

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Melbourne — 27 November 2017

Members

Mr Paul Edbrooke — Chair

Ms Cindy McLeish — Deputy Chair

Ms Roma Britnell

Dr Rachel Carling-Jenkins

Ms Chris Couzens

Ms Maree Edwards

Mr Bernie Finn

Witness

Dr Adele Murdolo, Executive Director, Multicultural Centre for Women's Health.

The CHAIR — Welcome to these public hearings, Dr Adele Murdolo, Executive Director of the Multicultural Centre for Women's Health. Thank you for attending here today. All evidence at this hearing taken by the committee is protected by parliamentary privilege as provided by the Constitution Act 1975 and is also subject to the provisions of the Parliamentary Committees Act 2003 and other relevant legislation. Any comments you make outside the hearing will not be afforded such privilege. It is a contempt of Parliament to provide false evidence. These proceedings will be recorded, and you will be sent a proof copy of the transcript. I invite you to make a 10 to 15-minute submission, and after that we would love to ask some questions too.

Dr MURDOLO — Should I begin now?

The CHAIR — I see no reason why we would not begin. Everyone is across the submissions and whatnot, so they should have a fair idea already.

Visual presentation.

Dr MURDOLO — Thank you very much for the opportunity to present here today. I am from the Multicultural Centre for Women's Health. First of all I will introduce our organisation. We have been going almost 40 years. We started off in 1978 with a very small organisation that provided multilingual information about contraception to migrant women in factories. The reason we provided that information to migrant women in their language in an outreach capacity in their workplaces was that it was very difficult for migrant women to get that information elsewhere, and they did not have full control of their fertility and reproductive health, so they could not choose whether they had children or not.

We have now grown into a much larger organisation that covers a whole range of women's health issues, not only contraception, and we do health promotion still directly with migrant women in their language. We now have 17 bilingual health educators who are trained and accredited to do that job. We cover a whole range of women's health issues from reproductive and sexual health to mental health and family violence, and we still go into women's workplaces, their community settings and their educational settings and provide them with education over a four to eight-week period. So it is a great program that reaches women before they have a health issue that they need to go to a doctor or anyone about and provides them with the links into the health system.

The CHAIR — Adele, just on that, are the employers supportive of the organisation coming in and providing this information?

Dr MURDOLO — Absolutely. Well, I have to say that we probably approach about 100 workplaces, and out of those 100 workplaces only five will even agree to meet with us, but once they have agreed to meet with us, they usually agree to run the program in their workplace and, once they have run the program, we often have ongoing relationships with that workplace. They see the benefit for their staff in doing it. But with the other 95 per cent, I guess that is the group that needs a little bit more education about the benefits of health promotion in the workplace.

We have been doing that same work for about 40 years, and now we have a much broader spectrum of health issues that we deal with. We also provide links to migrant women for services that are important to them in that perinatal period. We refer them on to maternal and child health and hospitals.

There is one example that is a really good example of the kind of work we do where we visited a factory recently; actually it was probably about three years ago. One of the workers there was a very newly arrived migrant. She was eight months pregnant, she was still working in this factory and she had not yet booked herself into a hospital for the birth. She was also homeless. She was staying with family members; she did not have a home. Through our bilingual health education, one of our staff members spoke to her in her own language and we were able to link her to a hospital where she was also then linked into the social work department and she was found a home, she was booked into the hospital for the birth and a whole range of other issues that she had were addressed through the social worker at the hospital. This woman had not yet spoken to any health worker in Australia. So I think the kind of service that we provide is a really important one for women who cannot access the health system in any other way.

The reason why we do this work in the way that we do, in women's language and in an outreach capacity, is because international evidence shows us that for migrant women access to services is very limited, so they are

less likely to get antenatal care at an early point and much less likely to link into preventative services or even primary care services. It is the same with family violence; they are much less likely to get assistance at an early point, and so they end up overrepresented in the crisis or acute end of the system. Our approach is to try and reach women at an early point before there is a health issue that is presenting to them at a point where they can take some preventative action so that they can better understand what services are available to them and also take their own preventative action.

