



**Australian Multicultural
Health Collaborative**

OUR CULTURES
OUR LANGUAGES
OUR HEALTH

An initiative of



The Federation of Ethnic Communities' Councils of Australia

Note

The term 'culturally and linguistically diverse' with the associated acronym 'CALD' is currently used within Australian governments, the public and private sector, and in research and academic institutions to describe populations other than the Anglo-Celtic majority. The term "multicultural" is also used in these contexts. For this reason, this document uses both terms interchangeably. There is, however, increasing academic and community debate about the usefulness of the term 'CALD'.^{1,2,3} It is also suggested that the term is not readily understood or actively used by the communities which are defined by it. The Collaborative would support a national conversation towards agreeing on terminology that is understood and acceptable to communities, and that is useful in informing practical action to address health inequities.

ACKNOWLEDGEMENTS

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1. WHAT IS THE AUSTRALIAN MULTICULTURAL HEALTH COLLABORATIVE?

The Collaborative intends to work at the national level to give a voice to the broad health and wellbeing needs, including research, of Australia's culturally, ethnically and linguistically diverse (CALD) communities.

The Collaborative will represent the voices of wide-ranging CALD health and wellbeing issues at the national level through a formal membership structure which includes CALD consumers, together with health and wellbeing services, health and social care practitioners, researchers, and organisations and institutions for whom the primary focus is health for CALD populations (see Section 6).

The Collaborative welcomes as members 'mainstream' services and organisations with a significant commitment to CALD health and wellbeing, and will enter into partnerships with relevant national organisations.

The title 'Collaborative' is significant as an indication as to how members will work – that is, in genuine collaboration on agreed priority areas, drawing on each other's areas of focus and expertise on particular issues.

There are similar models for a co-ordinated national response from a range of **health-related, membership-based and representative groups**, including the National Aboriginal Community Controlled Health Organisation (NACCHO), the National Rural Health Alliance (NRHA), the National Ethnic Disability Alliance (NEDA), LGBTIQ+ Health Australia, and the Consumer Health Forum of Australia (CHF).

In the multicultural health sector, there are some national organisations with specific interests, including the Refugee Health Network of Australia (RHeNA) and the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT). They too are **membership-based and representative** and play significant roles in representing the issues of their constituencies.

The Migrant and Refugee Health Partnership (formerly the Migrant and Refugee Women's Health Partnership), auspiced by Migration Council Australia (MCA), has done significant work, primarily with various medical colleges, in developing clinical competency standards⁴ and a guide for clinicians working with interpreters.⁵

The Collaborative acknowledges the important work of RHeNA, FASSTT, SCoA, RCOA and the Migrant and Refugee Health Partnership and looks forward to supporting and promoting their activities.

2. WHY IS THE COLLABORATIVE REQUIRED?

Australians from CALD backgrounds form a significant proportion of the population. *Appendix A* provides an overview of key demographic information derived from the 2016 Census.

The establishment of the Collaborative is all the more timely because the inherent and ingrained health inequities and barriers to access recently exposed by the COVID-19 response have gone substantially unaddressed for decades.^{6 7 8 9 10}

As far back as March 1993, these very same issues were identified and discussed at length in an Australian Government National Health Strategy Issues Paper *Removing Cultural and Language Barriers to Health*.¹¹

The Issues Paper makes many salient observations, including:

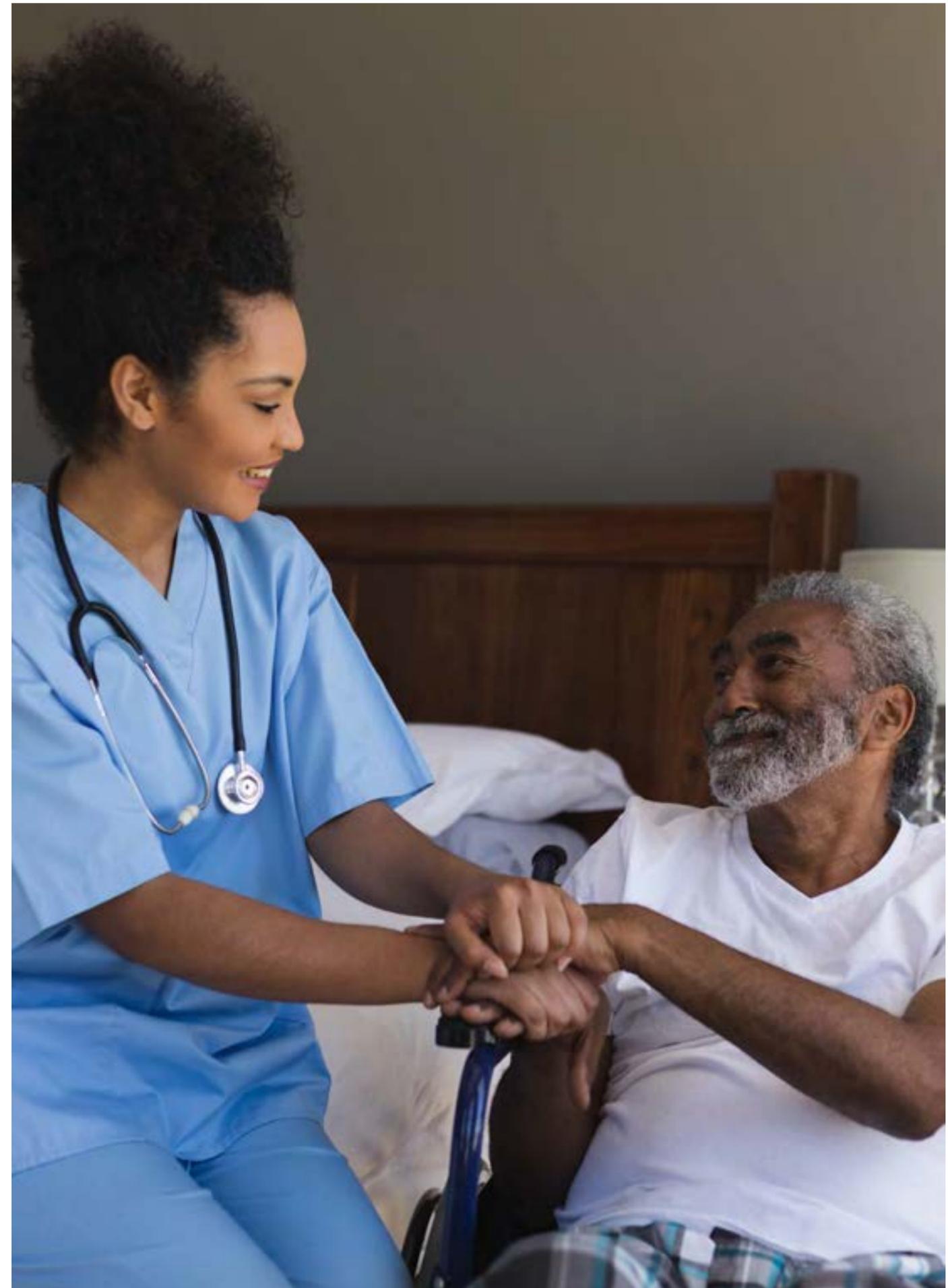
- In relation to service delivery: *"Community-based services are noteworthy for their relative success in responding to the needs of their local constituencies ... assisted with the direct participation of community members from non-English speaking backgrounds in managing their services, and in becoming attuned to local needs and accountability... Other services have been slow to respond ... hospitals and general practitioners do not utilise interpreters to their fullest potential. Services do not cope well with groups with special needs and are frequently not culturally appropriate for ethnic communities."*
- In relation to research: *"While there are many small studies, there is no coherent research examining specific health issues for people from non-English speaking backgrounds Data collections are ad hoc and unsystematic. In part this is due to methodological difficulties, but it also reflects the fact that the major health research funding bodies fail to prioritise this issue."*

Nearly 30 years on, the questions must be asked. What has changed for the better? What has not changed, and why not?

