

Panel session and discussion of the issues

What we can learn for the future?

The lessons for delivering health services in remote areas

Proposed follow-up

MR WAKERMAN: I have to say though that I'm still a bit shocked the fact that someone from Adelaide didn't know where Wagga was. So just to let you know, Geraldine Duncan's out doing a radio interviewer for local regional ABC radio, publicising the sort of issues that we've been talking about and hearing about today. That's great and we're grateful to Geraldine for that.

So we've had a fantastic series of speakers now and we've heard from the policy guy, the Department of Immigration. We've heard from Mitchell, the public health medicine specialist. We've heard from service providers on the ground. Please come up, Geraldine. We've also heard firsthand from the real experts, from Constance and Susan.

So we've got an opportunity now to think a little bit about what we can learn from this collective experience. What are the lessons for us in terms of providing appropriate services in rural and remote communities? Potentially there might be issues that the alliance can take forward in this area of refugee health and providing - I'm not sure about the term "refugee health" anymore, but at least providing services to a multicultural population that we find in rural and remote parts of this country. So those are the sorts of questions that we can explore now for the next 35 minutes or so. I'm happy to just open it up to the floor and to the panelists here to take those questions forward.

MR GREGORY: Gordon Gregory. There are very clearly some heroes involved in all of this. To what extent is a personality dependent system that we've currently got?

MR WAKERMAN: Who are you asking, Gordon?

MR GREGORY: I've got no idea.

DR VINE: I would say, Gordon, in response to that that anything that's new and developing and unfolding would have to be dependent on personalities, because there are people who have the vision to actually drive and make it happen. That's part of it, and then it becomes inculcated into the culture. I think at the moment it is personality driven, but that's because people like Mitchell have got the vision and they've got the energy to make it happen. I think that's the nature of development; you keep doing it until people take it for granted. There are many things that happened with the migrants that came to Australia in the 1950s and so on that we just now take for granted. The current drive around refugees is new. I think we've got to adjust to that and to come up to systems that are respectful and relevant to modern day.

DR SMITH: I think it's becoming less personality driven. Refugee health - and the terminology is difficult, but we have to talk the language that the UN talks, we have to talk the language that governments talk because otherwise people don't know what we're talking about, but I certainly acknowledge your point. It's a difficult one and something that services struggle with. I think it's becoming less so and the fact that there are now national policies, there are guidelines, there are people meeting around the country talking about this. There's a national level Working Group on Refugee and Humanitarian Health, so I think they're all

good things and hopefully along with that comes more resourcing to support the help that you or I produce.

MR WAKERMAN: Bruce?

DR HARRIS: I think we're probably all struggling to formulate our thoughts into clear - and in this case two questions. It's excellent to have you people coming into rural and regional Australia and that should not be a statement that's misunderstood. That is a good thing to happen. I think the major cities had migration following World War II but the country in general did not. We know that the process that has been described this afternoon sounds as though people are being eased from a previous bad circumstance into a much better circumstance, but we haven't heard about permanency or whether or not there are job opportunities. They're not going to be the Germans who grow beer in the Barossa and they're not going to be the Italians that grow wine in the Griffith area, but what does the Department see or what do you people on the panel see as the future of migration in rural and regional Australia? Is it just yet another staging post through to an urban future?

DR SIVAMALAI: Certainly. I mean, I thank you for the question. Certainly it's - I know the government has put in policies, has produced booklets, has produced papers, but I think once again, what is the reality out there in the rural, remote, regional areas? Are we looking at token examples that's working here, you know, at an ad hoc level? Do we have a system that is in place that has been consulted, coordinated and planned in a way looking at the needs out there rather than the top down approach to it? I'll leave my thinking there for you to ponder on. Thank you.

DR VINE: I was at a recent Ethnic Community Council conference in Bendigo and they were talking about the policy to settle people in the rural areas, particularly areas that had fruit picking and so on that was a policy in the past. But people from Mildura and Geelong have been talking about the economic development that's been happening in the area because of the recent influx of refugees and migrants. They're deliberately doing that because it's good for the town. I think that that policy is something that is going to be going forward. With the shift of the young people going to the big smoke, part of the policy is to put new arrivals in the rural areas. That's how I understand it.