I would like to also fill that picture out a little bit more by talking about who I mean when I talk about migrant and refugee women and what the numbers are showing us now that our 2016 census results are in. We have approximately 3 million women and girls in Victoria, and of those women and girls, 29 per cent are born in a main non-English-speaking country. There are about 1 million who are born overseas, but when you take away countries like England, the US, Canada and New Zealand, we have 885 061. That makes up 29 per cent of our female population, so it is a sizeable number of women who are born overseas in a non-English-speaking country.

Some of the trends that we note in our data collection are that there is quite a mix of temporary and permanent visa status amongst those women, and it is roughly half and half. There is a high unemployment rate. It is higher especially amongst newly arrived women than other women and higher than among men who are newly arrived, and there is a low labour force participation rate. We also know that there are high levels of social isolation amongst migrant women, a high level of financial stress and vulnerability to family violence, and I will go through a little bit of the research as well that shows us all of that.

When we look at the top countries of birth, probably no-one would be surprised to know that they are China, India, Vietnam, Philippines, Malaysia, Sri Lanka, Indonesia and Thailand, and we still have significant numbers of women born in Italy and Greece. It is quite a good spread of countries of birth and experiences. Also I guess the Italian and Greek numbers are reflecting the postwar migration period, but the other numbers are still looking at the newly arrived women.

One thing of note as well is that the age structure amongst women born in non-English-speaking countries is quite different to other age structures in the sense that there is a high proportion of migrant women of childbearing age. Those two dot points are a little bit complex; the figures are kind of similar. But if you think about it, out of all of the women in Australia aged 25 to 44 years, 36 per cent are from non-English-speaking countries, so they are overrepresented in that age bracket. So when we think about the services that we have available for women who are of childbearing age we really need to think about making those services accessible for roughly 36 per cent of our female population.

Now we have Australian data — the second-last and last dot points there. We also see migrant women born in non-English-speaking countries overrepresented in the numbers of women who are giving birth. Even though that group of women make up that 24 per cent to 25 per cent of the Australian population, they make up 31.6 per cent of women giving birth, and 20 per cent are from Africa, the Middle East and Asia.

Ms McLEISH — With the first dot point, is that Australian or Victorian data?

Dr MURDOLO — The first dot point is Victoria, and the second and the third — the last two — are Australian data because we do not have the Victorian data about that. But we would expect that it would be the same or even a little bit higher.

Regarding English proficiency, we have 266 000-odd people living in Victoria who say they have low English proficiency, and women represent 57 per cent of that group, so they are more likely not to have good English compared with men in their group.

The CHAIR — Adele, can we get a copy of this presentation as well?

Dr MURDOLO — Sure, very happy to provide that.

We also know that women with dependent children make up 25 per cent of that group of women who do not speak English well, and 15 per cent, or 22 378 women, have children between zero and 12. So I guess the significance for me of that data is that if we were to be thinking about specifically targeting programs to a particularly vulnerable group of women, it might be that group that we are looking at — women who do not

speak English very well and who have young dependent children — and that would be looking at 22 000 women in Victoria. So that is the data.

The next part of this presentation is really about what the research is showing us, and we have done this research because the very little that we know about migrant women's access to services has concerned us a lot and at the other end the health outcomes for migrant women concern us even more. That point that I mentioned earlier was about migrant women turning up in the acute and crisis end of both the health system and family violence system. Another trend is that migrant women actually come to Australia in quite good health. It is called the "healthy migrant effect", because there are a lot of health tests that migrants need to go through. They need to show a good clean bill of health in order to be accepted into the migration program, so we do get really the fittest. They are the healthiest. They tend to come in their healthiest years — you know, aged 20 to 30 — so we do get very healthy women, but there is a trend downwards in health over the first five years of living and working in Australia, and that is consistent with international data as well for migrants in general.

