Overview of the CALD community in South Australia and common nutritional issues faced by new arrivals

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Voluntary vs involuntary migrant

> Voluntary (economic, education, work, family)
  - Prepare
  - Say goodbye
  - Learn language
  - Bring household items etc with them
  - Have career recognised
  - Look forward to a new life

> Involuntary (refugee)
  - No time for preparation
  - Bring nothing
  - Lose contact with family and friends
  - Don’t know language
  - Lose career
  - Often still look back to what they have left behind
  - Mostly from countries with limited resources, infrastructure, health
CALD populations in South Australia

> 307,000 residents (20%) were born overseas in one of over 160 different countries
> 118,000 residents (8%) were born in Australia, but were the children of non-Australian born parents
> 13,440 overseas migrants settled in South Australia in 2008-09.
> 185,000 (12%) speak a language other than English at home
> In 2008-09 over 40% of all migrants were under the age of 24 years
> Since 2001 there have been substantial increases in the number of migrants from non-English-speaking countries eg Sub-Saharan Africa (Liberia, Guinea, Côte D'Ivoire, Congo, Sierra Leone, Malawi, Ghana, Uganda and Botswana), North Africa and the Middle East (including Sudan, United Arab Emirates) and Southern and Central Asia (Uzbekistan and Bangladesh).
Refugee profile

- 13750 refugees/year to Australia in 2008
- Boat arrivals 6% in 2008 -> 36% in 2011
- 1173 arrivals to SA in 2008 -> 2089 in 2011
  - 9% ->15% of national total
  - 437 in SE of SA
- 20% from Africa
  - 2/3 from Horn of Africa, others - Congo, Liberia, Sudan
- 50% from Middle East
  - 2/3 from Afghanistan, others - Iran, Iraq
- 30% from elsewhere
  - ½ Bhutan, 40% Burma, others - China, Sri Lanka
- 57% under 18 in 2006 ->34% in 2011
- 49% male in 2006 -> 64% in 2011

Refugee profile

- Higher levels of poverty
- Greater cultural differences
- Larger families with lower levels of education and English proficiency
- Older children have often been responsible for younger ones
- Long periods (often >10 years) in refugee camps - extremely unsafe, infectious diseases, poor sanitation and diet
- Limited or disrupted access to health care
Post migration
Drastic changes in lifestyle

Concepts of survival vs health

- ‘Survival’ is a priority, not necessarily health
- Coping with challenges of resettlement
- Dealing with grief, loss and dislocation
- Unfamiliar with role of the health profession
- Fear of being ‘sent back’ if chronically ill
- No concept of preventive health care
- Expectation that health will deteriorate with age
- Housing and food
- Health literacy
- Caring for family
- Education
- Aspirations for a better life
Infections vs Non-communicable Diseases

> Chronic disease contributes over 70% of disease burden in Australia and will increase to 80% by 2020
> In most developing countries the risk of dying at a young age from an infectious disease is much greater than the risk of dying of a chronic disease (NCD)
> 14 million people in Africa suffer from malnutrition and starvation
> Stunting or chronic undernutrition affects 35-40% of children
> May be protein, vitamin B12 or other deficiencies.

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Nutrition Challenges in CALD Migrants

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Thanks to Dr Lilian Miranni
Food insecurity

> High levels of anaemia and micronutrient deficiencies found in refugee camps, including Kakuma refugee camp in Kenya
  - United Nations World Food Program (WFP) and UNHCR have improved the quality of food including the addition of micronutrient powders (MNP).

> The Bhutanese customarily do not consume animal source foods and supplementation may be necessary

> Although people from Iran and Afghanistan do consume meat, many refugees have not been in refugee camps and so would not have received micronutrient supplementation.

> Residence in Australia will not necessarily result in a rapid improvement in dietary quality and quantity.
  - In a study of 31 refugees who had settled in Perth, 71% had experienced ‘running out of food’.
  - A 2007 study also found that immigrant women who have spent less than half their life in the U.S. were at higher risk of food insecurity.

Top ten source countries for refugees in the Australian off-shore resettlement program and risk of food insecurity

<table>
<thead>
<tr>
<th>2010</th>
<th>2011</th>
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<tr>
<td>Top ten refugee-source countries, Australian off-shore humanitarian intake</td>
<td>Risk of food insecurity</td>
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<tr>
<td>1</td>
<td>Burma</td>
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<td>2</td>
<td>Iraq</td>
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<td>3</td>
<td>Bhutan</td>
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<td>4</td>
<td>Afghanistan</td>
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<td>5</td>
<td>Congo (DRC)</td>
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<td>6</td>
<td>Ethiopia</td>
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<td>7</td>
<td>Somalia</td>
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<td>8</td>
<td>Sudan</td>
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<td>9</td>
<td>Liberia</td>
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<td>10</td>
<td>Sierra Leone</td>
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Vitamin B12 deficiency

