to suppress the virus level in their blood. Pap Smear testing and breast screening are not popular among refugees. If there is no significant pain there should be no need for medication or tests. *If you don't feel sick you are healthy.* This is because prevention of illness is an unfamiliar concept amongst most of the women.

The issue of trust was in raised in many ways. The women indicated that when an operation is needed they worry a lot because they get told what the risks are and are asked to sign a consent form which interpreted by them as: *'if something goes wrong you are the responsible not the health worker'.* This creates a mistrust as they think that the doctor won't take any responsibility for the procedure.

### 2.3 Employment, low-income & housing affordability

One of the other causes for too much stress here in Brisbane is expensive housing rent, some people pay up to 50% of their Centrelink income for rent and not enough money is then left to pay the bills. It is very difficult to find a job because of their language barrier and their children's needs become more and more as they adapt the Australian way of life. So a lot of Eritrean women are stuck with long term financial problems, which could lead to depression.

## 3. RECOMMENDATIONS

- Develop a priority system for newly arrived refugees that enables them to access public housing because of their low income and because they are unlikely to get a job in the first two, three years.

- Expand the capacity of the hospital waiting list to enable newly arrived refugees a chance to be treated in a timely manner as newly arrived refugees have never had a chance before for a good treatment.

- Build health literacy in the established community – especially in regard to hygiene education such as washing hands after visiting the toilet, cleaning the house, preparing a healthy meal, making healthy lunch boxes so that they become healthier communities.

- Develop a cultural support worker role for the Kunama women - at least two days a week to support them to access the health care, services and available resources.

**Health Action Plan Brisbane Rwandan Community**

*Angeline Mujawamariya - Health Development Worker – Refugee Women as Health Leaders Project*

## 1. RWANDAN COMMUNITY IN BRISBANE

Rwanda is a small country (26.338 square kilometers) located in Central/Eastern Africa and it is the most densely populated country in Africa. Christianity is the largest religion; the Christian God is viewed as the best health care provider. This small country has only one language that ties up with its culture, social and health realities. Music, dance, traditional arts and crafts are an integral part of Rwandan culture. The Rwandans believe that the physical state is the mirror of the mental health and the best healing of the psychological condition is provided by family, friends, traditional doctors and God.

According to the Rwandan culture a woman is said to be the heart of the family and the wisdom of the Community so her better health influences the wellbeing of the whole family. These values have been stamped on the ground by the 1990 civil war followed by the horrific genocide. The majority of Rwandans living in Brisbane are the survivors of the tragic slaughter, unjust arrests and persecution that left them in a deep grief. They fled to the neighbouring countries and have lived in refugee camps for many years before to being resettled in Australia.

## 2. THE HEALTH ISSUES IN THE COMMUNITY

Rwandan women in Brisbane have identified the following major health and related socio-cultural issues:

- Mental health and related physical/emotional concerns
- Language barriers
- The interpreting and the unfamiliarity to the Health system
- Cost of medicines, health care card, treatment
- Cultural differences and religious beliefs
- Employment, low income, housing
- Racism and discrimination

A significant number of women, especially the newly arrived ones, report suffering back pain, abdominal pain, headache migraine, allergies, Xenophobia, anaemia, high blood pressure, gynaecological problems, vitamin deficiency, dental and eye diseases and significant stress.

However the major issues are related to stress from their socio-economical and psychological state. Therefore, the health issue that seems to be the most important is mental health.

### 2.1. Mental /emotional health

The highest rated issue by the women consulted is the mental health. In fact, most Rwandan refugee women living in Brisbane/Logan areas saw their relatives being killed and also have been victims of different kinds of violence during the war and the shocking genocide, on the way to the refugee countries and within the camps. They saw the worst of human beings during these periods of times.