MR WAKERMAN: Thanks, Penny. Could you please identify yourself when you speak?

MS MOI: I think it's one thing to take people to the rural areas and it's another thing to give jobs to them. It's really very difficult and most people - those who are younger and stronger are able to go to the meat factory and work there and as we are heard from one of the speakers it's not one of the good places really to be in. They come back with so many injuries and really bad. So that's the only place where refugees can go and work, but most of us do not have jobs. It's a real challenge. This is becoming another problem of its own. How long will one stay without a job? So it's a big problem.

DR DUNCAN: I think we're coming from an uncoordinated approach gradually towards more groups of people recognising that coordination is important. Just yesterday I was invited that, "Even though you're busy, Geraldine, can you find time to get into the Wagga Wagga social plan on the website and write down everything that you've told me today so that it's actually there on the website and council can actually look at it, as we're developing a social plan for Wagga?" So that's a step in the right direction, but I've got to find the time

to sit down and put all my thoughts and emotions in order and put it in a logical, you know, academic, it'll be taken notice of, kind of appraisal. But it's important to know these things are beginning to happen.

How you tackle something like the Area Health Service in terms of coordinating it, the council is very important for jobs. Wagga was a resettlement area for Aboriginal people from about the mid-1980s and through to early 1990s and that created social problems of its own, all of which aren't solved yet. But other things will develop in terms of Wagga's multiculturalism, and we've already seen the development of that. I've been very impressed to see in the Daily Advertiser the impact that my African friends have had in our culture in dance and song, in presenting to the public. We have a very nice amphitheatre in Wagga near the Council Chambers and things like that have happened. Wagga has a Youth Voice program which has an annual busking competition where young people get out and busk. Some of our young African friends have been out there as part of that. Gradually these things become more important in people feeling part of a place, but it does take time. But at the same time, our leaders, I think, are gradually recognising, but it needs energy from other people to keep pushing that agenda.

DR HARRIS: Can I ask you then just as a follow-on, what I took from those presentations was that there was some organised effort, some real champions and leaders and quite a bit of patching things together as best we can. You're saying that there's starting to be more of a coordinated effort. Are there points that we can pursue? Are there policy points or are there issues that we can take up now that will help to better coordinate effort or better systematise the sort of effort that we've been hearing about today?

DR SMITH: That's a big question. Look, I hope there are and I hope that there can be recommendations that can come out of it that can, you know, a group of people here with expertise in rural and regional health, if you like, crossing over with a group of people with more expertise in delivering refugee health services can come up with ideas. As I said, it is something that, you know, Immigration, to give them credit, and federal Health, I think they are well aware of these special issues that do exist in rural and regional areas. There may not be much to see for that as yet, but, you know, I think it's on their agenda. So there is an avenue to take up issues.

DR DUNCAN: There's a bit of tension between the organisations that help people which are staffed by a lot of volunteers who have a lot of good will and desire to help their fellow man. I would never put that down, its importance. However, not all of those people have the expertise on how to run boards and actually think politically and actually work out what it is that we need to do to think globally in an expanding way for what our needs will be for the future. I can actually see that a little bit in Wagga. I'm not on any of the boards, not necessarily agitating to get on the boards, but I can actually see that there needs to be that other step where people have a slightly different approach to what our needs are, so we're not reactive to what's happening. We're proactive about our plan for the future. I think that's an important step that needs to happen.

Now, how can that happen? Well, it can happen as councils think, "This is what we need to do for our region. How can we work with our organisations to make that happen?" It can also act at a government level where the government says, you know, "What plans have you got? We recommend that you have this conversation for your region." So you need a bit of direction as to which corner to start taking as you see them on the pathway.