So all of this concerns us I guess, and that is why we do research to find out how things are. What kinds of things are putting the health and wellbeing of migrant women at risk, and in this case mothers and babies? So here is just a little overview of what the research is telling us about the availability and quality of perinatal services for migrant women. We have looked at an international systematic review, which basically looks at all the literature that is available out there and analyses that systematically — and this research included Australia but also the US, Canada and other countries — and that review found that there were poorer pregnancy outcomes among immigrant women in general.

We also know that there is limited access to satisfactory culturally appropriate perinatal care, and by that we know that migrant women are dissatisfied with the care that they get and they talk about there being communication difficulties and they do not experience what they expect to experience. Many women report that interpreters are not used or family members are used, and this is another point here, but they experience discrimination, prejudice and communication problems during maternity care. So there is quite a body of literature out there that is showing that we are not providing the kind of services that we need to provide in our health system.

We know that there is late presentation for antenatal care in Australia as well amongst migrant and refugee women.

Ms McLEISH — Sorry, what was that?

Dr MURDOLO — Late presentations for antenatal care — so later than the general population — which of course is a problem for a whole range of factors, including the health of the mother and baby throughout the pregnancy, but also the opportunities that we have for screening for other health issues during that antenatal period is a really important opportunity. I think the reform in the family violence sector is looking at that as a possibility, but I think one of our concerns is that migrant women will miss out on that screening as well because they are presenting late.

Another thing that we find from the research is that there is an increased risk of perinatal death and adverse birth outcomes for women from East Africa in particular. So one of the things we found from the research is a bit of an uneven result in terms of what the findings are. Some research shows us that there is no disadvantage to migrant women in terms of birth outcomes and other research shows us that there is. What we think this is due to is that there are some groups of migrant women that are at more risk, and when the studies have focused on specific groups they do find an increased risk. So this research that looked at East African women in particular found increased risk of poor outcomes. Similarly — that next dot point — this study that was done on Lebanese-born women found an increased risk of stillbirth amongst that group.

Ms BRITNELL — Was that stillbirth or stillbirth and perinatal death? Because that is lower than the 8.8 per 1000, but it depends on whether it is specific to stillbirth.

Dr MURDOLO — I can follow that up. I am not 100 per cent sure.

The CHAIR — That would be good, thanks.

Dr MURDOLO — An interesting point for us also is that we know that the teenage pregnancy rate in Australia is fairly low, but there are some groups of migrant women amongst whom the teenage pregnancy rate is quite high, so between 15 and 19, and Lebanese-born women are one of those groups. That is I think something that is of note when we are designing services as well — that there is a cohort of younger women who we need to be providing appropriate services for.

We have also looked at perinatal mental health because we know that there are obviously links along the chain, and we have found two international systematic reviews, which is pretty sound evidence, that migrant women experience many of the risk factors of perinatal depression and anxiety. So this is something that there has been very little research in Australia on, and I think that is something that there could be a little more of, but we know that migrant women have low social support, can have a low level of partner support in some communities and a history of domestic violence. We know from some of our research that migrant women are more vulnerable to family violence, unplanned or unwanted pregnancy. If migrant women do not have access to contraceptive education and information and an understanding of the pregnancy process, they are much more likely to have unwanted pregnancies.

Regarding present or past pregnancy complications, when we have a look at some of the literature there are some groups that are much more vulnerable to having pregnancy complications: pregnancy loss; adverse events in life, which for refugee women in particular is an important point; high stress; high social isolation; socio-economic difficulty and poverty, and when we looked at the data earlier of high unemployment and low participation in the workforce, obviously it brings with it socio-economic circumstances that can be quite difficult; low proficiency in a host language; refugee or asylum seeker status; and minority ethnicity. Again, that data is quite significant for us in terms of higher risks for perinatal mental health problems. There has been some other research in south-western Sydney that found that the combination of financial stress and being born overseas was a significant predictor of maternal depression.