Besides that, they had long stays in different camps in Africa in poor health conditions prior to their arrival to Australia. In their previous life they experienced excessive fear, grief, sadness and lost their self-esteem and trust in people. The majority of them are really deeply traumatized. Presently, some try to have a positive outlook on life in this society and tell their stories to friends or to health care providers in order to be helped while others feel worthless and hopeless, prefer a social withdrawal and tend to live in complete isolation because they do not see the value and the purpose of their life. Moreover, they do not think they need to seek medical help for mental illness. The stress of the women also has an impact on families. The following is the story of one of them:

> Ms X is hearing voices and seeing strange things at night. She avoids using tap water for the reason that she thinks someone who poisoned her mind would poison the water. She sits many times for long periods of time doing nothing but yelling at the children. When I suggested her to seek help from the mental health professional; her answer was:
>
> *"I met these professionals twice. It is enough! I do not trust these people and their interpreters. They are all spies. I trust only my God and the traditional medicine. I am not foolish or sick; I do not need your doctors. I am just tired because my Australian life is a full time job. When I will realise that I am mentally sick I will go back to Africa to seek help from an African traditional practitioner."*

Depression is common in the Rwandan Community. They have been seen once or twice by the professional counsellors and then declined to attend the sessions claiming that the depression is not a mental health problem but just a stress and anxiety. They also believe that modern medicine and western counsellors cannot assist a depressed African woman. Many think that the use of an interpreter worsens the condition.

### 2.2. Language barriers, interpreting and the unfamiliarity to the Queensland Health System

Although 80% of women in the Rwandan community are literate, 60% mentioned English skills deficiency. Even fewer are able to understanding health recommendations from the doctors and pharmacists. Some medical centres and private clinics such as dentist do not make use of professional interpreters (due to the high cost).

As women in the consultation meeting said:

> *One day, a cultural support worker took me to a medical centre for a health check-up. When we got there we discovered that the Centre did not book the interpreter. The doctor asked the CSW* [Cultural Support Worker- a worker from MDA employed to assist in settlement] *to play interpreting role, the CSW refused and explained that it is a medical issue and she is not a professional interpreter. The CSW referred the issue to my social worker who advised me to make another appointment.*
>
> *After being seen by a doctor, I took the prescription to the pharmacist; despite the long explanation given by the pharmacist I could not understand the recommendations on the medicines. Arrived at home I was wondering how to take these tablets, instead of to have them I started crying and threw them into the bin. I was physically and mentally sick. It made me feel like I was a lesser human being.*

The shame and frustration associated with English skills deficiency prevent them from effectively accessing health care services, useful resources and information.

There is also little confidence in confidentiality and privacy on the health information given by patients from non-English backgrounds. They do not trust all these health professionals and different interpreters. According to the Rwandan culture and tradition, the information known by more than two people has lost its confidentiality.

The Rwandan women reported that they do not really understand how the health system works. The requirement to sign consent is not understood and is profoundly misinterpreted.

*Why sign a consent form? It is unpleasant and worrying! It is like the health professional declines his responsibility on risks involved in case the procedure does not succeed.*

In addition, the lengthy waiting lists for the specialists and time spent in the waiting room to see a doctor are significant barriers to access. In Rwanda, the quality of healthcare is generally low. There is a shortage of qualified medical professionals in the country, and some medicines are in short supply, very expensive or unavailable - but when you succeed to make an appointment with a doctor you are warmly received and do not wait for hours before being received by the doctor. The waiting time in the Australian public health system is seriously very long. The community reports that they did not expect that could happen in public hospital in developed country. A few women stated that some Australian doctors can be rude and show impatience when dealing with a patient from a non-English speaking background.

### 2.3 Employment, low-income & housing affordability

Unemployment and low-incomes increase the stress in women and prevent them from getting to better health. The majority of women reported that they have difficulty accessing and paying for a suitable and affordable housing due to their low income and the lack of their private rental market history. At this point, those who do not have a job security expressed their distress; they cannot afford the dental, eye consultation, and cost of medicines because they are not eligible to get the health care card.