This is not to say that no progress has been made. There has been significant investment in migrant and refugee health, both in the community sector and in refugee health and transcultural mental health services within State and Territory Health Departments. In addition, RHeNA, FASSTT, the Settlement Council of Australia (SCOA), and the Refugee Council of Australia (RCOA) have advanced the health and wellbeing of newly arrived migrants, refugees and asylum seekers. The MCA auspices a Migrant and Refugee Health Partnership. A number of the Primary Health Networks (PHNs) have established dedicated programs/initiatives to address local CALD health issues.¹²

As the COVID-19 pandemic has shown, there are, however, still many issues to be addressed.

It must also be acknowledged that mechanisms are required to ensure that meaningful consideration of the social and cultural determinants of health and prevention are integrated into the development of policy, programs, service delivery and research.



At the national level, there must be a stronger focus to address systemic racism and health inequity in our health system to ensure that:

- National health and mental health strategies, plans, initiatives and policy are inclusive of and developed in consultation with and, where possible, co-designed with CALD communities. These should also include targeted strategies for CALD populations and targeted investment.
- Under-representation of these communities in social, health and medical research and clinical trials is addressed.
- National surveys that purport to represent the Australian population as a whole use sampling methodology that explicitly includes Australia's diverse communities.
- Significant and systemic data deficits in health research and service provision are acknowledged and resolved.
- Engagement with digital health initiatives (such as telehealth, electronic prescriptions and My Health Record) is improved.
- Appropriate language services are available.
- Education, training and support for health practitioners and researchers is enhanced.
- Across the social, and the health and medical research sectors meaningful and genuine consultation, collaboration and co-design occurs.
- The CALD health and wellbeing workforce is appropriately acknowledged and supported.

There is currently no broad national voice for CALD health consumers, for health services working with CALD people, or for health practitioners and researchers who may themselves identify as being from CALD backgrounds.

There are many academics and researchers who have published valuable insights into CALD health issues. However, serious gaps in multicultural health data and knowledge remain without a strategic multicultural health research agenda. Furthermore, all too often CALD people are not well represented in national surveys on health issues and are overlooked or excluded in health and medical research (including clinical trials) where English language proficiency is commonly an inclusion criterion.

There is therefore a clear need for a national voice on the broader issues of multicultural health and wellbeing.

3. WHAT ARE THE HEALTH INEQUITIES THAT THE COLLABORATIVE SEEKS TO ADDRESS?

The current COVID-19 pandemic has shone a stark spotlight on and has exacerbated health inequities already experienced by CALD communities in Australia, including in relation to mental health, aged care and disability.¹³

Although many of the issues described below may be construed as 'vulnerabilities', the Collaborative will adopt a strengths-based approach in addressing them and perceives that systems and services have left multicultural populations under-served, rather than inherent vulnerability causing health inequity.

3.1 Systemic Racism and Structural Barriers

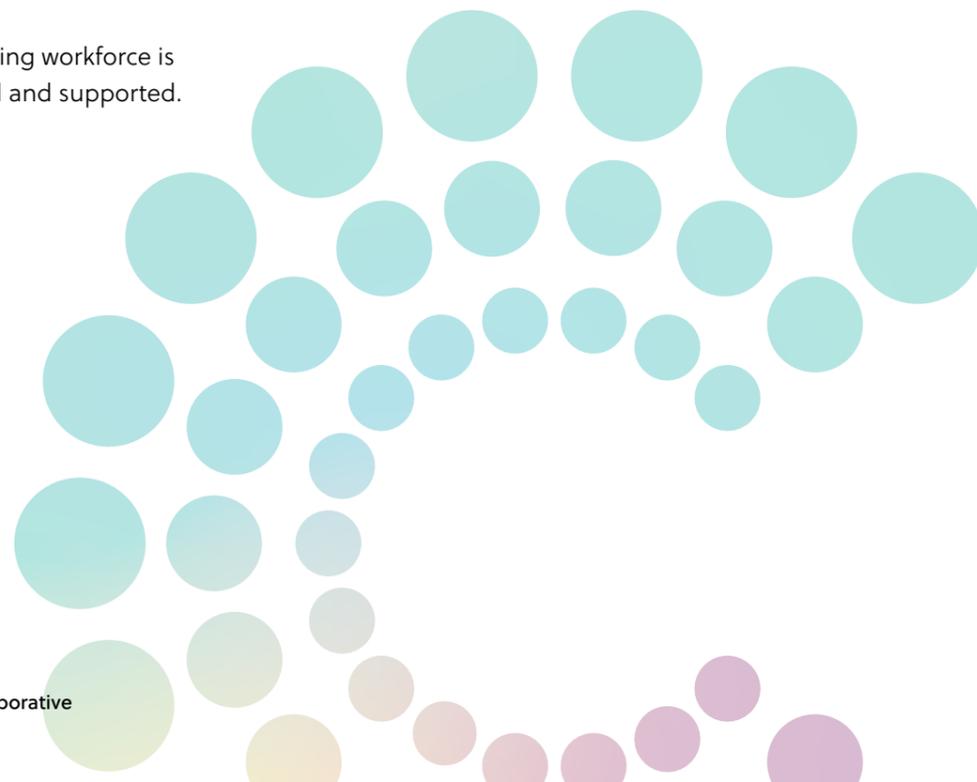
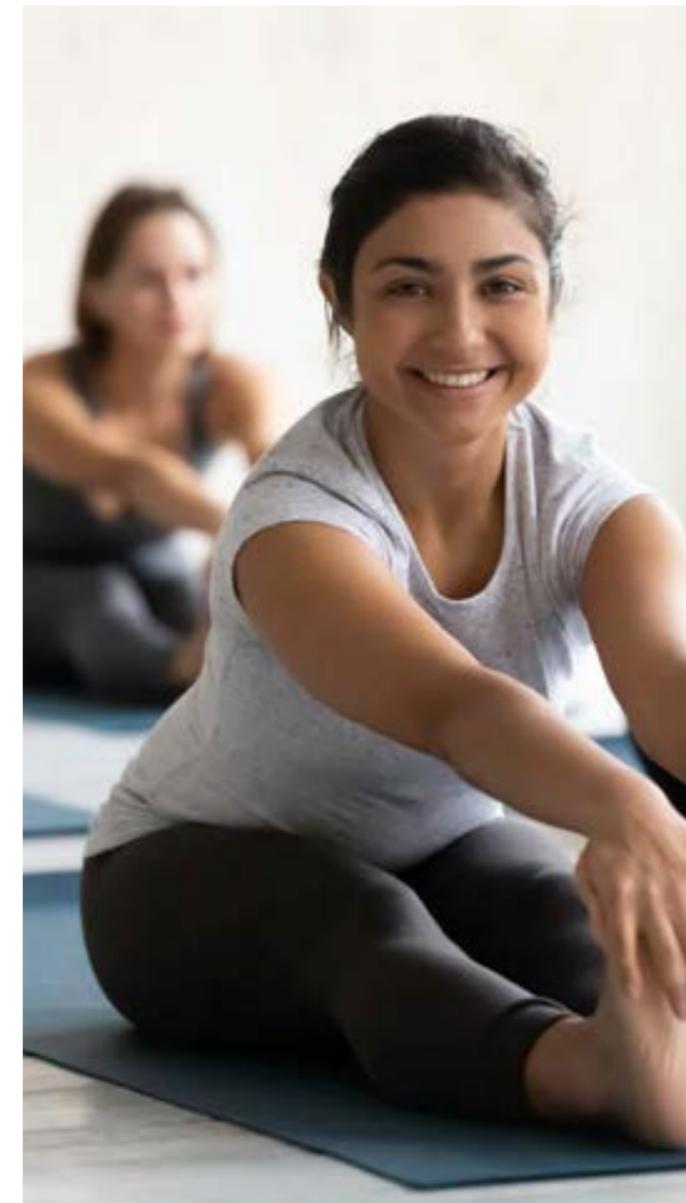
Health systems around the world have evolved in response to the perceived needs of the dominant cultural or ethnic group. Structural racism¹⁴ in a health system leads to a failure to be inclusive of the needs of other groups, and is a key factor underlying inequities and inequalities in health status, access to health care and impacts on the health workforce.

