

COMMON THREADS, COMMON PRACTICE

WORKING WITH
IMMIGRANT & REFUGEE
WOMEN IN SEXUAL &
REPRODUCTIVE HEALTH

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WORKING WITH IMMIGRANT & REFUGEE WOMEN
IN SEXUAL & REPRODUCTIVE HEALTH

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INTRODUCTION

Current evidence suggests that immigrant and refugee women have poorer health outcomes than Australian-born women, with a marked deterioration in their health status becoming evident within 3-5 years of settlement. With particular respect to sexual and reproductive health, immigrant and refugee women are at significant risk of adverse outcomes. They are less likely to have information about modern contraception methods, and less likely to commence timely antenatal care and/or access preventative services. Their poorer health outcomes are due to a range of factors, including barriers to accessing health services and the lack of culturally appropriate support.

While there is now a general acceptance of 'culture' and 'diversity' in health service delivery, there is still a lack of understanding of what is required to implement culturally appropriate and relevant services.

Immigrant and refugee women have the right to access culturally appropriate sexual and reproductive health services. A model of health that recognises the impact of

'Immigrant and refugee women' refers to all women from immigrant communities, including asylum seekers and women from both emerging and established communities. Unless otherwise stated, 'immigrant and refugee women' and 'women' are used interchangeably in this guide.

social, economic, cultural and political factors on health and wellbeing is the starting point for ensuring that women from these communities are receiving care that is both sensitive and responsive to their needs.

WHO WE ARE

The Multicultural Centre for Women's Health (MCWH) is a national, community-based organisation committed to the achievement of health and wellbeing for and by immigrant and refugee women. Its mission is to promote the wellbeing of immigrant and refugee women across Australia through advocacy, social action, multilingual education, research and capacity building.

MCWH advocates for a model of care that situates immigrant and refugee women's health needs at the centre of policies and practices. This is only possible if core ideas around social justice and equity form the basis of the provision of health.

AIM OF THIS GUIDE

To promote a gendered cross-cultural understanding and practice in the delivery of services for immigrant and refugee women based on best practice principles.

BACKGROUND

Our research shows that there is a need for more information tailored to best practice for working with women from immigrant and refugee backgrounds in sexual and reproductive health. This guide is the product of an extensive literature review of immigrant and refugee women's sexual and reproductive health, as well as key stakeholder consultations and focus group discussions with immigrant and refugee women themselves. This guide is based on those findings and accompanies the project report, *Common Threads: The sexual and reproductive health experiences of immigrant and refugee women living in Australia* (Hach, 2012).

A cross-cultural training program has also been developed from the Common Threads study. The training aims to provide community and health workers with an understanding of how to embed best practice principles into their work with immigrant and refugee women.

WHO CAN USE THIS GUIDE?

This guide is intended for health practitioners who work with immigrant and refugee women in sexual and reproductive health, community and clinical settings.

ABOUT THIS GUIDE

This guide has two parts. Part 1 examines the limitations of current models of cultural competency and common misconceptions of the term 'culture'. Part 2 puts theory into practice, and outlines four best practice principles for working with immigrant and refugee women. Scenarios are based on both the findings from Common Threads and MCWH's 34 years of knowledge and experience working with immigrant and refugee women in health.

'Women have the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice... and the right of access to appropriate health-care services...'

Cairo Declaration's definition of reproductive health. United Nations, 1994

WHAT INFORMS THIS BEST PRACTICE GUIDE?

This guide is informed by the principles of human rights, feminism and community development. Particularly drawing on the concepts of participation and inclusion, a rights-based approach provides the foundation for a feminist framework that emphasises non-discrimination and empowerment.

This framework provides a way of addressing inequity, injustice and disadvantages that impact on immigrant and refugee women's capacity to access sexual and reproductive health services.