NATALIE GRAY: Natalie Gray from the NT again. This is really a service delivery question so it's sort of directed at Mitchell, but anybody can answer. As I said before, in the NT we do have a refugee clinic and we do initial health assessments on everybody who arrives into the NT. From an addressing immediate medical needs perspective, it works pretty well. From a referring specialist care perspective through informal networks it works pretty well, although admittedly that is very person dependent. However, where it doesn't work well is because we are completely unfunded, we don't have the capacity to keep seeing people on an ongoing basis, so we don't have the capacity to provide, you know, proper, comprehensive primary healthcare for anybody. Unfortunately, we have not found ourselves a Geraldine yet, so we don't have GPs in the community who are, you know, particularly enthusiastic about taking newly arrived families into their practices.

I guess my question is whether New South Wales or anyone had any specific strategies for facilitating that transition for people between initial early healthcare are refugee clinics, if you like, into the mainstream private GP practices?

DR SMITH: Good question, Natalie. Right. Now this is the whole debate about specialised versus mainstream health services. What you don't want to do is set up a parallel health system. Okay, there are specific examples, Aboriginal controlled medical services, you know, specific circumstances where that's appropriate. As Susan was saying, you know, how long are people refugees? People need to be cared for by the mainstream system and so one of the strategies is up-skilling the mainstream and making them more confident, perhaps, and more linked into all the services that might be able to help them, and sort of encouraging the potential Geraldines out there to be involved. That's very difficult and it's more difficult in rural and regional areas where there's less ability to bulk-bill, where books are closed, and so it's harder for mainstream to deal with refugees.

A GPI I think in Lismore once said to me, "Look, why don't all the refugees have their major post-arrival assessments in the big cities, then they get dispersed to rural and regional areas?" I mean, that may not work in terms of best settlement plans, but you can see from the health perspective that would suit to some degree. The feds don't think that's the right idea. They think that the Medicare item number should solve a lot of the problems. It's not the answer, clearly, not the entire answer. It's great. It's a positive.

DR DUNCAN: It could help if you have a family of nine and you can charge a 794 for nine people one after the other.

DR SMITH: But I mean the others might talk about - I mean, really, it's hard. It doesn't happen in the big cities either, to tell you the truth. You know, we've got lots of GPs out there who speak all sorts of languages but whether we plug refugees into them well is debatable. Victoria's got a good model, I should say, in case you might want to talk about the model that is there.

MS PHILLIPS: Christine Phillips, [Companion House](#), Canberra. We're the ones that currently nag both Penny and Geraldine into their work. I just wanted to answer that question and discuss some models that exist in Canberra. I think it's critical that there be should be government funding into the health services and the ACT has put some funding into the Companion House model which is a transitional general practice service, so it actually functions approximately the first year after settlement. It functions as a training place for

general practitioners, so we've had three registrars go through that particular health service with the aim that they would ultimately then go back into their own general practices and move out into the general community and take some of that skill with them. So I think creating a training position in refugee health assessment is really critical in terms of building capacity out into the general community, but I think it will be difficult for you until you actually get some government funding for what you have at the moment.

DR DUNCAN: I spoke to our federal member two weeks ago and rang her and said, "Kaye, we need at least an initial health assessment service here." That primarily starts like the Coffs model, with a nurse so that nurse is there full time and can overview all the results and, you know, organise them for me and can start all the catch up immunisations and that's all organised and then we can con some more GPs to come in and do some sessions and we can provide a regular medical thing." I mentioned the Coffs model to her and the issue of course is number. Wagga doesn't have the number compared to some of the towns in Victoria, for example. What's the funding model for the one in Coffs? Well, I didn't know at that stage, but I know today because Mitchell's talked about it. I'm about also to send my student, who I just noticed leaving, who's doing a project for me on health services in Wagga Wagga, sending her up to Coffs to suss out that model as well.

The issue was numbers and how you define what the numbers are. So we know what the numbers are for families that have come under IHSS, but we don't know all the secondary migration figures. That's also difficult for the organisation supporting because they haven't got concrete figures when they're applying to the government for money to extend their services. So how you know who's going where, that affects service provision, is one of the difficulties.