Health equity – the notion that everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential if it can be avoided.

Health inequities – differences in health status between population group that are socially produced, systemic in their unequal distribution across the population, avoidable and unfair

Health inequalities – factual and measurable differences in health status between population groups.

Source: [VicHealth](#)



The importance of addressing systemic racism is clearly articulated within the [National Aboriginal and Torres Strait Islander Health Plan \(2021-2031\)](#). Our CALD communities are similarly impacted though structural barriers to access and participation. These include, but are not limited to:

- understanding and accessing the complex Australian health care system, including mental health^{15 16 17}
- engaging with digital health platforms^{18 19}
- availability of culturally appropriate and resonant health information in languages other than English^{20 21}
- capacity of health services to provide care that is culturally appropriate, responsive and safe
- failure to include a CALD perspective in national policy development and service planning
- inadequate data²²
- exclusion from health surveys and from social, health and medical research, including clinical trials^{23 24}
- absence of national multicultural public health policy.

3.2 Cultural and Religious Influences

In addition, it is important to recognise that a person's cultural or religious background, particularly if they are recent arrivals, can impact on:

- perceptions of and beliefs about health, mental health and wellbeing²⁵
- beliefs about causes of disease
- lifestyle choices that can affect health status and outcomes
- attitudes to prevention
- how illness and pain²⁶ are experienced and expressed
- where and when people seek health care
- preferred treatments and therapies^{27 28}, including traditional medicine
- the involvement of families and carers in a person's health care and decision making
- practices around childbirth^{29 30}

- beliefs and practices about end of life, including advance care planning, palliative care and organ donation^{31 32 33}
- awareness about the role and value of clinical research.³⁴

The Australian mainstream model of 'patient-centred' care is predicated on a notion of individual responsibility. Many cultures adopt, however, a more collectivist or familial stance, and decisions about health care may lie with others apart from the patient.³⁵

Successful communication is vital in health care and, in addition to the need for accessible language services, there may be cultural constraints which affect consumers' communication and engagement with services and practitioners.^{36 37}

3.3 Ethnicity and the Cultural and Social Determinants of Health

It has been suggested that a person's ethnicity (which may be distinct from culture) may influence disparities in health outcomes. However, underlying these disparities are the social and cultural determinants of health, and the ongoing impacts of colonisation and racism. Some examples of these impacts are as follows:

- Low socio-economic status, poor education, loss of cultural identity,^{38 39} and experience of racism and discrimination^{40 41 42 43} linked with higher cardiovascular risk.
- Socioeconomic status (unemployment, poverty, lack of health insurance or paid sick leave, poor quality education), family or household composition, environmental factors (crowded housing, food insecurity, reliance on public transport, lack of access to the internet) associated with greater COVID-19 incidence and mortality.⁴⁴

The use of ethnicity in descriptive statistics can play an important role in identifying inequities in health outcomes. However, in Australia, data collected on ethnicity often inadequately describes our actual cultural, ethnic and linguistic diversity unlike in other comparable English-speaking countries such as New Zealand, the United Kingdom and the United States.



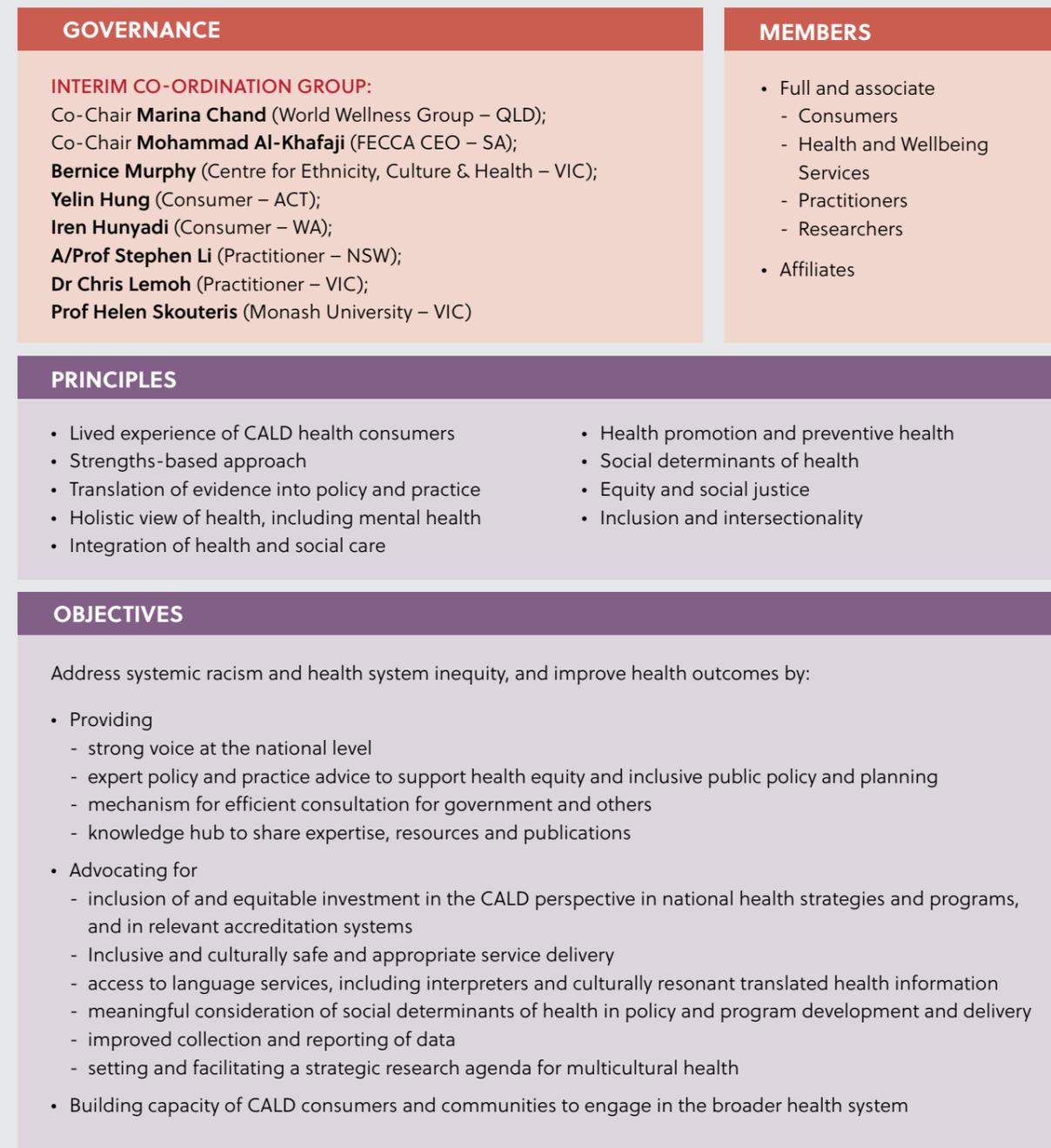
The impact of ethnicity on health outcomes must be interpreted carefully as it can amplify inequalities if used inappropriately,⁴⁵ and should be considered in conjunction with the considerable impact of social and cultural determinants of health⁴⁶ for which ethnicity is currently used as a proxy measure.