BEST PRACTICE PRINCIPLES

The following principles are at the core of what we mean by best practice when we engage with immigrant and refugee women. These principles are the backbone of the MCWH's successful health education sessions which have been conducted in industry and community settings for more than 30 years. Sessions are conducted using a participatory model that acknowledges and respects the knowledge that women already have about their health and their bodies.

- ✔ WOMEN'S EMPOWERMENT
- ✔ CULTURAL AND LINGUISTIC APPROPRIATENESS
- ✔ ACCESS AND EQUITY
- ✔ COLLABORATION

PART 1

BEING 'COMPETENT' IS NOT ENOUGH

What constitutes competent practice in relation to social and cultural diversity and how do you know when you have achieved cultural competency? With the growing number of people from diverse cultural and linguistic backgrounds in Australia, there is an increasing need to re-examine the approach that clinical health services take in delivering culturally appropriate services.

The challenges associated with working with women from immigrant and refugee communities have been widely documented. Services have responded in some way to these challenges, through what is generally referred to as culturally competent practice. However, there is still a lack of understanding of what is required in the implementation and delivery of culturally appropriate services. Immigrant and refugee women in particular, bear the brunt of this failure.

WHAT IS CULTURAL COMPETENCY?

There is no single universally accepted definition of cultural competency. Part of the difficulty in defining cultural competency is the fluidity of the components contained in the term. Culture, by its very definition is constantly changing and evolving. Mainstream cultural competency models tend to represent culture as a set of traits or characteristics that can be 'known' which often results in cultural stereotyping. While there is not one model of cultural competency, conceptions of cultural competency in the health sector share a number of common characteristics. They tend to:

- Take a skills development approach. This approach assumes that once a certain amount of knowledge or skill is acquired, an individual is 'culturally competent'. It also assumes that skills are observable and assessable.
- Assume that cultural competency can simply be reached with training and interaction with clients from other cultures rather than recognise that it is a dynamic, continuous process.
- Have a 'one size fits all' approach to culture, which does not leave room for dialogue, flexibility or mutual exchange.
- Take a gender neutral approach.
- Downplay the specific and often sensitive needs of women from immigrant and refugee backgrounds.
- Link cultural competency to linguistic competency. Organisations and individuals often describe themselves as culturally competent if they have policies concerning the use of multilingual resources or interpreters. While linguistic appropriateness is important, it is not the only component of cultural competency.

‘The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.’

WHO, 2012

One of the problems with the cultural competency model is that it can take a 'one size fits all' approach to service delivery. Rather than take a perspective which acknowledges the social determinants of health, mainstream health initiatives continue to focus on individual risk factors related to physical health and do not consider how factors such as migration experience, education levels, income, and cultural norms impact health and wellbeing. Furthermore, the lack of a gendered perspective is particularly problematic when discussing immigrant and refugee women because gender and culture both have an impact on health outcomes.

Within this model, cultural incompetence is presumed to arise from a lack of exposure to and knowledge about the patient's culture, in addition to individual biases and prejudices.

An alternative approach is needed if immigrant and refugee women are to truly exercise their right to access culturally appropriate and relevant health care. What is needed is a gendered cross-cultural understanding of the needs of immigrant and refugee women. At a basic level, cross-cultural understanding can only be realised in practice if ideas about culture are redefined to encompass all the factors that make up immigrant and refugee women's complex and changing identities.

A complex understanding of culture is crucial to ensuring that women's diverse needs are accommodated. It is also important to understand that cross-cultural understanding is a continuous process of dialogue, reflection and mutual exchange.

WHAT IS CULTURE?

Culture is a term that is used freely, without much thought as to where it comes from, and how it impacts on our lives. We assume that we are who we are because of our experiences and belief systems. However, if we give it deeper thought we realise how all-encompassing and important culture actually is.

Culture is often described as the lens through which we view the world, meaning that our culture influences our perceptions and interactions in everyday life. For many of us, culture might be the food we eat, the language we speak and the religion that we follow. For many others, culture might influence their whole way of life and underpin all their beliefs, attitudes, and customs. Culture impacts social relationships, family life, child rearing, health and wellbeing.

