To: Mr Elton Humphery
Secretary
Committee of Community Affairs
Gynecological Cancer Inquiry
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Submission to the Australian Government Gynecological Cancer Inquiry from the Queensland Multicultural Health Network

The Queensland Multicultural Health Network is committed to information sharing, networking and advocating to ensure the health needs of people from culturally and linguistically linguistic backgrounds in Queensland are met. The Network has approximately 80 agencies, both government and non-government with a sub-branch in Townsville, as well as other interest sub-committees (e.g. Mental Health). The Network has been in existence for over 10 years but has been convened through the Multicultural Development Association Inc. since 1999.

Members of the Network appreciate the opportunity to provide input into the Gynecological Cancer Inquiry. Significant barriers exist for many women from culturally and linguistically diverse (hereafter CALD) backgrounds in accessing health services, especially with sensitive health issues. Of particular concern are refugee women who are at risk, given their history and special needs. Guideline 94 in the Guidelines on the Protection of Refugee Women mentions 'gynecological services are frequently inadequate'[1] and highlights the need for health services to provide specific healthcare for refugee women.

This submission addresses the following terms of reference:

c) Capability of existing health and medical services to meet the needs of Indigenous populations and other cultural backgrounds; and those living in remote regions;

With particular reference to the needs of women from other cultural backgrounds (i.e. culturally and linguistically diverse), the Queensland Multicultural Health Network submits that existing health and medical services do not sufficiently meet these needs due to a number of factors, including language and cultural barriers.

[1] Guidelines for the Protection of Refugee Women, Office of United Nations High Commissioner for Refugees JULY 1991

Many women from culturally and linguistically diverse backgrounds in Queensland experience a number of barriers to equality of access to and level of service within the health and medical services.

A US National study[2] revealed that disparities do exist in the quality of care received by minorities and non-minorities and those sources of these disparities range from the way healthcare systems are organized and operate, patients' attitudes and behaviours, through to health care providers' biases, prejudices and uncertainty when treating people from minority backgrounds.

A recently published review into the Queensland Health System[3] recommended culturally safe and accessible health services for people from CALD backgrounds as a priority because of the current health inequities for these people compared to the general population.

The use of interpreters in the provision of health care in Queensland has be an ongoing issue for CALD communities and one that has been highlighted by the Queensland Multicultural Health Network. The 2004 report *Lost in Translation – a Discussion Paper on Interpreting Issues in Health Care Setting in Queensland*[4] highlighted significant problems with interpreting services.

Treat Me Fairly, the final report of the Complaints in Health and Employment, Equity and Rights (CHEER) project[5] reported that interpreters are often not offered or that patients are unaware of their rights to request an interpreter.

The report said a common mistake was the perception that because a person spoke some English, this meant an interpreter was not necessary.

> *One worker spoke about a woman who had been to see a doctor. She spoke some basic English and so the doctor did not use an interpreter. The doctor explained to the lady what was wrong with her. She went home shocked, because the word in English used by the doctor was close in her language to the word for Leukemia. She didn't know how to talk to her family to tell them that she was dying.*[6]

The report also reported some patients being provided with interpreters who spoke a completely different language to them or with a dialect so different from their own that they were impossible to understand.

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[2] Institute of Medicine (2002) *Unequal Treatment: What healthcare providers need to know about racial and ethnic disparities in healthcare*, National Academy of Sciences, United States of America
[3] Queensland Health Systems Review Final Report, September 2005
[4] *Lost in Translation – A Discussion Paper on Interpreting Issues in Health Care Setting in Queensland*
[5] *Treat Me Fairly*, final report of the Complaints in Health & Employment, Equity & Rights Project, Multicultural Development Association, 2005.
[6] *Ibid*, p51

Many people reported requesting an interpreter of the same sex but finding at their appointment that the booked interpreter was of the opposite sex. This is particularly distressing for appointments regarding a gynecological matter. A community worker in a regional area of Queensland reported that a Sudanese client refused the offer of an interpreter because she knew the only interpreter available in the area was a man.[7]

Aside from the interpreter issue, the cultural and socio-economic issues affecting many women from CALD backgrounds accessing health and medical services to meet their needs, particularly in relation to gynecological cancer, its early detection and treatment, require a multifaceted approach from health, medical and community services.

The Cancer Prevention Program for Women from Culturally and Linguistically Diverse Backgrounds in the Logan and Beenleigh Area in 2003 aimed to increase the number of women from CALD backgrounds regularly using cancer-screening services.

'The program demonstrated that there are no simple or quick "fixes" to achieving this aim.'[8] The final report of the program recommended an integrated strategy 'which addresses barriers across each to the three areas of awareness and knowledge, access to services and cultural appropriateness of services'[9]

The report emphasized the need for such a strategy to include a community awareness component and a health services development component. A copy of the report's recommendations has been included as Attachment One in this submission.