## 3. RECOMMENDATIONS

- Translate in Kinyarwanda language some resources such as the consent forms, information pamphlets on the health care system, healthy lifestyles and other related to maternity.
- Promote the use of professional interpreters in all medical central and pharmacies
- Develop the role of the Community Health Worker to:
    - Build health literacy in the community – especially with new arrivals. This includes providing information about Queensland Health system, nutrition, reducing the stigma and improving appropriate access to the health care providers.
    - Bridge the cross-cultural communication and build trust and relationships between the health care providers and their patients

- Develop capacity in the health workforce to address the needs of traumatized refugee patients, including providing adequate explanations and in the case of women's health concerns, be seen by female health professionals.
- Continue to address the social determinants of health including – job opportunities, access to income support and low income support, access to public housing
- Remind researchers and all persons interested in Refugees' wellbeing in Brisbane the importance of not only assessing the community needs and collecting data but also giving something back to the community
- Improve coordination and collaboration between community, the patient, health practitioners, the multicultural/ethnic organizations, the policy-makers, researchers and the government to ensure that the health care resources are used to maximize health improvement.

**Health Action Plan Brisbane South Sudanese Community**

*Maria Phaltang - Health Development Worker – Refugee Women as Health Leaders Project*

## 1. SOUTH SUDANESE COMMUNITY IN BRISBANE

South Sudan is the World newest Country that gained its independent from the Sudan on 9th July 2011 following the referendum with 99% votes for separation after over 25 years civil war that claimed more than 2.5 million lives and displaced more than 5 million human beings in which the South Sudanese Community in Brisbane today are the survivors. There 3500 to 4000 Sudanese estimated to be living in Brisbane, most of them are living in the south side of Brisbane suburbs such as Acacia Ridge, Logan, Goodna, Moorooka, Ipswich and Redbank mainly because the rent is cheaper and some government properties are in these suburbs. There is a good number of South Sudanese living in Toowoomba mainly the Dinka people with few other Tribes.

The Republic of South Sudan is a landlocked country in the East Central of Africa that is part of United Nations **subregion** of Eastern African. South Sudan Republic is bordered by Ethiopia to the East, Kenya to the Southeast, Uganda to the South, the Democratic Republic of Congo to the Southwest, Central Africa Republic to the West and the Republic of Sudan to the North.

The main Religion in South Sudanese society is Christianity in which most people believe that God is everything. In the other hand South Sudanese people strongly follow their traditional and cultural beliefs and values even though they are Christians (mix believe). There are over 60 Indigenous languages in South Sudan where most of them are just spoken and not written.

### Health beliefs and practices

South Sudanese people have a very strong culture and traditional beliefs and values; family means a lot to every member whereby people live a communal life helping each other in every way possible as community and not just as relatives. Among southern Sudanese people, relative age is important in interpersonal relationships. Men of the same age call each other brother (even if not related) and act informally with one another. Older people are usually shown a higher level of respect. This spirit helped South Sudanese during difficult times especially crossing countless boarders fleeing for safety during the war and it is still being kept alive here in diaspora.

In South Sudanese culture a man is the head of the family and the woman is the mother of all including the husband, when this person is sick the whole family and the community is sick.

## 2. THE HEALTH ISSUES IN THE COMMUNITY

South Sudanese women pointed out the following issues during the consultation as their main health concerns.

- Mental health/ mental illness/ stress
- Chronic diseases
- Language barriers
- Long waits to see a specialist
- Employment problems, lack of skills to get a job

### 2.1 Mental health/ mental illness/ stress

Most of the South Sudanese women have been through a lot of trauma during the civil war between North and South direct or indirect, physical torture that include rape and beatings were just part of the story. Emotional distress such as losing a big part of a family to the war in which lots of women are widowed and have to raise their children as single mothers today because they lost their partners or husbands during the war.

South Sudanese women saw the chance of coming to Australia as the biggest gift God could ever give to a human being. It was seen to be such a life changing opportunity because these women have been living in the refugee camps for years and years with no sign of a place to call home. Coming to Australia meant better future for the families especially their children the children to get better education and good life in general.

In contrast this seem not to be the same anymore, during the consultation almost every woman interviewed mentioned the concern they have about their children that seem to be one of the contributing factors of their mental health issues.