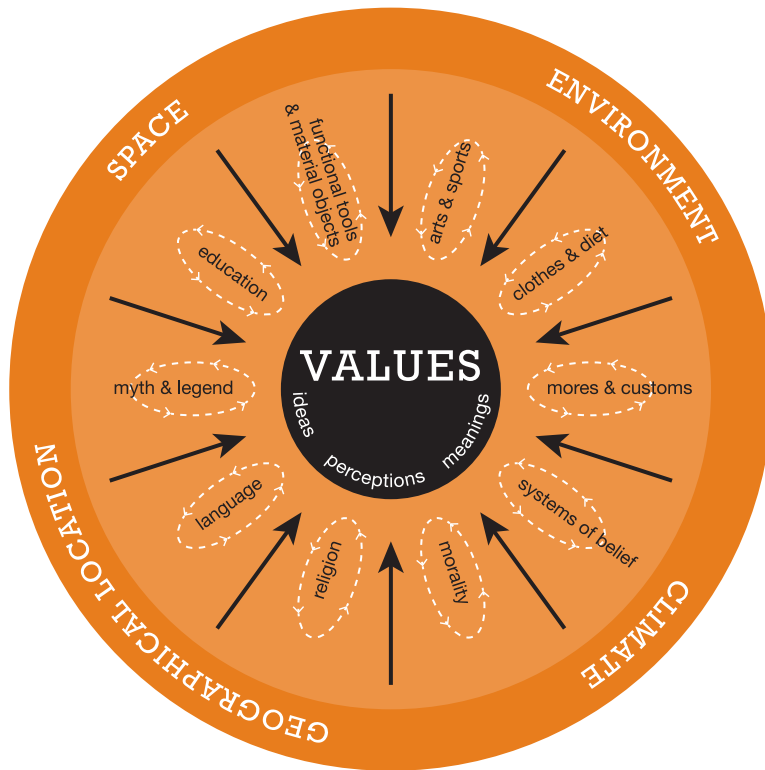
Individuals or groups may be influenced by the following:

- Cultural Identity
- Ethnic Identity
- Nationality
- Acculturation
- Class
- Education
- Language
- Literacy
- Perception of time
- Family configuration
- Social history
- Religion
- Spiritual views
- Gender
- Sexuality
- Political orientation

List adapted from the National Centre for Cultural Competence (cited in Ethnic Communities Council of Victoria, 2006)

'Culture is the distinctive way of life of the group, race, class, community or nation to which the individual belongs. It is the first and most important frame of reference from which one's own sense of identity evolves.'

O'Hagan, 2001



An understanding of the role of culture in people's lives is fundamental in terms of providing needs-based and person focused healthcare. Unfortunately, culture is frequently seen in narrow terms (usually as more or less equivalent to ethnicity and race) and this narrow definition is often what informs mainstream approaches to cultural diversity.

Culture and identity, two things that are inextricably linked, change and evolve. A static view of culture can perpetuate the belief that culture is primarily an 'ethnic' phenomenon rather than the notion that everyone has a culture. Groups that have more social power are generally seen as not having a culture and are excluded from the concept of cultural diversity.

Narrow definitions of culture can also lead to the stereotyping of particular cultural groups and the attitude that 'one approach fits all.' For example, representations of immigrant and refugee women are often limited in their diversity. The stereotype is that these women are all essentially married, heterosexual and always put their family's needs ahead of their own. Descriptions of immigrant and refugee women

tend to focus on their disadvantages and problems, and to construct women as passive victims who are subject to the control of their husbands, their cultures and their religions. Culture is seen as the cause of immigrant and refugee women's problems and something that can't change or be challenged.

Immigrant and refugee women are not a homogenous group. There is as much difference within cultures as there is in between cultures. Stereotyping a group means that they are not seen as individuals with distinct, individual needs. Immigrant and refugee women have different life experiences and, as such, have different ideas about health and goals for treatment.