In many regions women from CALD backgrounds are more disadvantaged due to their small numbers and isolation from their own communities. The availability of interpreters and bi-cultural support workers is also significantly less, which impacts on CALD women accessing services for either detection or treatment purposes.

d) Extent to which the medical community needs to be educated on the risk factors, symptoms and treatment of gynecological cancers;

The medical community not only needs to be better educated on the risk factors, symptoms and treatment but also on the perceptions, fears and reluctance of many women, particularly women from CALD backgrounds, to discuss their symptoms or readily understand treatment options etc.

A recent project in Queensland "The Logan and Beenleigh Cancer Prevention Program" found that the information given by medical professionals, and the manner in which it was given, had a significant impact on the responses of women to the program.[10]

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[7] *ibid*
[8] Cancer Prevention Program for Women from Culturally and Linguistically Diverse Backgrounds in the Logan and Beenleigh Area 2003, *Final Report* p31
[9] ibid
[10] ibid

Many women have come from a culture of reverence for doctors and find it difficult to question their doctors or ask for fuller explanations. On why one woman considered cancer screening unnecessary she said 'I have a very good doctor. She cares for me. She knows even my children's names, she asked me how were they. She never told me…if I need it my doctor would tell me.'[11]

It is not uncommon for medical or health practioners to underestimate the power that cultural beliefs play in many CALD women either accessing care or undergoing medical procedures and treatment. Health professionals need the interpersonal skills and information to discern if cultural views and beliefs will obstruct any diagnosis or treatment required. The cooperation and comfort of the client is paramount to ensuring appropriate and necessary medical care, particularly for CALD women who are not fully versed with the Australian health system, including specific health treatments.

e) Extent to which women and the broader community require education of the risk factors, symptoms and treatment of gynecological cancers

As the National Breast Cancer Centre argues, 'language barriers and cultural misconceptions have the potential to stop women receiving vital support and information'.[12] They cite the following examples of cultural misconceptions:

- Explanations of cancer among Chinese women referred to concepts of karma, retribution and fate.
- Many Vietnamese women tend to have a fatalistic approach to cancer, accepting illness as part of one's destiny.
- When speaking about cancer, many Italian women tended to avoid the name of the disease and instead spoke about 'that terrible illness'
- In the Greek community there is a stigma attached to receiving a cancer diagnosis and some believe cancer is contagious.[13]

Not only are there many cultural beliefs that may impact on how a person from a CALD background receives the general health messages broadcast within the wider community, there are also differences in *how* people most effectively receive messages.

This is also supported by overseas research. Karen Jackson, an African-American woman who founded the Sisters Network Inc after surviving breast cancer has found that teaching people one-on-one works best. 'We go where the people are, door-to-door, to churches, to hair salons and talk to ladies under the hair dryers…it's what we call reaching the grass roots'.[14] Jackson's work within her own minority community

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[11] ibid p35
[12] '*Breast Cancer: Bridging the cultural divide*' Media Release published by the National Breast Cancer Centre
[13] ibid
[14] Davis, Jeanie, '*Seeking Equality in Health Care, For Many Reasons Some Minorities Aren't Getting Necessary Care*' WebMD Medical News, p3

demonstrates the effectiveness of peer education and understanding the people she is working with.

In Australia there is increasing recognition of the need to employ bilingual and/or bicultural consultants on many community development and education programs including health, which targets specific CALD communities. However it is imperative that health systems and providers ensure this occurs in both in systemic structures and is sustainable.

Any education program on particularly sensitive issues as gynecological cancer needs to be tailored to specific groups and involve the most effective methods of communication within those particular communities and include the use of bilingual/bicultural consultants in the development and delivery of such programs.

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Logan Women's Health Centre (2004) Cancer Prevention Program for Women from Culturally and Linguistically Diverse Backgrounds in the Logan and Beenleigh Area 2003, *Final Report*

Multicultural Development Association (2005) *Treat Me Fairly*, final report of the Complaints in Health & Employment, Equity & Rights Project.

Multicultural Development Association (2004) *Lost in Translation – A Discussion Paper on Interpreting Issues in Health Care Setting in Queensland*

National Breast Cancer Centre '*Breast Cancer: Bridging the cultural divide*' Media Release

Queensland Health Systems Review Final Report, September 2005

Attachment

Recommendations from the Cancer Prevention Program for Women from Culturally and Linguistically Diverse Backgrounds in the Logan and Beenleigh Area 2003, *Final Report*, published by Logan Women's Health Centre