Health Promotion

Promoting the health of women of non-English-speaking backgrounds in Australia

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Immigrants with non-English-speaking backgrounds face many linguistic and cultural barriers when trying to use Australia's health services. Gender inequities make matters especially difficult for women with such backgrounds, who largely belong to the lower socioeconomic categories. The present article describes two health promotion projects whose success is largely attributable to their recognition of the difficulties faced by these women and to the strategies devised to overcome them with the aid of liaison workers and bilingual community educators.

One of the most significant aspects of immigration to Australia after the Second World War has been the ethnic diversity of the people concerned. The Australian population is made up of people from over 110 countries, and a quarter of Australians have a non-English-speaking background.

Until the 1970s, learning to communicate across cultures was considered to be the responsibility of only those members of Australian society whose first language was not English. Since the mid-1970s it has become clear that the health care delivery system, the practices of health professionals, and the educational structures do not always reflect the diversity of values, beliefs concerning health and illness, practices and lifestyles of the Australian population (1).

Some of the barriers encountered by women with a non-English-speaking background who wish to make use of the health system, such as those relating to financial matters, transport and facilities for child care, are the same as those faced by many women whose first language is English, especially those belonging to the lower socioeconomic categories. However, women with a non-English-speaking background also have to contend with substantial linguistic and cultural barriers.

Many of these women do not have a command of the English language which is adequate for an understanding of health care procedures and for the giving of informed consent. Their access to English classes is hindered by Australian immigration policies, which regard men as having priority because they are the principal applicants and bread-winners. Furthermore, the burden of working for many hours both at home and outside the

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home leaves little time or energy for attending classes.

The Australian health system is largely monolingual, and service providers are often unaware of the subtleties of cross-cultural communication (2). Conveying messages is a major issue even in monolingual, monocultural societies where, for example, words and symbols may be differently interpreted. In multicultural societies, where the problems are even more pronounced, health promotion should be both linguistically and culturally appropriate. There are many instances where literal translation from English is inadequate, most notably, perhaps, in publications on nutrition based on Anglo-Australian eating patterns.

Campaign material such as posters and television advertisements has often portrayed only blue-eyed, blond Australians, and for this reason people of other types have found it difficult to relate to it. There are also many cultural differences in attitudes towards sensitive issues, such as those related to the reproductive role of women and women’s cancers.

Over the last two decades, however, several initiatives have been undertaken to improve the access of non-English-speaking people to the health system. Most notable has been the establishment of a body of interpreters whose services can be obtained both by telephone and on site. Other strategies include the translation of information into many languages other than English, and the introduction of cross-cultural training programmes for a wide range of personnel involved in delivering health services.

However, experience has shown that, at least for first-generation immigrants, these measures need the support of bilingual and multicultural health workers who can provide a link between the system and the consumer. The issue is particularly important for women with non-English-speaking backgrounds, who, as well as experiencing limited access to English classes and to reasonably well-paid employment, have special needs in relation to their biological and social roles.

Reproductive health and women’s cancers have been identified as two key health issues for many of these women (3). There are elevated incidences of obstetric complications and cervical cancer among some of them, and there is evidence that their attendance at prenatal and postnatal classes and cancer screening programmes is markedly lower than that of women born in Australia. Formerly this was thought to result solely from the inhibitions of women with non-English-speaking backgrounds, but structural barriers have now been recognized.

The importance of addressing these barriers has been demonstrated in the Ethnic Obstetric Liaison Programme, located in Sydney, and the Bilingual Community Educator Project, piloted by the Brisbane Women’s Health Centre.

**Ethnic Obstetric Liaison Programme**

This programme arose from the conclusions of a ministerial task force on obstetric services in New South Wales. The use of bilingual female attendants was highly recommended.
because many women with non-English-speaking backgrounds did not feel comfortable or had religious and cultural constraints when confronted by male health care providers.

The Ethnic Obstetric Liaison Programme provides information and support to pregnant women and new mothers of Arabic, Cambodian, Chinese, Lao, Spanish and Vietnamese backgrounds, all of whom belong to emerging communities that are often unfamiliar with the Australian system of health delivery. Several of these communities have rates of obstetric complications which are higher than average.

The major aim of the programme is to provide effective liaison between the women and the health care providers. The women are considered to have the following rights:

- to receive information on pregnancy, childbirth and mothercraft;
- to have access to community resources and support services;
- to be communicated with in their own languages.

Moreover, it is recognized that health care providers should be sensitized to the women’s needs.