CULTURE AND HEALTH

Culture and health are inseparable. Culture plays a part in the production, presentation and experience of illness and wellbeing. For example, how might culture and the migration experience impact on a refugee woman's sexual and reproductive health? Let's examine the scenario on page 12.

SCENARIO 1

Aabida arrived in Australia with her husband 3 years ago after spending almost 5 years in a refugee camp. She never finished high school because of the war in her country.

She had her first child in her home country, and she is now pregnant with her second child. Her husband is supportive and tries to comfort her when she is upset, but Aabida is anxious because when she had her first child, her mother and aunts were there to help her and made sure she followed traditional birthing customs.

As her husband works long hours, she is wondering how she will manage looking after two children as well as doing all the housework by herself.

When she went to the hospital in Australia for a check-up, the nurse became angry with her for not presenting earlier. She didn't understand what she had done wrong, because women who gave birth in the camps rarely saw a doctor or nurse before they went into labour.

She thought she was doing the right thing and she even made her husband take a day off work when she knows how hard it is for him to do so, so he could attend the appointment with her. Aabida is worried that she has harmed her baby but she is scared to go back to the hospital.

DISCUSSION

This scenario tells us that the migration experience can be a difficult and isolating one. Furthermore, health and a sense of wellbeing are inextricably tied to notions of family, kinship and cultural practices and traditions. As war broke out in her country, Aabida's education was interrupted so it is unlikely that she was ever taught about sexual and reproductive health. Everything she knows, she has learnt through her own personal experiences and from what others have told her in the refugee camp.

Aabida's story tells us that while cultural factors are important, health outcomes can be less about 'culture' (in its narrowest definition) and more about the political and socio-economic context in which a person lives. That is why a definition of culture must include not only ethnicity and race but also (at least) gender, age, income, education, and socio-economic status. Furthermore, as the scenario suggests, newly-arrived migrants are more likely to lack support networks and have competing priorities like gaining employment and learning English which often put sexual and reproductive health needs on the backburner.

8 THINGS TO KNOW ABOUT 'CULTURE'

- 1 Everyone has a culture.
- 2 Culture is individual. Individual assessments are necessary to identify relevant cultural factors within the context of each situation for each person.
- 3 An individual's culture is influenced by many factors, such as race, gender, religion, ethnicity, socio-economic status, sexual orientation and life experience. The extent to which particular factors influence a person will vary.
- 4 Culture is dynamic. It changes and evolves over time as individuals change over time.
- 5 Reactions to cultural differences are automatic, often subconscious and influence the dynamics of the health professional-client relationship.
- 6 A health professional is influenced by personal beliefs as well as by professional values.
- 7 The health professional/community worker is responsible for assessing and responding appropriately to the client's cultural expectations and needs.
- 8 There is as much difference within cultures as there are between cultures.

Adapted from College of Nurses of Ontario: Practice Guidelines, Culturally Sensitive Care, 2009. p. 3.

PART 2

FROM CULTURAL COMPETENCE TO A GENDERED CROSS-CULTURAL UNDERSTANDING AND PRACTICE

Being culturally competent (as it is widely understood) is not enough when it comes to working with immigrant and refugee women, particularly in terms of sexual and reproductive health. It is much more than just an awareness of cultural difference, and an understanding of cultural customs and traditions, although this is important. What is needed is cross-cultural understanding and an awareness of the relationship between gender and health.

Health professionals should understand how their own values and beliefs impact upon their interaction with clients, and how their cultural prejudices and assumptions might come across during care. By learning, implementing, and supporting the following best practice principles, quality of care can be strengthened for immigrant and refugee women.

PRINCIPLE 1 WOMEN'S EMPOWERMENT

Women's empowerment is a process rather than an outcome in which individual women who feel disempowered engage in dialogue with each other and come to understand the social sources of their powerlessness and see the possibility of acting collectively to change their social environment (MCWH, 2010). It implies that there are hierarchies of power that need to be recognised in the first instance.