We did some research between 2014 and 2016 on migrant and refugee women's experiences of family violence, and that found that migrant women are more vulnerable to family violence due to structural and systemic factors. We interviewed 46 migrant women from Victoria and Tasmania for that research in partnership with the University of Melbourne and the University of Tasmania, and one of the significant findings was that at least six of the 46 women we interviewed were in what we described as extreme socially isolating circumstances, so their only contact for many years was their immediate families — so husband or husband's family — and they had no contact with services and very little outside social contact. So that rang alarm bells for us in terms of any person's needs for social participation.

Ms McLEISH — Is that in a particular area?

Dr MURDOLO — We did choose specific areas —

Ms McLEISH — Or a particular cultural group?

Dr MURDOLO — No, it was across cultural groups. We did choose specific areas, but we wanted to have a good mix of rural, outer urban and inner urban centres. Rural women were particularly isolated because there were not the services in the rural areas, but the women who were particularly socially isolated were living in outer suburban areas. It was not really about geography; it was more about the migration process — where they had come to Australia on a spousal visa or some kind of sponsorship or they were a secondary visa holder on a temporary visa and their main person and liaison between the world and their home was their husband, who was the perpetrator of the violence — so very, very difficult circumstances to be experiencing family violence in, and for many it was many, many years before they could escape their situation.

Of course what we do know as well from the VicHealth burden of disease data is that anxiety and depression make up 58 per cent of the disease burden resulting from violence against women. There are very strong links between family violence and mental health for migrant women. There have been some quite high profile cases in Victoria around maternal infanticide. Three of the women we have been having a look at in terms of those cases have been from migrant communities. The most recent case was Sofina Nikat, who was recently sentenced. I am not sure whether anyone has had an opportunity to hear the sentencing from Justice Lasry, but he made some very strong links between the woman's experience of family violence, mental health issues, social isolation and really Ms Nikat's capacity to cope in that situation. Obviously I am making no judgements or excuses, but we have a responsibility to have a look at that kind of perfect storm that is created when we see

that combination of family violence, social isolation and mental health issues. Of course, like the research is showing us, all of those seem to be consistent factors across most cases, including the factor of migration from a mainly non-English-speaking country.

What is needed? I guess you have heard a lot of negative stuff, but what are the answers? What do we need to see in our system? I think we definitely need to see some programs that are focusing on equitable access to services for migrant women. We need to turn that trend around where migrant women are seen less in the preventative system and more in the acute system, and we need to provide some opportunities for them to better understand what services are available to them at a really early point and make sure that they know not only what services are available but also what will happen when they get there, that they are culturally safe services, that they can get what they need from them and that the care that they receive is culturally responsive.

I think we need to look at some new models for maternal health care. We have been doing the same things for many years, but in fact our social context has changed a lot. We have a much more diverse cohort than we used to in Victoria. We have not quite caught up with that. We now have the challenges that are posed to us from increased temporary migration. Whereas before, with permanent migration, all women had access to our health system without having to rely on health insurance or without having to pay out of pocket, today we have a huge cohort of temporary migrants who are relying on the private health insurance that they have to take out in order to use our health system, and there are exemptions to what is claimable under their health insurance. Most notably for international students, for the first 12 months they cannot claim on pregnancy-related matters. From contraception right to birth in the first 12 months they are not able to claim on their health insurance, so they have to pay out of pocket for all of those expenses. That creates huge difficulties for women.

Ms McLEISH — That is the same, though, for everybody, isn't it? When you take out health insurance for the first time you cannot make claims on things like that for the first year.

Dr MURDOLO — Yes, but the difference is that for international students they do not have the option of using the public system instead.

Ms McLEISH — I see.

Ms BRITNELL — But you are not allowed to come to Australia without private health insurance, so it is a change to the need to have one that covers them straightaway for these areas.