The involvement of the CALD communities in fields such as genomic medicine is required to ensure these technologies benefit all. While genetic variability within and among human groups does not follow racial or ethnic lines⁴⁷, it is important that CALD communities are appropriately represented in the participation, interpretation, and implementation of genomic research. Without their full engagement there are risks that inequities may be exacerbated through inappropriate interpretation of biased health data and the inappropriate integration of these data into genomic interventions.⁴⁸

Combinations of all the factors discussed above can lead to communities being under-served and to poorer health outcomes.



4. HOW WILL THE COLLABORATIVE FUNCTION?



4.1 Objectives

The objectives of the Collaborative are to address systemic racism and health system inequity by:

- Providing
 - a strong voice at the national level for CALD health care consumers, CALD health services, practitioners and researchers
 - national expert policy advice to support health equity and inclusive public policy and planning
 - a mechanism for efficient consultation for government and others
 - a knowledge hub to share expertise, resources and publications
- Advocating for
 - the inclusion of and equitable investment in the CALD perspective in national health strategies and programs, and in relevant accreditation systems
 - meaningful consideration of the social determinants of health in policy and program development and delivery
 - improved collection and reporting of data in relation to CALD communities.
- Setting and facilitating a strategic research agenda for multicultural health.
- Supporting initiatives to build the capacity of CALD communities to engage in the broader health system, including improving health and digital literacy.

4.2 Guiding Principles

The approach and work of the Collaborative will be based on a commitment to:

- The lived experience of CALD health care consumers
- A strengths-based approach
- Translation of evidence into policy and practice
- A holistic view of health, including mental health
- Integration of health and social care
- Health promotion and preventive health
- Social determinants of health

- Equity and social justice
- Inclusion and intersectionality.

Key documents informing the work of the Collaborative include but are not limited to:

- [Australian Charter of Healthcare Rights](#)
- [National Safety and Quality Health Service \(NSQHS\) Standards](#)
- [National Safety and Quality Primary and Community Healthcare Standards](#)
- [Ottawa Charter](#) and [Jakarta Declaration](#)
- [Multicultural Lived Experience Framework](#) (World Wellness Group)
- National health strategies, including:
 - [Australia's Long Term National Health Plan](#)
 - [National Preventive Health Strategy 2021–2030](#)
 - [Australia's Primary Health Care 10 Year Plan 2022–2032](#)

4.3 Membership

The Collaborative is membership based. Membership categories are described in Section 6. There are no membership fees.

Membership includes and expert advice and content is derived from:

- CALD health care consumers and organisations supporting them
- CALD health services and health practitioners*
- Researchers/Research institutions with a demonstrated focus on CALD health issues.

The Collaborative welcomes as members other services and organisations with a significant commitment to CALD health and wellbeing.

** This includes organisations and individuals delivering social care services/programs that address the social and cultural determinants of health.*

4.4 Consumers

Central to the work of the Collaborative is engagement with and the participation of CALD health care consumers who can reflect the diversity of Australia's CALD communities.

An early priority is the establishment of a Working Group which will draw on the learnings of many successful consumer programs⁴⁹ to develop mechanisms to ensure that consumers are properly supported and remunerated so they can represent the consumer perspective internally and nationally as required. A Consumer Speakers Bureau will be established to respond to invitations to share their lived experience of accessing and using services.

4.5 Governance

An Interim Co-ordination Group has been established to lead the initial establishment and development of the Collaborative.

The Group will nominate Collaborative representation as required on national committees, advisory or reference groups. At an appropriate time in the development of the Collaborative, a governance mechanism that would support policy and strategic objectives will be agreed by members and implemented.

4.6 Secretariat and Administrative Support

The Federation of Ethnic Communities' Councils of Australia (FECCA) provides secretariat support for the Collaborative. FECCA is neither a health services organisation, nor an academic/research institution. It has, however, been engaged in successful advocacy on a range of health issues and has demonstrated experience in contributing a consumer perspective to a number of national health initiatives (see [Appendix B](#)). This perspective is derived from its network of State/Territory/Regional members, each of which is a local peak organisation with a broad membership base of multicultural community groups, and the relationships established with many services and organisations through funded projects.

FECCA successfully advocated for the establishment of the National COVID-19 CALD Advisory Group and amendments to data required for the National Notifiable Diseases Surveillance System (NNDSS) and the vaccine rollout.

FECCA is leading national discussion about deficits in CALD data collection, particularly in health, and has released a comprehensive issues paper, together with recommendations:

[If we don't count it ... it doesn't count!](#)⁵⁰

FECCA has the capacity and expertise to support the establishment of the Collaborative by offering:

- Secretariat services
- Administrative support
- Policy Coordination
- Strategic Communications

The Collaborative has its own name, governance, structure and brand.

FECCA is initially providing these services from within existing resources. FECCA will then assist and support Collaborative applications for funding from various sources.

4.7 Development of Collaborative positions

Much of the work of the Collaborative will be progressed through Reference or Project Groups established in response to identified priorities, within available resources and where the most effective investment could be made. These Groups are ongoing or time limited, and all will include strong consumer representation.

All Groups will consider and commit to understanding how the issue might affect specific CALD groups such as: new arrivals, women and children, young people, older people, rural and regional CALD people, CALD people with a disability, LGBTIQ people, and at-risk groups such as refugees and asylum seekers.