Indicators:

- ✓ Health information is exchanged in a non-hierarchical manner and women feel safe to contribute their knowledge and experiences. Their choices are respected and considered within treatment options.
- ✓ The information shared increases women's knowledge about their sexual and reproductive health and builds their capacity for making informed choices.
- ✓ Encounters are non-discriminatory and non-judgemental, and conducted in a safe, non-threatening environment.
- ✓ The uniqueness of the experiences, needs and aspirations of each individual woman is respected and acknowledged.

You cannot fully comprehend the meanings of the cultural practices of another group. Every interaction with another person is cross-cultural. If you want to know more about women's beliefs and values, just ask. Cross cultural communication is about reciprocity and a willingness to engage in unfamiliar discussions.

SCENARIO 2

Lita is a young woman from the Philippines who has come to Australia to study marketing and international relations. She has had an Australian boyfriend for a year but they recently broke up. She has never been to a GP in Australia before, but she has missed two periods and thinks that she might be pregnant.

While the GP conducts a test for pregnancy, she asks Lita how she feels about the idea of being pregnant. Lita explains that she has been raised in a strict Catholic family and that she would be afraid to tell them.

As a Catholic, she does not agree with abortion, but if she is pregnant she doesn't think she will be able to complete her studies and she has no idea how she could financially support the child. She is on a student visa now, so she is afraid that if she doesn't keep up with her studies, she will violate the terms of her visa.

The GP suggests that Lita might want to speak to a counsellor of a similar cultural background to help her decide what she wants to do, and calls the local community health centre to help her to find one. She also suggests that a community legal centre can give her good advice relating to her visa, and gives Lita their contact details.

She discusses each of Lita's options in relation to her pregnancy, including methods of abortion, and she provides Lita with written material about each of her options. She offers to send Lita the information in Tagalog, if she would like, and she reassures Lita that it is her choice to make about her body and her pregnancy, and that the GP will support her decision, regardless of her choice. The GP then arranges a follow up appointment for Lita to get her test results.

DISCUSSION

The GP listened to Lita's story without making assumptions about her family background, cultural or religious beliefs. She was able to make Lita feel comfortable enough to talk about the personal concerns and questions she was facing and she responded to Lita's situation without judgment. The GP recognised and addressed the issues particular to Lita's situation, and was not afraid to seek external assistance and support for issues that were outside her expertise. She provided information about all of Lita's options both verbally and in writing, and provided her with culturally appropriate resources and support to build her capacity to make informed decisions. Finally, the GP reassured Lita that her health choices would be respected and that she would be supported in her decision.

PRINCIPLE 2

CULTURAL AND LINGUISTIC APPROPRIATENESS

Cross cultural understanding is about being responsive to immigrant and refugee women's cultural and linguistic needs. It is the recognition of women's complex and multiple identities along with the impact of added layers such as migration, settlement and socioeconomic context.

Indicators:

- ✓ A qualified interpreter is used when and wherever possible. The gender of the interpreter is considered.
- ✓ If the situation is not critical and the woman indicates she wants to learn more about her sexual and reproductive health, she is referred to a community health centre or organisation such as MCWH. (Sessions conducted by trained bilingual and bicultural health educators who share the same gender, cultural and linguistic background of participants are an appropriate and effective form of health promotion).

SCENARIO 3

- ✓ Encounters are non-discriminatory and non-judgemental, and conducted in a safe, non-threatening environment.
- ✓ Multilingual health information is provided to women and is available in a number of different mediums such as written information, DVDs, CDs, posters, charts and 3D models.

Mariam is a recently arrived refugee woman from Sudan. She has developed a good relationship with the nurse in the local community health clinic.

On a visit, she asks the nurse how to arrange for female genital cutting for her daughter. The nurse, having educated herself about FGC, understands the cultural meaning and deeply ingrained nature of the practice in some communities. Although FGC is illegal in Australia and the nurse personally believes that it is wrong, she explains to Mariam in a non-judgemental manner, the potential risks and harm associated with the practice and the legal implications.