Dr MURDOLO — Yes, and you can take pregnancy care out as an extra, but a lot of international students who come here are unlikely to ask their parents for pregnancy-related —

Ms BRITNELL — But if we are seeing the statistics of 35 per cent, or whatever it is, of people having children, it is not only students; it is —

Dr MURDOLO — It is not only students. That was just an example of where there are exemptions to what health insurance provides, and it leaves women without access to services. So I guess the issue is about what new modes of maternal health care we need to be really understanding of what that trend towards higher rates of temporary migrants means to our maternal healthcare system in Victoria, because we do have international students who do not have access to —

Ms BRITNELL — Unless the recommendation is that they cannot come without the health insurance that covers that if 35 per cent of people are having children of non-migrant or whatever —

Dr MURDOLO — It could be, yes. I would suggest, though, that the 35 per cent is less made up of students, because one of the things we also know from research is that there is a higher rate of termination of pregnancy amongst international students. They come to study; they do not come to settle.

Ms BRITNELL — No, that is what I am saying. So the recommendation is if anyone comes from another country they have to have health insurance to be able to enter the country so they are not a burden on the health service. There is a gap that we need to make sure is attended to.

Dr MURDOLO — Yes, and one way of attending to it would be to have another look at the deed that has been signed between the federal government and health insurance companies.

Ms BRITNELL — Correct.

Dr MURDOLO — Because that exception was not there before. I do not remember the date now, but we have had two terms of the deed, so 2011 is my best guess. Before that students had access to all pregnancy-related services. Once this deed was signed in response to the high rate of terminations on behalf of the health insurance companies, that has been the exemption that came in, and it has created quite a few problems for international students.

Ms BRITNELL — But not only students — it should be all people. It is not just about females — what we should be looking at.

Dr MURDOLO — Well, yes, all women should have access to pregnancy-related services, I believe. Also we have a much greater awareness of the impact of family violence, and that needs to become part of our understanding within our maternal health care. Our program which provides bilingual education I think is a really good example of a best-practice model that is evidence-based that we know gets to women at an early point and helps them access services.

I will provide you with our annual report as well, but on page 6 of our annual report we did a snapshot survey with 100 women who had used our service. We asked them, ‘Are you likely to do anything differently now that you have attended our program?’, and over 90 per cent of the women said that they would now visit a doctor or another health professional to talk about their health concerns. So it made a big difference to them in terms of understanding what services were available to them. Over 90 per cent said they would talk to their family about health concerns, so it was also a way of encouraging them to talk about what was going on for them. And then in lower numbers, but pretty much around the 70 per cent mark, they said they would change some of the things that they did — so the preventative health aspect of that — pay more attention to their health and wellbeing and share the knowledge that they have with friends and community members. We would suggest that a program that is able to reach women where they are without them having to call or without them having to go out of their way to access a service, to visit somewhere or even to use the internet for information, because we know that migrant women tend not to most generally, would be a really good addition to our programs that we have in Victoria.

We really need a better trained and qualified workforce to do this kind of work when we are thinking about a third of the population of women who are using these services. We need to make sure that there is a workforce that understands the context of women’s lives, particularly for mothers, and that is able to take a social model of health; it is understanding the systemic factors impacting on women. We also need a bit more training on non-discriminatory practice, because we have had reports from women that they have experienced discrimination.

The other gap of course is research and data collection, because I do not think we can say for sure that in the data collection area, for example, we know whether our services are actually responding to that 36 per cent, because the data collection is not telling us that. I think that if we were able to collect much more robust data, we would have a better indication of whether we do have good access to our services and what we can do about it, and of course further research. We have cobbled together the research that we know about from all over the world, but not very much of it is actually happening in Victoria, so it would be good to get a better handle on exactly what is happening in this context.

The CHAIR — Have you got time for some questions?

Dr MURDOLO — Absolutely.