Reference or Project Groups will include external expertise on the particular topic or theme.

Indicative topics could include, but will not be limited to:

- Primary Health
- Preventive Health & Health Promotion
- Health and social research
- Chronic Disease
- Health and Digital Literacy
- Medication Safety
- Palliative Care and End of Life
- Health Communications & Language Services
- Data

4.8 National Advisory Groups

The Collaborative will participate in relevant national advisory groups on health and wellbeing issues and nominate appropriate members to represent the Collaborative. The Secretariat will provide any required support.

4.9 Research and Data

Research is fundamental to improving CALD health and wellbeing through:

- improving data collection;
- addressing research gaps; and
- providing a strong evidence base.

The Collaborative will set, in collaboration with consumers and researchers, a Multicultural Health Research Agenda that will have maximum impact on meeting its strategic objectives. The Agenda will include health and medical research (including clinical trials) and research conducted across different disciplines, such as public health, primary care, psychology, sociology and social work. From this national agenda, research could be commissioned or encouraged, and a network of academic and research institutions established.

A Research and Data Community of Practice will be established to encourage collaboration, reduce duplication and promote best practice for research involving CALD communities, and data collection and reporting. The Collaborative will maintain a strong focus on the translation and implementation of research into policy and practice, and into health initiatives, strategies and programs.

4.10 Knowledge Hub

Information about and links to relevant projects, reports and research findings on health and wellbeing issues will be posted on a web-based knowledge hub. In addition, members will be able to post information about their activities and events.

4.11 Partnerships

The establishment of partnerships with other appropriate national health related, academic or research organisations through memoranda of understanding or other mechanisms will enhance the Collaborative and bring mutual benefits.

The Collaborative seeks to engage with and bring a CALD perspective to the important health promoting work of organisations such as: the Heart Foundation; Diabetes Australia; Dementia Australia; Asthma Australia; Cancer Council Australia; Arthritis Australia; the Australian Health Promotion Association; the Australian Public Health Association; and others, such as Palliative Care Australia, Carers Australia and the Primary Health Networks.

The Collaborative will have a focus on the intersection between health and disability, recognising the National Ethnic Disability Alliance as the peak body advocating at the national level for the human rights of people from CALD backgrounds with disability and their families.

The Collaborative will work with:

- The National Aboriginal Controlled Health Organisation (NACCHO) on issues that affect both our constituencies, including service access, health and digital literacy, racism and discrimination.
- The Consumers Health Forum of Australia (CHF) to enhance the voice of CALD health care consumers.

5. POTENTIAL BENEFITS

The objectives of the Collaborative are outlined at 2.1 above. The initial establishment and, over time, the development and maturation of the Collaborative has the potential to bring considerable benefits to multicultural health and wellbeing services, consumers and their families and carers, the broader health sector, researchers, policy makers and governments, and the Australian economy and people.

These include:

- A voice at the national level
- The provision of authoritative advice and input to government as required
- An efficient, central mechanism for government and others to consult meaningfully

The Collaborative will lead and shape discussion and consideration of CALD health issues through:

- Participation in national advisory or reference groups on health and wellbeing issues
- Submissions in response to government and other inquiries, consultation drafts, or issues papers
- Publications and Reports (including a State of Multicultural Health report, potentially co-developed with the Australian Institute of Health and Welfare to complement its biennial Australia's Health reports)
- A web-based knowledge hub
- Information and education/training resources
- Consumers Speakers Bureau
- Communities of Practice
- A health literacy and digital literacy program
- Research prioritisation through a National Multicultural Health Research Agenda
- A biennial National Multicultural Health Conference.

The Collaborative will lead initiatives to:

- address systemic racism in the health system
- resolve deficits in the national collection and reporting of CALD health data
- increase CALD participation in health and medical research and clinical trials.

6. BECOMING INVOLVED

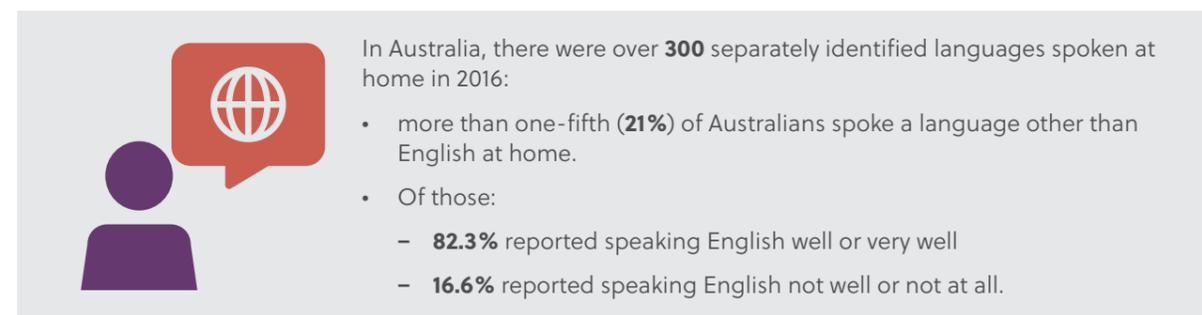
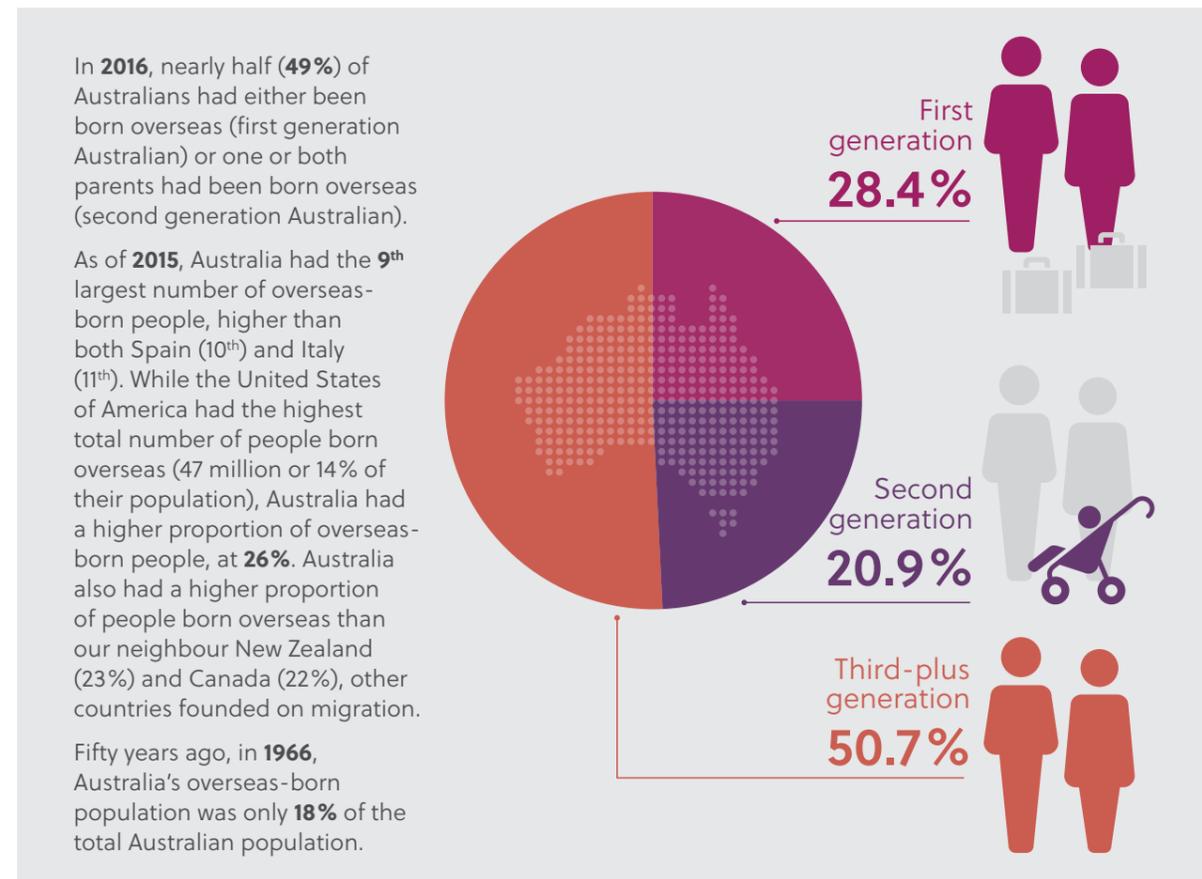
Membership is invited in the following categories. There are no membership fees.