The nurse calls a FARREP (Family and Reproductive Rights Education Program) worker who she has worked with in the past, and asks for her advice about how to best handle the situation. She then explores the custom with Mariam and answers any questions that Mariam has.

The nurse also refers Mariam to the FARREP service as she knows that FARREP workers provide support to women and their families affected by FGC in a culturally sensitive and appropriate way. At the end of the discussion, the nurse provides Mariam with multilingual information about the sexual and reproductive health issues associated with FGC.

DISCUSSION

Regardless of her personal feelings about female genital cutting (FGC), the nurse understood this custom as a culturally complex one that is often viewed by family members as an important cultural tradition and a social necessity. The nurse discussed FGC with Mariam in a non-judgemental manner, while still informing her of the illegality of the practice in Australia and of the potential risks and harms to her daughter's health.

By approaching Mariam's inquiry in this way, the nurse had a better chance of preventing a practice that carries considerable risk of harm. The nurse also consulted with FARREP and offered Miriam multilingual education, increasing cultural and linguistic appropriateness.

Some communities & cultures favour & rely upon oral forms of information sharing. Being aware of this enables you to provide information for your client in the most appropriate form.

PRINCIPLE 3

ACCESS AND EQUITY

Barriers to accessing sexual and reproductive health services are complex and real for immigrant and refugee women.

Access and equity should be founded on social justice principles; immigrant and refugee women have the right to access affordable and culturally appropriate sexual and reproductive health care. While equality means that individuals receive the same services regardless of their level of need, equity implies that people's access to services is based on the need for those services. Specific structures and policies should be put in place in order for women to exercise their right to access affordable sexual and reproductive health services.

Indicators:

- ✓ Additional time and resources are available for immigrant and refugee women, including flexible, longer and multiple appointment times.
- ✓ Information and delivery is tailored to the specific and diverse needs of all immigrant and refugee women, including women with disabilities, same-sex attracted women, outworkers, shift-workers, mothers, carers, rural women, young women and newly-arrived women.
- ✓ Encounters are non-discriminatory and non-judgemental, and conducted in a safe, non-threatening environment.
- ✓ A qualified interpreter is used when and wherever possible. The gender of the interpreter is considered.
- ✓ Health providers or organisations have flexible hours. If this is not possible, they are able to refer women to organisations that provide sexual and reproductive health education and information in an outreach capacity. (For example, MCWH goes to workplaces, community settings, homes, educational institutions and other locations any day of the week and at any time of the day suitable to the particular group or individual).

'Access means that Australian government services should be available for culturally and linguistically diverse (CALD) clients and accessible by them. Equity means that these services and programs deliver outcomes for CALD Australians that are on par with those other Australians can expect to receive.'

DIAC, 2012

SCENARIO 4

Linh is a newly arrived young Vietnamese woman. She has a job working night shift at the chicken processing plant.

She has lower abdominal pain every time she gets her period, but does not know why. Due to the nature and hours of her work, she cannot find the time to access mainstream services. She is also worried that she will lose her job if she takes time off work.

As the pain grows worse, she finally makes an appointment with a local GP, as she doesn't know where to find a Vietnamese speaking doctor. The GP she sees is male, and she is very embarrassed that she has to talk to him about these sensitive issues. Although she has requested an interpreter and one is provided, the interpreter is also male.

The GP ascertains that Linh has a very basic level of knowledge about women's health and her body and senses that she is very uncomfortable and distressed to be there. He provides her with the name of some medicine to take for her lower abdominal pain but also looks up other clinics in her area with Vietnamese-speaking female GPs.

Linh indicates via the interpreter that she wants to know about contraception options and the menstrual cycle. The GP understands the difficulties with Linh's work hours so he contacts a women's health organisation on her behalf and arranges for a Vietnamese Health Educator to visit her at home, at a time of her convenience. He also asks the organisation to send Linh information in Vietnamese.