MS BROWN: I'm Rosyln Brown. I'm from the [Mental Health](#) branch in FACSIA. There's something strikes me throughout today and this may - I'm sorry if I'm naïve in this area, but it seems to me that when we looked at the different cultures that were within, I think it was Wagga, very different cultures I presume with very different needs, very different requirements in the ways of working, I'm curious about how providers of services are able to know the best way to work with those different cultures. As you know, funding does go to quite small organisations. It seems to me that there is potentially quite a burden on the organisations and on the people using those organisations to have some kind of dual education burden around that. So I'm wondering, what is the networking like to support the providers of people who are using those services to help inform them of the best practices, for example?

DR DUNCAN: There isn't anything coordinated in Wagga Wagga, although recently the Sisters Housing organised a talk by [Eileen Pittaway](#), who has worked at the Kensington Campus of the University of New South Wales for some years. She has worked and researched and reported on life in many of the African camps and she came down to Wagga to talk about her experience. It was interesting that there were about 15 or 20 different organisations who came to listen to her talk, from policing to school, to church organisations, Anglicans were there, and I can't remember all the churches but Lutherans were there and different churches, as well as the early childhood, domestic violence, you know, a whole range of organisations. She was actually quite impressed at the good will there was in Wagga and said so, that she hasn't talked anywhere else where so many different organisations came. So clearly there's the good will there. Somehow or other we need to work out how to put it altogether so we are working altogether. I don't have the solution from myself at the

moment. I'm always very careful to try not to be seen as the doctor wanting to make the medical model work everywhere, because that also creates opposition and then you don't get anywhere. So I try to be diplomatic where I can, but it would be really good to actually have us all around the table and do that. I'm not depressed about it. I think we're getting there slowly.

I think you've got a delicate balance between the top down, you have to do it this way, which may come with funding and outcome based and something that develops from within the community and people responding to identified needs. So that's one of the difficulties. Perhaps what we're doing with family law about recognising the importance of networking and getting people to address all aspects might be the direction we need to go in eventually, but as I mentioned, it very much is a community based response. Lismore's got - I'd be interested to hear what's happening in Lismore in terms of how they're responding to support services for the refugees there.

DR SIVAMALAI: I think I want to further endorse that as well. Particularly in the rural, remote areas of Australia, there are examples there these are being serviced in a systematic way, but there are many more other places. Because of the good will of the community and the informal network that goes on, people tend to hear, "He say, you say, I say," and therefore services are addressed. But certainly there are some good examples and certainly, I mean, we have to also give credit to the government and their attempt to do something which we all believe in, but at the same time it's an process, I think, that we're all going through. Let's be positive about it as well.

MR JEEAWODY: It's so pleasing to hear the word "Wagga Wagga." I've heard the word "Wagga Wagga" for about 15 times. I'm afraid I'm from Wagga Wagga as well. My name is [Basseer Jeeawody](#). I'm from Charles Sturt University but I'm also the coordinator for the Multicultural Hub of the newly established [Centre for Inland Health](#). I've been the chairperson of the Multicultural Council for Wagga Wagga for about three years and have been connected with that organisation for a years. I'm also connected with Community Relations Commission for Multicultural in New South Wales. First of all, I think I'd really like to thank Geraldine and all the positive things you mentioned about Wagga Wagga and the work you're doing and Constance and Susan whom I've met before.

The question I have is in relation to capacity building. A lot of the stuff we tend to do are very much a top down approach and I think the word "top down" was mentioned by two members of the panel. The capacity building, for example in Wagga Wagga we established a consortium with Multicultural Council, other members, together with Centacare and St Vincent de Paul. The consortium is doing wonderful work for the whole of the region of the Riverina. Listening to Susan about women's health, we had a women group of diverse culture. We got funding from the CRC, [Community Relations Committee](#), to set up a women's health support group. Also, we'd like to thank DIAC for funding to establish a pilot scheme to give driving lessons to refugees. I particularly don't like the word "refugees" as well.

But my question for the panel is some capacity building from a ground up there happening, and I wonder what other options there is, what other challenges, for capacity building for the new migrants and also for the community at large? One of the observations I have made is all the little things happening, say within Wagga, have to be done in relation with the community, like engaging the community appropriately and the advantage of that

was, you know, demystifying some of their values or some of attitude, you know, we do explain(?) constantly. So comments would be great. Thank you.