Consumers	Full Membership	<ul style="list-style-type: none"> Individual health care consumers from a CALD background CALD organisations that support CALD health care consumers
	Associate Membership	Other health care consumer organisations that are <ul style="list-style-type: none"> inclusive of and support CALD consumers engaged in relevant health and digital literacy programs which include CALD consumers
Health and Wellbeing Services	Full Membership	Services that <ul style="list-style-type: none"> are predominantly focused on CALD patients/clients have a majority of CALD staff
	Associate membership	Other services that <ul style="list-style-type: none"> are inclusive of and provide services to CALD patients/clients have diversity and inclusion policies provide access to language services
Health and social care practitioners	Full Membership	<ul style="list-style-type: none"> Individual practitioners from CALD backgrounds Organisations representing CALD practitioners (e.g., Chinese/Indian/Islamic Doctors or Medical Associations)
	Associate Membership	National organisations representing practitioners, including CALD practitioners (e.g., Australian Nursing and Midwifery Federation, Australian Association of Social Workers, Allied Health Professions Australia etc..)
Research (social, health and medical)	Full Membership	<ul style="list-style-type: none"> Individual researchers from a CALD background Individuals or Organisations that have a significant focus on and record of CALD research and engage meaningfully with CALD communities
	Associate Membership	<ul style="list-style-type: none"> Individual researchers or Organisations with an interest in CALD research
	Affiliate Membership	National organisations that do not have a primary focus on CALD health and wellbeing but seek to engage at the national level (e.g., Heart Foundation, Australian Federation of AIDS Organisations, Dementia Australia, Palliative Care Australia etc....)

Individuals and organisations interested in becoming part of the Australian Multicultural Health Collaborative are invited to apply online at www.multiculturalhealth.org.au or contact admin@multiculturalhealth.org.au



APPENDIX A: KEY CALD DEMOGRAPHICS (CENSUS 2016)



Source: ABS Census of Population and Housing 2016

APPENDIX B: RECENT FECCA INVOLVEMENT IN HEALTH ISSUES

COVID-19

Successful advocacy has contributed to:

- Formation of National CALD COVID-19 Advisory Group and related COVID Data Group
- More appropriate national CALD communications and engagement
- Addition of CALD indicators into the National Notifiable Diseases Surveillance System (NNDSS)
- Improved national CALD data on the vaccine rollout
- Organisation of roundtables on vaccine roll out (community and religious/faith leaders)
- Administration of CALD COVID-19 Small Grants Program
 - Engaged more than 300 community groups to address vaccination challenges.

Therapeutic Goods Administration

- CALD perspectives delivered on projects related to:
 - Opioid Use
 - Vaping
- Medical Devices Action Plan - Consumer Working Group.

Australian Digital Health Agency

- Partnership to advise and guide the Agency on digital health engagement, education and promotions, and awareness activities for CALD communities.

Cancer Australia

- Submission to the development of the National Pancreatic Cancer Roadmap
- Contracted to lead initial CALD consultation process.

National Disability Insurance Agency

- Advice on whole of agency cultural awareness training
- Input to the development of the next CALD Strategy.

Donate Life

- Funded project to increase CALD awareness of and participation in organ and tissue donation.

Mental Health Australia

- *Embrace* (national multicultural mental health project) – alliance member.

National Ageing Research Institute

- Steering Committee on project addressing research gaps in dementia in CALD Communities.

NPS MedicineWise

- Ongoing advice on CALD engagement
- Chronic Kidney Disease Program – Stakeholder Reference Group
- Anticholinergic Burden: Unintended Consequences for Older People Program -Stakeholder Reference Group.

Australian Clinical Trials Alliance

- Contribution to national workshop and position paper on CALD inclusion in clinical trials
- Health Studies Australian National Data Asset (HeSANDA)
- Consumer Engagement, Equity & Diversity Working Group.

Palliative Care and End of Life

- Palliative Care Australia – National Expert Advisory Committee
- CareSearch – National Advisory Group
- End of Life Directions in Aged Care (ELDAC) – National Reference Group
- National CarerHelp – Steering Group.

System Navigation

- Disability - CALD Community Connectors Project, in conjunction with National Ethnic Disability Alliance, funded by NDIA
- Aged Care - EnCOMPASS - Multicultural Aged Care Connector Project, funded by Department of Health.

Autism

- Reference Group - National autism practice guideline, Autism CRC.

Blood Borne Viruses and STIs

- CALD Affiliates Group, Australian Federation of AIDS Organisations.

Health Literacy

- Sax Institute – Sydney Health Literacy Lab Supporting development of National Health Literacy Strategy by providing feedback on: *Consumer experiences accessing, understanding, appraising and applying preventive health information; Approaches for enhancing health literate environments; and Approaches for ensuring Strategy is relevant and practical for Australia's diverse populations.*

Health and Medical Research

- Medical Research Futures Fund (MRFF) - Consumer Reference Panel
- Current Research Projects
 - Partner organisation in National Health and Medical Research Council funded project: *Identifying the predictors and consequences of disparities in the uptake of HIV prevention and treatment programs in Australia: a national data linkage study* (Kirby Institute)
- Partner organisation in Research Proposals under development
 - MRFF Application by Consortium led by Murdoch Children's Research Institute: *addressing underrepresentation of CALD populations in genomic research*
 - University of Sydney – NSW Data linkage project around CALD people and cardio-vascular disease risk and outcomes
 - Centre for Population Genomics - *Development of culturally-aligned and language-appropriate participant information and education resources for Australian ethnic minority ancestry groups under-represented in genomics research and genetic services research.*