Southern Sudanese people invest in their children and expect them to be good adults in the future, but here in Australia that seems to have significantly changed as the system is completely different and the parents feels that their children lost track in because of too much freedom and as parents they cannot do anything about it. Below are the words of a mother who is trying to discipline her child:

> *My little girl picked the phone up and called the police saying there is a woman beating her. Now I am a woman not her mother. I felt as bad as the day that I lost my husband to the war. I lost it all now. I feel like I did not give birth to*

*children as my two daughters are busy with their own lives that I am part of anymore.*

Depression is a one very common condition among the South Sudanese women, but the problem is none of these women will seek help because depression or stressed is never considered a health issue in Sudanese society. There is also a stereotype around stress and depression or any kind of mental disturbance that when you visit a health professional or a counselor, you are given medication that worsens the condition. As a result women tend to deny that they are going through such conditions; hence this has a great impact on women's mental wellbeing

**2.2 Chronic disease**

Being born in Rural African is already big issues when it comes to health, as people never get any check-ups, but for most South Sudanese women they lived in the refugee camps for up to 15 years or more where there is rarely any medical access. Of course everyone gets checked before they get their approval to Australia but that is just for obvious infections such as HIV/AIDS, TB etc. Diabetes is a growing concern but difficulties with health literacy and language make it very difficult to manage. Below is a story of Mrs Y being diagnose with diabetes.

*I was to start taking a medication and monitor my blood sugar levels with a machine that looks like a watch. How would I do this? I asked the female doctor, she replied there is a reading that will show on the screen every time you take your blood.*

*I raised both of my hands in front of the doctor and told her I am not going to do this because I cannot read or write and whatever is shown this machine will never make sense for. I leave this to God and he is going to heal me with his power. In Africa we used believe only in God for healing.*

**2.3 Language barrier**

Most South Sudanese are illiterate and cannot even read or write in their own languages/ dialogues. Culturally there is a big gap between genders especially when it comes to health issues between men and women. In most cases women will prefer a female interpreter which is not really easy to get.

*The female nurse ran after me with a bundle of leaflets that were all written in English, of course that was another insult because if I had to read it for myself I wouldn't need an interpreter. I got them off her and threw them into the bin when she left because I did not want to look rude to her.*

This issue of interpreters make most women(older ones) not to visit health care providers because they feel like what they discuss with their health professionals is over the place and not confidential through interpreters.

### 2.4 Long wait lists

Australian is one of the developed countries with advanced medical interventions. It surprises a lot of refugee backgrounds that this is happening in Australia. More than half of the women consulted repeatedly said how disappointing it is to wait for so long to see a specialist because this was not expected of Australian public health system.

### 2.5 Employment problems and lack of skills to get a job

Unemployment rate is high among the South Sudanese women. Many never had any form of formal education and work experience before they came to Australia thus they don't have enough skills that can help them get an employment. Women reported that Centrelink expects them to be doing some form of numeracy and literacy course so that they can still get paid especially if their last child turns 6 years old. Studying and taking care of the children is difficult and this is so depressing for the women because it is very difficult at a certain age to start learning a different language.

## 3. RECOMMENDATIONS

- Promote the use of professional interpreters and be sensitive to gender issues.
- Create an awareness about mental health
- Provide information about health system in Australia to the South Sudanese women directly as most of them cannot read for themselves.
- Give a chance to individuals women that are willing to work hard and eager learn in health department so that can be role model to other women.
- Address the needs of traumatised persons coming from a refugee background.

**Health Action Plan Brisbane Togolese Community**

*Zita Kounou - Health Development Worker – Refugee Women as Health Leaders Project*

## 1. TOGOLESE COMMUNITY IN BRISBANE

The Togo community is predominantly Black African who are seeking a happy and healthy life after leaving a poor, oppressed background. They are deeply spiritual people who believe that healing can be both spiritual and physical. The wellbeing of the mind and spirit are as important as the physical wellbeing of the body. The respect and social standing of physicians in the community, both here and overseas is second to none. At the same time, the same group of people is taught from an early age that "witch doctors" can provide cures that are not available in Western medicine.