DR SIVAMALAI: I'll have a go. Certainly before we community development or capacity building, first and foremost we need to identify what's out there. What are the opportunities, you know? What are the needs out in that region or remote area of Australia? Certainly if I could relate to the work that the Federation of the Ethnic Communities Councils are doing, certainly we are trying to create some identified regional, local ECCs to that they would have some sort of organisation being set up so they can link up with some of the local areas and, as such, they would begin to get the network going so that there is an opportunity there, as I mentioned in my address, that we should be looking at if you feel that there are some regions that are lacking where there could be an organisation to support the services.

Although the focus is on Ethnic Community Council or sometimes you call it multicultural society or organisation, end of the day, I think it says "all Australians." I think perhaps if you have a network going to identify what's out there, I think that's a start for capacity building. Certainly, as we mentioned before, all these need funding, again to look at how this is going to be funded. I might stop and let someone else and lets someone else who wants to take it on and contribute as well.

MS OKOT: Actually - this means Wagga Wagga. We are still talking about Wagga Wagga. Wagga Wagga, I think because they are many of the people are older people, you will find the networking is even in the community because since I came, when I found my house, my neighbour used to come to me and everybody on the street you find will greet you. You don't know anything. You sometimes feel scared, but when you find somebody, you just ask, "Can you help me, please?" and this person can actually give you the help you need. I have seven children actually and you will find that people actually sit with me with the children, with all the trauma I went through, with all support in the community make me actually to be a new me. It's like I'm born again, the big Constance. I don't know how to say it.

So you find even the education system the children - all the children you find the educational people have a lot of support with them. I don't have to see that my child - I don't know where my child is going. Finally, if it's time for school, all the children are at school. If it's time to come home, all the children are at home. This actually helps somebody like me with what you are having to cool things actually down.

DR SMITH: Community development, community engagement can start - it can be small beer, you know. The DVD I showed earlier was one small example whereby people of a refugee background themselves were involved in being actors, they were involved in contributing to the script and what should be in it and saying what they thought their community needed to hear, and then overdubbing that English in six other languages. I think local communities need to be asked, "What are you lacking?" I don't know. Constance and Susan should tell us more, but I think it's worthwhile. People want to be asked, "What are you lacking? What's wrong with our maternity? What's it like having a baby in our hospitals?" or, "What local foods can't you get? What could we maybe advocate with local businesses on in terms of getting traditional foods into this place?" So I think that is a good way to engage communities.

More broadly, in terms of what makes people well, I can tell you what the international literature says, and again our friends here can confirm it, but what makes people well is having your family with you, settlement services that help you get settled, being able to access language training, because without English here you're in trouble, being able to access education, training and jobs. For those that are actually sick, some targeted health services including mental health services. So broadly speaking, those are the things that are going to help people to be well and stay well.

DR DUNCAN: Other things, Basseer, you might be able to support; there's been a thought about a community garden getting up and running in Wagga. I don't know whether it's actually happened yet. There's been talk about it. It's a dream that I've had also that people who want to who come from rural backgrounds have got the opportunity to go and work with the earth and move that forward. I think things like that are important. It's pleasing to note that of our communities, you know, some people have entered into tertiary education; some in Wagga at Charles Sturt University, and some in other States as well, some in the ACT, some in Tasmania. Other children have gone to TAFE and are doing things at TAFE.

I must stress again the importance that TAFE has played, particularly in our community. The teachers are extremely dedicated and interact a lot with the people, an important player. But I think it's being creative. The people that are involved be creative, think outside the square and find the opportunity to liaise with the community members and think, well, where do we need to go? as Mitchell says. What's the next thing we need to do to try and work it forward? They're all things I expect Jess to find out when she does her focus groups.