**Recruitment and training of ethnic obstetric liaison officers**

The positions of liaison officers were advertised in the press, with the requirement that applicants should be general nurses with a midwifery certificate. However, in some language groups, midwifery training lasts three years and midwives can practise without having been trained as general nurses. On this basis, only a Chinese applicant qualified. The posts for Cambodian, Lao and Vietnamese liaison officers were filled only after they had been re-advertised with a request for midwifery experience only. The Arabic and Spanish positions were filled by midwifery students awaiting the results of their final examinations.

After recruitment the officers undertook an eight-week training programme to update their knowledge of obstetrics and other matters. Lectures were provided by obstetricians, maternity educators, physiotherapists and allied staff. The training has enabled the officers to work independently of nursing staff, with whom they liaise in order to discover the mothers’ educational needs, which they then provide. The initial orientation programme included placement in the community. Subsequently, the officers met each team of primary health nurses in the Bankstown, Fairfield and Liverpool sectors of Sydney. This has allowed the officers to promote their role, discuss ways of improving communication, assist in making easier the transition from hospital to community, and facilitate early access to primary care and early childhood services.

A coordinator has visited each maternity ward to advise staff about the role of the liaison officers. New staff are seen while receiving hospital orientation, and arrangements are being made to see midwifery students while they are attending their first study block. The officers have been providing in-service advice to hospital staff on cultural beliefs and practices relating to pregnancy and childbirth, among them special dietary practices and the belief that the newly delivered
mother and child should not be bathed or exposed to draughts.

**Major activities and achievements**

The liaison officers provide information and support to women both before and after birth, and, where possible, assistance is given during birth. Various impediments to care were encountered by women with non-English-speaking backgrounds, among them the following:

- Lack of knowledge about the Australian system and the services available.
- Language and cultural barriers.
- Lack of family and other networks that might help the women to feel secure.

An important activity of the liaison officers consists of contacting the women early in pregnancy, providing information on obstetric services, and improving access to them. The women are also provided with explanations for tests and procedures conducted during pregnancy, so as to reduce fear, improve understanding and acceptance of what is done, and raise attendance rates. The knowledge of liaison officers and the care they provide to women with non-English-speaking backgrounds and their partners have reached a high standard.

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One indicator of the success of the programme is that participation in antenatal classes has improved since its introduction. Previous attempts by mainstream services to provide antenatal classes, particularly in the Arabic and Vietnamese communities, did not succeed. Now that classes are being run by people who can speak their languages and who are aware of and sensitive to their needs, the women and some of their partners are keen to attend. Classes have been organized and run by liaison officers in all languages spoken. Attendance has been high, reflecting the women’s desire to learn about their bodies and pregnancy. A birth plan has been developed to enable each woman and her support person to make informed decisions and to express their individual needs and preferences for the options available as they prepare for labour and childbirth.

At present the liaison officers visit three hospitals attended by a large number of women of non-English-speaking backgrounds. Contact is made with each maternity unit by either a daily visit or telephone call in order to find out whether there are any new arrivals. In addition, maternity staff make individual requests for liaison officers to visit particular areas.

A weekly movement sheet, which is updated each month, is distributed to all maternity areas to advise staff of contact points for liaison officers. The officers do not provide hands-on care. The amount of time that liaison officers can dedicate to giving support in delivery is limited because of other commitments, among them antenatal classes and postnatal education. In most instances a support person is organized prior to admission. However, the officers provide support if possible when this is requested.

Mothers can also request support from the liaison officers in connection with early discharge, postnatal follow-up, and babies in special care nurseries. Concern was expressed initially by certain staff on postnatal wards, particularly in relation to unregistered liaison officers and those who had not practised in
New South Wales. To meet these doubts, arrangements were made with the midwifery educators in each hospital to assess the liaison officers. Hospital policy and procedure is adhered to in all areas of postnatal care.

The programme has enabled hospital staff to be increasingly effective in meeting the needs of women with non-English-speaking backgrounds. The most common problems cited by staff in their dealings with the women related to communication, teaching mothercraft skills, understanding cultural practices, education about personal hygiene, and coping with relatives and visitors. Since the introduction of the programme, 78% of hospital staff have reported significant improvements.

**Bilingual Community Educator Project: cervical smears and breast self-examination**

In 1990 the Brisbane Women’s Health Centre was funded to employ a multicultural worker to identify pressing health concerns for women with non-English-speaking backgrounds. Breast and cervical cancer were identified as sensitive key areas in which it would not be possible to conduct group sessions through interpreters. Bilingual community educators who were familiar with the cultures of the target groups were considered to be more appropriate.