REFERENCES

- ¹ Mousaferiadis, P., Why 'culturally and linguistically diverse' has had its day. *Cultural Infusion* <https://www.diversityatlas.com.au/heres-why-cald-has-had-its-day/> (accessed 13 April 2022)
- ² Sawrikar P, Katz I. How useful is the term 'Culturally and Linguistically Diverse' (CALD) in Australian research, practice, and policy discourse? Proceedings of the Australian Social Policy Conference; 2009 Jul 8-10; Sydney, AUST. Sydney: University of New South Wales https://www.aspc.unsw.edu.au/sites/www.aspc.unsw.edu.au/files/uploads/aspc_historical_conferences/2009/paper276.pdf (accessed 14 April 2022)
- ³ Marcus, K., Balasubramanian, M., Short, S. and Sohn, W. (2022), Culturally and linguistically diverse (CALD): terminology and standards in reducing healthcare inequalities. *Australian and New Zealand Journal of Public Health*, 46: 7-9. <https://doi.org/10.1111/1753-6405.13190> (accessed 14 April 2022)
- ⁴ <https://culturaldiversityhealth.org.au/wp-content/uploads/2019/02/Culturally-responsive-clinical-practice-Working-with-people-from-migrant-and-refugee-backgrounds-Jan2019.pdf>
- ⁵ <https://culturaldiversityhealth.org.au/wp-content/uploads/2019/10/Guide-for-clinicians-working-with-interpreters-in-healthcare-settings-Jan2019.pdf>
- ⁶ Weng, Enqi, Mansouri, Fethi and Vergani, Matteo 2021, The impact of the COVID-19 pandemic on delivery of services to CALD communities in Australia, Alfred Deakin Institute for Citizenship and Globalisation, Deakin University, Geelong, Vic.. <https://apo.org.au/sites/default/files/resource-files/2021-08/apo-nid313720.pdf> , accessed 29 November 2021
- ⁷ Mac OA, Muscat D, Ayre J, Patel P, McCaffery KJ. Coronavirus (COVID-19) vaccination information must pay attention to health literacy: analysis of readability of official COVID-19 public health information. *Med J Aust* 2021; <https://www.mja.com.au/journal/2021/coronavirus-covid-19-vaccination-information-must-pay-attention-health-literacy>
- ⁸ Tsirtsakis, A. How is race affecting COVID-19 outcomes? May 2020
- ⁹ Clibborn, S., & Wright, C. F. (2020). COVID-19 and the policy-induced vulnerabilities of temporary migrant workers in Australia. *The Journal of Australian Political Economy*, (85), 62–70. <https://search.informit.org/doi/10.3316/agispt.20200701032596>
- ¹⁰ Australian Bureau of Statistics 'COVID-19 Mortality in Australia' Australian Bureau of Statistics accessed 3 March 2022, <https://www.abs.gov.au/articles/covid-19-mortality-australia#death-due-to-covid-19-country-of-birth>
- ¹¹ Issues Paper (National Health Strategy) (Australia) No 6, March 1993. ISSN 1038-028. ISBN 0642191913
- ¹² Including: North Western Melbourne PHN, Brisbane South PHN, Western Sydney PHN, and Central and Eastern Sydney PHN
- ¹³ Weng E., Mansouri F., Vergani M. (2021). The impact of the COVID-19 pandemic on delivery of services to CALD communities in Australia. ADI Policy Briefing Series 2(2). Melbourne: Alfred Deakin Institute for Citizenship and Globalisation, Deakin University. <https://apo.org.au/sites/default/files/resource-files/2021-08/apo-nid313720.pdf> accessed 13 April 2022
- ¹⁴ <https://www.aspeninstitute.org/blog-posts/structural-racism-definition/>
- ¹⁵ Harrison R, Walton M, Chitkara U, et al. Beyond translation: Engaging with culturally and linguistically diverse consumers. *Health Expect*. 2020;23(1):159-168. doi:10.1111/hex.12984
- ¹⁶ Au, M., Anandakumar, A.D., Preston, R. et al. A model explaining refugee experiences of the Australian healthcare system: a systematic review of refugee perceptions. *BMC Int Health Hum Rights* 19, 22 (2019). <https://doi.org/10.1186/s12914-019-0206-6>
- ¹⁷ Raymundo, G., Smith-Merry, J. & McNab, J. (2020). Experiences of health service literacy and access amongst Australian young adults from migrant backgrounds. *Health Promotion Journal of Australia*, 32(1), 69-79.
- ¹⁸ Isautier JM, Copp T, Ayre J, Cvejic E, Meyerowitz-Katz G, Batcup C, Bonner C, Dodd R, Nickel B, Pickles K, Cornell S, Dakin T, McCaffery KJ People's Experiences and Satisfaction With Telehealth During the COVID-19 Pandemic in Australia: Cross-Sectional Survey Study *J Med Internet Res* 2020;22(12):e24531
- ¹⁹ O'Mara B, Monani D, Carey G. Telehealth, COVID-19 and Refugees and Migrants in Australia: Policy and Related Barriers and Opportunities for More Inclusive Health and Technology Systems. *Int J Health Policy Manag* 2021, x(x) 1-5 https://www.ijhpm.com/article_4027_b6a467e726dc737146c439bc17b6e18d.pdf , accessed 21 Feb 2022
- ²⁰ Shepherd, S.M., Willis-Esqueda, C., Newton, D. et al. The challenge of cultural competence in the workplace: perspectives of healthcare providers. *BMC Health Serv Res* 19, 135 (2019). <https://doi.org/10.1186/s12913-019-3959-7>
- ²¹ Jongen, C., McCalman, J. & Bainbridge, R. Health workforce cultural competency interventions: a systematic scoping review. *BMC Health Serv Res* 18, 232 (2018). <https://doi.org/10.1186/s12913-018-3001-5>
- ²² The Federation of Ethnic Communities' Councils of Australia (FECCA) 2020 Issues Paper: If we don't count it... It doesn't count! Towards Consistent National Data Collection and Reporting on Cultural, Ethnic and Linguistic Diversity <https://fecca.org.au/wp-content/uploads/2020/10/CALD-DATA-ISSUES-PAPER-FINAL2.pdf>, accessed 19 November 2021.
- ²³ Woodward-Kron R, Bresin A, Hajek J, Parker A, Phan T, Hughson J, Story D. *Improving Access to and Participation in Medical Research for Culturally and Linguistically Diverse Background Patients: A Bilingual, Digital Communication Approach*, in *Cross-Cultural Health Translation: Exploring Methodological and Digital Tools*, 1st Ed. Routledge Studies in Empirical Translation and Multilingual Communication, 2019
- ²⁴ Hughson J, Woodward-Kron R, Parker A, Bresin A, Hajek J, Knoch U, Story D, Phan T. A review of approaches to improve participation of culturally and linguistically diverse populations in clinical trials. *Trials* 17(1):263 2016. DOI: 10.1186/s13063-016-1384-3
- ²⁵ Malathi G. Nayak et al *Socio-cultural perspectives on health and illness* Nitte University Journal of Health Science, Vol 2, No 3 September 2012
- ²⁶ Brady, B. (2018). The experience of pain and pain management among culturally and linguistically diverse communities living in Australia. <https://researchdirect.westernsydney.edu.au/islandora/object/uws:50905/>
- ²⁷ Shahin, W., Kennedy, G. A., & Stupans, I. (2019). The impact of personal and cultural beliefs on medication adherence of patients with chronic illnesses: a systematic review. *Patient preference and adherence*, 13, 1019–1035. <https://doi.org/10.2147/PPA.S212046>
- ²⁸ University of Technology Sydney, 2019. Traditional medicines must be integrated in CALD health care, <https://www.uts.edu.au/about/faculty-health/news/traditional-medicines-must-be-integrated-cald-health-care>, accessed 15 November 2021.
- ²⁹ Ou L, Chen J, Hillman K 2010. Health services utilisation disparities between English speaking and non-English speaking background Australian infants. *BMC Public Health* 10:182 <https://www.health.gov.au/resources/pregnancy-care-guidelines/part-a-optimising-pregnancy-care/pregnancy-care-for-migrant-and-refugee-women>
- ³⁰ Australian Government Department of Health, 2020. Pregnancy Care Guidelines 4: Pregnancy care for migrant and refugee women, <https://www.health.gov.au/resources/pregnancy-care-guidelines/part-a-optimising-pregnancy-care/pregnancy-care-for-migrant-and-refugee-women>, accessed 15 November 2021.
- ³¹ Australian Government Department of Health, 2019, Exploratory Analysis of Barriers to Palliative Care: Issues Report on People from Culturally and Linguistically Diverse Backgrounds, available <https://www.health.gov.au/sites/default/files/documents/2020/01/exploratory-analysis-of-barriers-to-palliative-care-issues-report-on-people-from-culturally-and-linguistically-diverse-backgrounds-issues-report-on-people-from-culturally-and-linguistically-diverse-backgrounds.pdf>, accessed 15 November 2021
- ³² Broom, A., Good, P., Kirby, E. & Lwin, Z. Negotiating palliative care in the context of culturally and linguistically diverse patients. *Intern. Med. J.* 43, 1043–1046 (2013).
- ³³ Cain, C. L., Surbone, A., Elk, R. & Kagawa-Singer, M. Culture and palliative care: Preferences, communication, meaning, and mutual decision making. *J. Pain Symptom Manage.* 55, 1408–19 (2018).
- ³⁴ Woodward-Kron R, Bresin A, Hajek J, Parker A, Phan T, Hughson J, Story D. *Improving Access to and Participation in Medical Research for Culturally and Linguistically Diverse Background Patients: A Bilingual, Digital Communication Approach*, in *Cross-Cultural Health Translation: Exploring Methodological and Digital Tools*, 1st Ed. Routledge Studies in Empirical Translation and Multilingual Communication, 2019.
- ³⁵ Coyne I, Holmström I, Söderbäck M. Centeredness in Healthcare: A Concept Synthesis of Family-centered Care, Person-centered Care and Child-centered Care. *J Pediatr Nurs.* 2018 Sep-Oct;42:45-56. doi: 10.1016/j.pedn.2018.07.001. Epub 2018 Jul 10. PMID: 30219299.
- ³⁶ Brooks, L. A., Manias, E., & Bloomer, M. J. (2019, June 1). Culturally sensitive communication in healthcare: A concept analysis. *Collegian*. Elsevier B.V. <https://doi.org/10.1016/j.colegn.2018.09.007>
- ³⁷ Levesque, JV, Gerges, M, Wu, VS, Girgis, A. Chinese-Australian women with breast cancer call for culturally appropriate information and improved communication with health professionals. *Cancer Reports.* 2020; 3:e1218. <https://doi.org/10.1002/cnr2.1218>
- ³⁸ Stoner L, Matheson AG, Perry LG, Williams MA, McManus A, Holdaway M, et al. Social contributors to cardiometabolic diseases in indigenous populations: an international Delphi study. *Public Health.* 2019;176:133-41.
- ³⁹ Stoner L, Matheson AG, Perry LG, Williams MA, McManus A, Holdaway M, et al. Principles and strategies for improving the prevention of cardio-metabolic diseases in indigenous populations: An international Delphi study. *Preventive Medicine.* 2017;96:106-12.