The CHAIR — Because we would love to ask you some. Just in regard to the training that is already in place for healthcare professionals and hospital staff, what is your understanding of the education they go through for diversity, inclusivity and whatnot?

Dr MURDOLO — It is very ad hoc. Some health professionals do that kind of training, but there is no standard and it is not across the board. There is a whole range of different organisations offering the same kind of training that we offer, but it is not coordinated, and there are also private providers in that space as well. Yes, I think that there would be some benefit in coordinating that kind of thing and also making it either mandated or more attractive for health professionals to take part in.

The CHAIR — Also you gave the example of a woman who was eight months pregnant in the workforce. Are you able to just elaborate on how the labour rights of women who are pregnant in the workforce and from a migrant background are being protected?

Dr MURDOLO — We do have pregnancy discrimination, and I guess we do not hear a lot about those rights not being maintained. But again we do not really have the research. I know that the human rights commission recently did some research about pregnancy discrimination across the board, and they found that it is a problem in Australian workplaces, but we do not have the next layer of data that tells us how that impacts on migrant women. I guess that is a problem with the research, but of course we can expect that, given the vulnerability of migrant women in Australian workplaces, they would also experience that kind of discrimination.

Ms McLEISH — I have got just a couple of questions. We talked a lot during this inquiry about high risk and poor outcomes. You mentioned East African women. One of the things we have heard a lot of is the high risk associated with obesity and diabetes. I doubt that the East African women are obese?

Dr MURDOLO — It was not a part of the study.

Ms McLEISH — What are the high risk factors for them?

Dr MURDOLO — I think it comes down to their experience in the health system. If there is late presentation for antenatal care, that is one factor, because there is a lot that can be picked up and addressed at an early point in pregnancy. That can then impact on the outcome. There is discrimination that they have told us through the research that they experience in the health system. If they are not being treated equally or respectfully in the health system, then that is going to impact on their care.

Ms McLEISH — Is a poor outcome their physical health or their mental health?

Dr MURDOLO — Both.

Ms McLEISH — And the child?

Dr MURDOLO — And the child, yes. The other little bit of research we have done with La Trobe University most recently was called the LaCE study. The reason that research was conducted was that they found that migrant women were more likely to have intervention in their births, so our research was evaluating what the impact of having a birth companion with women in the birthing suite would be, and the ultimate aim was to reduce intervention. That had some really good findings. It was a very small study, so the findings were not enough to say definitively that that was something that was going to be of benefit to women. But there was also that lack of support in the birthing suite — lack of language support and also just someone who was able to negotiate an unsafe cultural environment for the women.

Ms McLEISH — You have actually started to address a couple of the questions that I had to follow on from that. One is about the late presentation for antenatal care. How can that be addressed?

Dr MURDOLO — I think we need to get to women at a really early point —

Ms McLEISH — How?

Dr MURDOLO — One example is the bilingual education that we have where in the woman's own language we go to reach women at an early point of arrival and access them where they live or where they work or where they have their children in day care or at school and provide them with the education about why they need to access antenatal care at an earlier point — what the benefits are to them. It even goes before antenatal care, because many of us know that folate is going to improve our babies' outcomes down the track, so we will start that before we even get pregnant. That kind of information would be really beneficial to migrant women at an early point. I think it needs to be in their language and it needs to be getting out to women where they are.

Ms McLEISH — You talked about culturally appropriate perinatal care and that in our birthing system there was a degree of dissatisfaction with language; interpreters are not used. Were those surveys done face-to-face or pen and paper? How were they done?

Dr MURDOLO — That is a good question. I would have to go back and have a look at the studies, but I believe it was qualitative data, so they would have had interviews with women. But I can come back to you about that.

Ms McLEISH — Yes. I was quite interested in what questions they were asked and particularly what their expectations were.

Dr MURDOLO — I think that generally our expectations when we use the health system would be that there is a level of understanding between the health practitioner and the patient who is using the system. I guess that is why we have an interpreter.

