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# Forming a migrant community network to build capacity of communities re BBV/STI prevention

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# Multicultural Community Action Network
# M-CAN

- developed by MHSS to build upon the success of their Peer Education program
- opportunity for education and networking
- increase the capacity of CALD communities to address their BBV/STI health needs
- evolve with increased community input


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# The M-CAN model


- A minimum of 4 meetings
- Ongoing communication
- A steering committee of 12 members
  - Specific interests in refugee and migrant well-being & high level of education and skill
  - MHSS's community engagement officer chairs
  - Responsible for recruiting members and determining format and forums and TOR

# M-CAN Terms of Reference

- Provide guidance on cultural appropriateness
- Get feedback on health promotion
- Advocate on issues of health and wellbeing
- Help identify support needs re sexual health
- Provide a link between MHSS and community

On World Refugee Day, we launched the new Multicultural Community Action Network (M-CAN) to help improve the sexual health of people from refugee and migrant backgrounds.

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# Strategic communication and planning

- M-CAN members highlighted unmet needs relating to communication
  - not regular or useful enough, keep them informed, how they could contribute, plan ahead, keep them "in the loop" on issues that may be of interest
- Non-members still wanted to feel engaged
  - welcomed contact that may benefit their communities
  - want to be kept informed about initiatives or ideas that they could potentially be consulted on

# Personal motivations and incentives

- Community minded and engaged - crucial to the work of MHSS and the success of M-CAN
- The main incentives for volunteers was the fulfilment of their own obligations and ambition
- Each of them mentioned their competing schedules
- Potential for personal drive to wane and personal fulfilment to no longer be incentive enough

# Modes for building community capacity

- Community members revealed conflicting ideas around the mode of capacity building
  - Some recognised that building their own knowledge, skill and networks via M-CAN meant that they were more equipped to service their community by aiding community participation and assisting MHSS to sustain a connection with their communities
  - Others preferred peer education as a method of BBV/STI related health promotion for their communities and wanted it to continue

# Recommendations

- Communication strategies and structures need to be integrated into the day-to-day processes of MHSS
- The MCAN steering committee should be well resourced and supported to sustain interest/energy
- MHSS should plan ways to better transition and/or disengage with individuals not currently involved
- Adequate indicators and study methods need to be designed to capture and measure community benefits of M-CAN

# M-CAN's progress to-date

- Over 70 members from various communities
- M-CAN integrated into other MHSS activities
- M-CAN members have become integral to most of MHSS's initiatives
- Primary source of community engagement
- Members collaborate with partner agencies

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