- ⁴⁰ Brewer LC, Cooper LA. Race, Discrimination, and Cardiovascular Disease. *AMA Journal of Ethics*. 2014;16(6):455-60.
- ⁴¹ Cuevas AG, Ho T, Rodgers J, Denufrio D, Alley L, Allen J, et al. Developmental timing of initial racial discrimination exposure is associated with cardiovascular health conditions in adulthood. *Ethnicity & Health*. 2019:1-14.
- ⁴² Panza GA, Puhl RM, Taylor BA, Zaleski AL, Livingston J, Pescatello LS. Links between discrimination and cardiovascular health among socially stigmatized groups: A systematic review. *PLOS ONE*. 2019;14(6):e0217623
- ⁴³ Hammond G, Johnston K, Huang K, Joynt Maddox KE. Social Determinants of Health Improve Predictive Accuracy of Clinical Risk Models for Cardiovascular Hospitalization, Annual Cost, and Death. *Circulation: Cardiovascular Quality and Outcomes*. 2020;13(6).
- ⁴⁴ Karmakar M, Lantz PM, Tipirneni R. Association of Social and Demographic Factors With COVID-19 Incidence and Death Rates in the US. *JAMA Network Open*. 2021;4(1):e2036462-e.
- ⁴⁵ Vyas DA, Eisenstein LG, Jones DS. Hidden in Plain Sight Reconsidering the Use of Race Correction in Clinical Algorithms. *New England Journal of Medicine*. 2020;383(9):874-82.
- ⁴⁶ Public Health Ontario 'COVID-19 what we know so far about social determinants of health' Synopsis 5/24/2020 <https://www.publichealthontario.ca/-/media/documents/ncov/covid-wwksf/2020/05/what-weknow-social-determinants-health.pdf?la=en>
- ⁴⁷ American Association of Biological Anthropologists AABA Statement on Race and Racism Created by the COD subcommittee on revising the AAPA statement on race. March 8, 2019 Accessed at <https://physanth.org/about/position-statements/aapa-statement-race-and-racism-2019/>
- ⁴⁸ Geneviève, L.D., Martani, A., Shaw, D. et al. Structural racism in precision medicine: leaving no one behind. *BMC Med Ethics* 21, 17 (2020). <https://doi.org/10.1186/s12910-020-0457-8>
- ⁴⁹ Health Issues Centre 2022 Consumer Model – Partnering with Healthcare Organisations. <https://hic.org.au/wp-content/uploads/2022/01/HIC-SCV-Consumer-Model-Partnering-with-Healthcare-Organisations-FINAL-VERSION.pdf>
- ⁵⁰ The Federation of Ethnic Communities' Councils of Australia (FECCA) 2020 Issues Paper: if we don't count it... It doesn't count! Towards Consistent National Data Collection and Reporting on Cultural, Ethnic and Linguistic Diversity <https://fecca.org.au/wp-content/uploads/2020/10/CALD-DATA-ISSUES-PAPER-FINAL2.pdf>, accessed 19 November 2021.





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