The GP assures Linh that it is a free service.

DISCUSSION

The GP's commitment to client-centred care prompted him to explore ways of meeting his client's needs within the limits of the clinical setting. The GP was sensitive to the fact that Linh was uncomfortable because the interpreter that was provided was male. By referring her to an organisation that provides bilingual health education by women at any time, the GP provided Linh with greater access to health information. He was aware of Linh's financial situation and also made sure she knew that the service was free. The GP also encouraged greater equity and access by providing Linh with the names of other GPs in the local area who speak Vietnamese and also by providing information in Linh's own language.

PRINCIPLE 4 COLLABORATION

Collaboration is needed between organisations that work with immigrant and refugee women and mainstream health providers in order to share information and best practice ideas.

Collaboration also ensures that women are well linked with their local ethno-specific/multicultural women's health and welfare services.

Indicators:

- ✓ Mainstream health providers collaborate with women's ethno-specific/multicultural health and welfare agencies and refer women to appropriate sexual and reproductive services.
- ✓ Mainstream health providers collaborate with women's ethno-specific/multicultural health and welfare agencies to promote appropriate services among immigrant and refugee women.
- ✓ Community health centres collaborate with information centres that specialise in offering multilingual information about women's sexual and reproductive health.

SCENARIO 5

A Spanish speaking woman arrives at a local hospital with her 10 year old son. She is badly injured and appears very scared and shaken.

The woman speaks very little English. The child says he can interpret. A nurse sees the woman and decides not to use the son as an interpreter and instead calls for the hospital's Spanish interpreter. The woman tells the interpreter that she hurt herself in an accident. The nurse suspects a situation of intimate partner violence.

The nurse takes the son to the children's play area, where there are toys, magazines and a television.

After treating the woman for about half an hour, and with some gentle questioning via the interpreter, the woman reveals that her partner has been violent towards her, but that it was her fault, and she just wants to go home. The nurse listens without judgement and tells her about culturally specific organisations that work with women who experience violence. The nurse also prints off information in Spanish for the woman about where she can go for help. When the woman leaves the hospital, the nurse contacts the multicultural crisis support service, and notifies them of the incident.

DISCUSSION

While it is often convenient to rely on children to interpret for their parents, the nurse in this scenario was sensitive to the needs of the mother and the child. The National Health and Medical Research Council's (NHMRC, 2004) advice for practitioners on communicating with clients is that qualified interpreters should be used when and wherever possible. This is backed up by other cultural diversity guidelines at both national and state levels. In this situation, a qualified adult interpreter was required to ensure a thorough and comprehensive assessment. The nurse also suspected that domestic violence was involved, and displayed cultural sensitivity by not forcing her own ideas onto the patient, instead referring her to a multicultural organisation that works with immigrant women. The nurse has educated herself about where to go for multilingual resources about women's issues, and is able to provide this information to the woman.

THINGS TO THINK ABOUT – WORKING WITH IMMIGRANT AND REFUGEE WOMEN

- Everyone has a culture! Think about your own. What makes you, you? How might your culture influence your response to illness or the type of care you give your patients?
- You can never know enough. Seek to broaden your understanding about cultural ideas and concepts. Reflection and learning is an ongoing process.
- Be sensitive about issues of power, trust and respect.
- Cultural difference can sometimes mask other things such as socio-economic position, gender, class and age which might be more important to women.
- Make efforts to accommodate women's cultural values and beliefs in a way that does not compromise safety.
- Use open ended questions to understand women's beliefs and ideas.
- For example: What treatment do you expect? What fears do you have about your treatment? Do you observe any religious or traditional practices that will affect immediate care? Tell me about your migration experience.

WANT TO KNOW MORE?

You can access more information on cross-cultural understanding on our website or contacting us on the phone numbers below.

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Thank you to MCWH's Bilingual Health Educators whose dedication to best practice ensures that immigrant and refugee women are able to access health information in an empowering and culturally sensitive way. Your work has inspired this guide.

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