Ms McLEISH — Was that what they were dissatisfied with, or was it the system? Was it not understanding the language and not understanding what was going on compared to the level of health care that they were given? Were they dissatisfied with that?

Dr MURDOLO — Some of the research that we have done has found that women, when they get into an interaction, say, with a GP, would like to be able to tell their GPs more about their health conditions, but because they feel the doctor has only got a really short time to spend with them, and on many occasions an interpreter has not been arranged for them in advance, they feel like they cannot actually communicate with the GP. They just cannot actually talk about what their health conditions are, and that means that the care that is provided is then limited because the doctor does not know the full context. That is one example of dissatisfaction with health services.

Ms BRITNELL — I was thinking more about where Cindy was coming from, so she has probably asked a lot of the questions. I suppose if there is no interpreter there, they are often using the children —

Dr MURDOLO — Sometimes.

Ms BRITNELL — or the husband, and that may not be appropriate when you are talking about certain factors around women's health. I had not really thought too much about that before, but that is probably very challenging. There are so many languages that it is very difficult to have a system, but what about the interpreter phone service? Is that utilised, or are there problems with people accessing it? What are the challenges with that?

Dr MURDOLO — I think there are problems with people accessing, particularly for smaller languages because there is just not enough of a workforce out there. But even with the larger languages — people have told us about problems they have had getting Greek interpreters for health consultations that happen in the inner city, so I think there is an access issue. I do not know that there is as much understanding within the health system about the importance of using interpreters. Often the way we see it is that the woman needs help communicating. But I think that if we could turn it around a little bit and think about the need for a GP or a health practitioner to actually communicate, then we can see the interpreters as being there to assist the health professional rather than the woman, because communication is probably about 70 per cent of the effectiveness of that consultation.

Ms BRITNELL — Do you know if they are using the phone interpreter service?

Dr MURDOLO — Yes, I think all of the interpreter services are being used but not to the degree that they are needed.

Ms BRITNELL — So it is not that there is such a demand on the phone one that is not able to be met; it is that people are not utilising it?

Dr MURDOLO — That is correct. It is probably a bit of both actually. With the smaller languages there are just not enough interpreters available, and there have been shortages reported to us across the board, really, as well as health practitioners just not even picking up the phone to use the interpreter service or arranging for an interpreter to be present.

Ms McLEISH — With regard to the links to family violence, is there a link with particular cultures? You have listed the backgrounds that people come from. Is family violence stronger in certain cultures?

Dr MURDOLO — There is no evidence for that. None of the research that has ever been done has shown that it is more prevalent in one culture than another. It happens across the world, just in different ways. The ASPIRE research that we did a couple of years ago, which resulted in the report in 2016, found that cultural factors are important to the ways that migrant women experience violence, but structural and systemic factors are equally important — things like having access to services. Social isolation was a huge one that really contributed to their capacity to understand what family violence was and what to do about it. So I think they are both important factors.

Ms McLEISH — Moving country is extremely stressful. Has the family violence been pre-existing, prior to them coming to Australia, or has it been the stress of moving and settling into an isolated area?

Dr MURDOLO — Amongst the women we interviewed there was a bit of both. Some of the refugee women said that it started in the camp, when they were refugees in a refugee camp, and then continued in Australia, and some said it started in Australia.

Ms McLEISH — In their countries they had no family violence?

Dr MURDOLO — No-one said they had no family violence.

Ms McLEISH — You are saying that it either started in Australia or in the refugee camps.

Dr MURDOLO — Yes, that was the women who we interviewed, but research across the world shows that family violence happens across the world. It happens in every single country in the world. It just happened that the women we spoke to talked about it happening either as refugees or happening once they came to Australia.

The CHAIR — Interesting. Thank you very much, Doctor, for coming in today and spending time with this. You have given us a lot of information to go forward with.

Dr MURDOLO — Pleasure; thank you very much for the opportunity.

Witness withdrew.