DR SMITH: I was just whispering to Penny that the health system can play a part as well, you know, a bit of positive discrimination instead of people pushing trolleys around. I get despondent when I see the African guys in Sydney pushing trolleys around Westfields, you know. I mean, they're probably more qualified than I am, some of them. So I think a bit of support from the health system itself to train up people who have nursing training or medical training or whatever it is, or social work.

DR DUNCAN: We actually have had people whom I have seen originally some years ago now working as nursing sisters in Wagga Base Hospital so there gradually is movement through.

MS CASEY: I might just comment, in Victoria - a couple of things I might comment about. We're certainly looking at - I'm Sue Casey from [Foundation House](#) and actually worked with the Department of Human Services in Victoria around multicultural policy. We're doing a lot of thinking and working people around sustainable employment pathways and looking at things like an ESL course and bi-cultural health work. It's not just about people having tertiary qualifications but thinking about pathways in; how do people get those first jobs in the health sector? There's challenges, I think, to the health sector about where people can get jobs. It's not always with the tag of multicultural or whatever. It's sometimes around getting an admin job or an assistant's job and then getting supported and mentored, getting the appropriate support to be able to make your way into the sort of job you want in the long term. There's been a lot of feedback from a number of African colleagues around, people doing multiple short courses and there's not really a job at the end and how do people get that right sort of support to get where they need to go?

Just on an earlier question, I might just comment on that as well. In Victoria we've got a model of refugee health nurses and whilst that's only funding for about eight nurses across the State, those positions have acted as a focus in a number of rural areas where there might be nurse to provide some capacity and resource to develop up a range of strategies, with leadership not necessarily from the nurses themselves but from community health, from people - you know, it might be the primary health manager in the hospital - coming together. There's about 10 or 11 rural towns now in Victoria that have quite significant settlement and I think there's some really great things that are happening.

I suppose the other comment I wanted to make is that often it's not just about people arriving directly into rural towns. A lot of community leaders in Melbourne are talking about thinking it's a better option for their community to move to rural towns. It's about size and it's about opportunities for work, housing, all sorts of things. So there's all sorts of reasons why people are moving and that needs to be acknowledged. It's not just something happening to people. It's people making choices.

MR WAKERMAN: Could you just pass the microphone back. I'd like to just ask a question while we're waiting. Gordon would be very upset if we didn't talk about research. Mitchell, you were talking about the dearth of evaluation of these sorts of services. We've seen several case studies of what looked to me like pretty good or very good services in this area. Is there literature around refugee health services and does it tell us what works and what the components of those services are?

DR SMITH: Look, a lot of it is around. That debate I mentioned earlier about mainstream versus specialised services, I mean that debate occurs not just in refugee health too, doesn't it, and really there is no one answer. I think the answer is you need a mix of models depending on the size of your town or the size of your city and the number of refugees that are settling there. There's lots of stuff now around physical health for refugees arriving in Australia; lots of screening data, pathology results, all that. We know what percentage have and all these wonderful things. In terms of health services, I don't think there's a lot of evaluation yet. I think, Sue, the Victorian model is being evaluated. There is supposed evaluation going on of the settlement services, some of which is health related because there's a psycho-social health assessment which Immigration funds as part of their package for new arrivals. That's being evaluated supposedly.

My comment earlier did relate to the 15 or so million dollars nationally that goes into torture and trauma services nationally. Again it'd be interesting to hear Susan's and Constance's views of those, but there hasn't been any formal evaluation of counseling services in Australia for refugees despite those services being funded for well over a decade now. They just got another 12 million, which is wonderful, I think.

MS NAYLOD: Just another small comment. I'm Alice Naylod and I'm one of the councilors on the Rural Health Alliance. I live in a small town that is in the vicinity of Coffs Harbour and I just wanted to make the comment not to discount those small towns that are around the bigger regional centres where immigrants have gone to. We have two Somali families in our town and the town has embraced them wholeheartedly. It certainly helps that their kids are talented and very sporty, but the small towns - there are problems, obviously, because there's access to the health services that aren't in my small town and they have to go to Coffs Harbour, but we have a very active volunteer driving service. Just a comment not to discount the small towns that are around those regional centres that perhaps can provide as

warm a community and maybe some other issues in terms of no targeted violence and things like that that can occur in some of the bigger regional centres.