Togo is a small nation in West Africa. It has a long, narrow profile, stretching more than 550 kilometres from north to south but not exceeding 160 kilometres in width. At 56 785 square kilometres, Togo is roughly 20 per cent smaller than Tasmania. It borders Ghana to the west, Benin to the east and Burkina Faso to the north. Togo has a short coastline on the Bight of Benin to the south. The capital, Lomé, is a port located on this stretch of coast.

That Togolese community in Queensland is about 100 people but the number in Brisbane would not exceed 50. Half of the Togolese are widely spread across Queensland for different reasons.

One of the benefits of this community is that all members are ''Tight knit'' so the support network is extensive. The community will gather together to discuss political and social events and ways to influence those occurrences in a positive manner.

Most of the Togolese community in Brisbane have come here through refugee camps in Africa. Health care in camps where Togolese have sought refuge is often limited. Commonly reported medical conditions affecting Togolese refugees are: Stress (Post traumatic stress disorder), vision problems, lower back pain, abdominal cramping, menstrual pain, knee pain, breathing difficulty due to alteration in climate and in rare cases - issues with fertility.

## 2. THE HEALTH ISSUES IN THE COMMUNITY

The majority of Togolese people living in Australia are survivors of torture and trauma. About seven out of 10 refugees in Australia have been tortured or gone through some kind of war-related trauma. Some forms of torture (such as beatings, death, and disappearance of a family member, friend or colleague, harassment by authority figures, forced child soldiering, amputation, and rape) harm the body and cause lasting scars. Other torture methods are

painful, but don't cause scarring, such as starvation. Examples of trauma related to Togolese experience include imprisonment, seeing the rape or murder of a loved one, or a dangerous journey to freedom.

### 2.1. Mental /emotional health

Mental health or "stress" is the most significant issue affecting the community and has the most debilitating effects on my community. The stress can be related to the shock of entering a new country and adapting to a different way of life.

Those who are survivors of torture and trauma live with their memories for years, or even for the rest of their lives. They remember the event in daydreams and nightmares, while certain things (such as objects, situations or people) remind them so much of their trauma; they experience strong physical and emotional reactions of stress, terror, grief and despair. Without treatment, survivors of torture and trauma can have ongoing problems including:

- Inability to trust others
- Inability to form close relationships
- Problems with school or work
- Anxiety disorders, such as phobias or panic attacks
- Severe depression
- Problems with alcohol or drug abuse.

There is a distinct lack of understanding in the community regarding mental health issues. As a result of this, the patients may not believe in the remedial effects of the medication they are taking; being forced to accept the medication increases the stress level of the patient.

### 2.2. Family issues

There is also a settling in period and the responsible members of the community must adapt their thinking to allow their children to integrate into the Australian way of life and all of its quirks. This must be paramount in the thinking of the adults so their children are readily accepted by the broader community and do not stand out any more than necessary.

There are different techniques for discipline and the rules of the host country must be observed. The standard of what is acceptable in Togo is different to Australia. If a parent is allowed to discipline their child in the manner accepted in African communities it may result in a harsh penalty in Australia due to the differing rights of the child. The fact that this discipline may result in the child being removed from the parent will add to the level of stress being felt by the parent.

### 2.3 Employment, low-income & housing affordability

When refugees enter Australia they have no meaningful employment, but their living expenses are quite high and finding the money to meet these expenses can be very stressful for people who are known for their pride in providing for their families.

## 3. RECOMMENDATIONS

- Build health literacy in the community – especially in regard to mental health issues and also stress management so the effects of these conditions are not as prevalent. This can be done through the local GP and via leaflets and counseling, as well as community gatherings where the community can chose a designated representative to be fully informed of current treatments and procedures. These community members can then return and pass this knowledge onto their fellow members to raise the overall awareness of the particular subject matter.

- Improve access to health and support services through educating community members as to the cost, whereabouts and provision of government backed health services.

- Build health service capacity by increasing GPs awareness and cultural sensitivity to their Togolese patients as well as being aware the affects and types of diseases can vary greatly between Australia and the patient's country of birth. The doctor needs to inform the patient of any rebates available through the Medicare system.