**Recruitment and training**

The communities chosen to participate in the project were Arabic, Chinese, Croatian, Greek, Italian, Philippine, Samoan, Serbian, Spanish-speaking, Tongan and Vietnamese. The project was discussed with welfare workers from these communities, and it was agreed that the major requirements for the educators would be fluency in both English and their native language, a background in nursing, teaching, welfare or health education, and a good knowledge of the networks in their communities. After selection, the educators attended a one-day training workshop comprising small groups that focused on breast and cervical cancer. A representative of the Brisbane Royal Women’s Hospital spoke about cervical cancer and examination of smears, and one from the Queensland Cancer Fund discussed breast cancer and breast self-examination.

Details of the project were publicized in a leaflet, a newspaper advertisement and a radio announcement translated by the educators. The leaflet was printed by the Women’s Health Centre and the radio announcement was made by the educators over a multilingual radio station at hourly intervals during a two-week period. Word-of-mouth methods were also used by requesting key people to publicize the project among members of their communities.

There was a varying response to the pre-programme publicity. The highest level of enthusiasm was displayed by communities with well-established networks. The initial information sessions were conducted at diverse venues, including community centres, church halls, social clubs, private homes and the premises of ethnic and welfare organizations. Over a period of six weeks, 767 women participated in 80 group sessions. These meetings revealed many reasons why cervical smears were not taken regularly, such as:

- lack of awareness of the procedure and/or its significance;
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- fear of receiving bad news: many women said they would rather not know if they had cancer because nothing could be done about it;

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- embarrassment and shame, heightened by a lack of female doctors;
- belief that women aged over 45 years did not need examination of smears;
- lack of knowledge about services;
- language barriers.

It also emerged that very few of the women knew how to perform breast self-examination.

From August 1991 to January 1992, a total of 210 women were organized in 12 groups to have cervical smears and mammograms at the Royal Women's Hospital or the Family Planning Association. Unfortunately, many of the women did not have their own transport and were nervous about using public transport as a means of travelling to unknown destinations. This problem was resolved when the organizers managed to arrange free transport in buses.

The need to use interpreters lengthened the procedures and this frustrated hospital staffs. Many Chinese and Vietnamese names had been incorrectly entered in the computer booking system and consequently were difficult to retrieve. There was lack of knowledge of the administrative system, and many of the women did not know their dates of birth, an item of information which the staff considered essential. Only after considerable persuasion by the multicultural workers did the staff accept that in some cultures such information is not regarded as significant.

Several women who could not attend on appointed dates sent a friend or relative along instead and reported at the next group session. Consequently, at each group clinic up to five women who had not been booked in were asked to go home. This upset the women, who had summoned up a great deal of courage to attend the clinic and felt very anxious about it. Much time was spent by the bilingual community educators in persuading them to make other arrangements. However, as the group visits continued the hospital staff learned how to deal with the women in a more sensitive and flexible manner.

Major achievements

The project benefited both the educators and the participating women. It helped to raise the self-esteem and feeling of usefulness of the workers, who, like many other immigrants, had suffered because their overseas qualifications had not been recognized in Australia. The participating women reported a raising of both awareness and confidence levels. The staff of the participating organizations were sensitized to the problems experienced by women with non-English-speaking backgrounds in their attempts to gain access to the health services.

The Brisbane Women’s Health Centre has been given further funding for the continuation of the project because of the success achieved so far. Funds have also been granted to two other women's health centres that have decided to adopt the same model.

Previous health promotion campaigns in Australia have tended to regard the population as
homogeneous, and it was assumed that the provision of information to people would be enough to enable them to gain access to health services. In recent years this approach has proved too simplistic. Health education may create awareness but does not necessarily result in healthy behaviour or better health. It would be incorrect to explain this in terms of people being lazy or superstitious. The women’s health movement has highlighted the special problems facing women, although gender alone does not account for all the problems. Social class and ethnicity are also important, especially for women with non-English-speaking backgrounds.

Both the Ethnic Obstetric Liaison Programme and the Bilingual Community Educator Project identified and addressed the following issues.

- The need to provide linguistically and culturally appropriate information to women with non-English-speaking backgrounds.
- The need to recruit and train workers with whom the women can relate. The Ethnic Obstetric Liaison Programme demonstrated that unduly strict adherence to qualification requirements can impede this process and that it is necessary to recognize the importance of linguistic and cultural skills and of the ability to build a relationship of trust with people.

- To be fully effective, health promotion programmes should target not just the clients but also the health service providers.
- Health promotion should focus not only on health issues but also on the related matters of access, child care and the understanding of administrative procedures.

The models reviewed here are well worth considering in health promotion strategies for women from ethnic minorities living in multicultural societies.

References
2. Culture, communication and health care. Connexions, 1993, 3 (Newsletter of the Ethnic Health Policy Unit, Queensland Health Department; available from GPO Box 48, Brisbane 4001, Australia).