MS ARMSTRONG: Thank you. Hello, I'm Fiona Armstrong from the [Australian Nursing Federation](#) and a member of the National Rural Health Alliance. I just wanted to say it's been a fantastic session. It's been really interesting to hear from all of you and particularly useful to hear those firsthand stories from Constance and Susan and to applaud you coming along, for your courage in sharing your stories. I just wondered if you could tell us a little bit more. We've heard a little bit about what you think would be helpful in terms of providing services from Constance on the structure and the support that's provided in settlement services to provide structure, and Susan around women's health, or I might have that back to front. Sorry. But could we hear from each of you about what else might be important in terms of services that would be appropriate to meet your needs, the needs of your families and the people in your community?

MS OKOT: For me I think it's very hard to tell what I want, because what I have - when I came actually from Africa I really couldn't make it, but I first came to multicultural and then I went to Dr Duncan and then I was sent to Centacare for counseling. The problem is actually in the question. Somebody like me who can speak English it's easy. But somebody who don't understand English and there are some people who actually came from even in the country they haven't been in the city and from their village to the camp and from the camp to here. So everything is just new. It is very hard to adjust what really you want. You feel somebody need to help you and you don't know how to help you. You need something but you don't know what actually you need. I'm saying in Wagga because of this networking or just something coming from I don't know.

MS MOI: I think for me, one of the difficulty things is really financial constraints, particularly for services not fully covered by Medicare such as going to see a specialist. When there is something beyond Dr Duncan, what do we do? That is a challenge because that is not covered and so we do not really have that kind of resources to go and see a specialist. I think in complete skills of health professionals really to detect some of the things that are unfamiliar to them and it brings back the risk of re-traumatisation when healthcare treatments are conducted in a way that is not proper, you know. I know we are all human and sometimes things really happen, but the perception of racism and discrimination is still there.

Someone told me that he went to see a doctor and the doctor told him, "What brought you people here? You have come with all your diseases and you are coming to contaminate this race." Now, this is someone who is sick and somebody who has been traumatised before. What do you think is going to happen to this man? There was a person also who told me that they took their child to see a doctor and when it was the nurse or somebody who was caring for the child says, "I am not able to see the disease on the skin of your child because I don't know how to see it on a black skin." Or if you are given a shot then she says she doesn't know where the spot is.

Those are some of the things that we live with. These are heavy things. I am not saying that there are answers to those things and I'm not saying that that is a general thing. They are not general but they are there. What do we do? I guess we need some kind of training for the nurses probably and for some doctors who are not used to different people, but I am not medical person myself, but I do believe that human beings are all the same. So

some people need to be trained and probably they may change their ways of dealing with people. I don't know.

MR WAKERMAN: Okay. Well, we might wind things up after Alan has a question.

UNIDENTIFIED MALE: It recalled to my mind when you were saying those things that sometimes the buffer against this type of day-to-day discrimination which, as most of us know, is a common complain of our local indigenous population as well, is in the ability to socialise widely and with perhaps more like-minded people. How are you find that in Wagga, the big society thing? I mean, you mentioned some smaller aspects, but.

MS MOI: I guess as I say it's not a general thing. I cannot say that Wagga is bad. Wagga is good. The people are really lovely. They are so wonderful people there, but still there are those who also take it upon themselves to behave the way they want. I cannot blame them, because some of them have really not seen Africans, you know. We come with all the shapes and the looks and yeah, it's funny sometimes. So there are those who wonder, "What kind of human beings are this?" But, yeah, probably with education and things like that they'll get through it because we are here and here to stay.

(Applause)

MS OKOT: And even if it is that, even back in our country we have the same problem. Even in your family you may have a mother who is having seven children. All these children are not the same. Their minds are different from their father and their mother. They bring their own mind and sometimes a father can divide children or a mother can say, "This child is not good," and she's the one who delivered the child. So all these things for me, I guess it is part of our body wherever you are. Not only in Australia, not in big city or small city. It is all over the world. That is why the war broke out.