> Vitamin B12 deficiency is common in many countries of origin of refugees
> 16.5% of participants in recent national Australian research had Vitamin B12 deficiency (< 150 pmol/L)
> One-third of participants from Iran and Bhutan, and one-quarter of participants from Afghanistan had Vitamin B12 deficiency.
> Vitamin B12 essential vitamin for nerves and blood
> Low levels in mothers associated with neural tube defects in babies
> Low levels associated with irritability, depression and anxiety
  - These are common symptoms in CALD people and Vitamin B12 deficiency is very easy and cheap to fix

National Health Survey 2007-08 (ABS, 2009a): Long term health conditions for Australian born and overseas born Australians, South Australian residents (%)
Common Chronic diseases in refugees and other migrants

> Diabetes
> Hypertension
> Asthma
> Hepatitis B
> Rheumatic Heart Disease
> Coronary heart disease
> Cerebrovascular disease
> Mental Health problems
> Pain

Diabetes

> CALD Australians have significantly higher rates of diabetes, diabetes-related hospitalisations and deaths
> Men born in North Africa have 3.6 times more diabetes
> Increased reliance on convenience foods and not on healthy food prepared in the home
> The ‘thrifty’ genotype
> If undernourishment in pregnancy increased risk of insulin resistance in the children
> Some ethnicities seem to have insulin resistance and some insufficient production of insulin
> Pre-migration often very active with lots of walking to get to school or the shops, get wood or water
  • No TV or computer games
> Often rapid weight gain within 5 years of arrival
Cardiovascular and cerebrovascular disease

- Migrants are more affected than those born in Australia
- Increased risk factors – smoking, diabetes, hypertension, diet
- Language and other barriers mean the presentation is often late
- Angina and TIs are initially clinical diagnoses and so need accurate language
- Safety to go out and walk
- Difficulties with changing views of food
- Difficulties with the idea of preventive health care and chronic medication

Attitude to food after arrival in Australia

- The food in refugee camps or in areas of poverty is often scarce and of poor quality, so food may be overeaten in Australia
- Food was about survival and not about taste or preference and now there is a huge range
- Multi-generational deficiencies of vitamins and iron passed from mother to child but this is not a priority
- Dietary guidelines and a ‘balanced diet’ are completely unknown
- Thin means poor, diseased, not loved, despair,
- Fat means rich, powerful, doing well, well cared for, blessed by God
Stages of change in Health Promotion

- **Precontemplation**: The patient has no intention of changing their behaviour in the foreseeable future. The patient is perhaps unaware that there is a problem.

- **Contemplation**: The patient is aware that a problem exists and is thinking about changing their behaviour but has no firm commitment to take action.

- **Preparation**: The patient intends to change and develops a plan and a time-frame for its implementation.

- **Action**: The patient begins to modify their behaviour to overcome the problem. This requires considerable commitment and energy.

- **Maintenance and relapse prevention**: The patient works to prevent relapse. This stage may last for many months or years.

Socio-political issues affecting nutrition and chronic disease management

- **Religious and traditional issues**
  - Can affect attitude to management—God’s will
  - Fear of addiction to medication

- **Stigma**
  - Denial of certain illnesses because of stigma eg TB, Hep B
  - View that diseases are contagious eg mental illness

- **Poverty and transport issues**
  - Not enough money to pay for food, for a test or medication

- **Discrimination**
  - Interpreters, staff attitudes
  - Health system literacy

- **Gender issues**
  - Access to healthcare for women
  - Women often look after health of family rather than their own
The Health professional issues

- Time
- Communication style
- Cultural awareness
- Language
- Expectations
- Sticking to the ‘evidence’
- Hopelessness
- Ethnocentricism
  - Only a small percentage of motives, beliefs and reactions are conscious for both health professional and patient
  - The ‘ethnocentricism’ of the health professional needs to be conscious to properly recognise the cultural beliefs and expectations of the patient
- Learning about cultural practices
  - Eg where do you buy camel’s milk in Adelaide?

The patient

- Language
  - Importance of an appropriate interpreter
- Literacy and Education
  - Draw pictures and other visual cues for medication etc
  - Difficulties with numbers, time
- Health literacy
  - Importance of explanations and diagrams
- Expectations – Conscious and unconscious
  - Expect a short-term treatment that will cure the problems
  - Unusual to have personal responsibility for health
  - Prevention of chronic illness a very foreign concept
  - Health is expected to deteriorate with age
- Priorities
  - Education and care of family come before chronic illness

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The health-professional-patient interaction

- Mismatch of style
  - Authoritarian
  - Empathic
  - Informative
  - Collaborative

- Use of Cultural Awareness Tool

- Religious and gender issues

- Differences in world-view
  - Ego-centric vs socio-centric

- Patient-centred therapies
  - Narrative therapy
  - Inco-operating traditional therapy

Cultural Awareness Tool

- What do you think caused your problem?
- Why do you think it started when it did?
- What do you think illness does to you?
- What are the chief problems it has caused for you?
- How severe is your illness?
- What do you most fear about it?
- What kind of treatment/help do you think you should receive?
- Within your own culture how would your illness be treated?
- How is your community helping you?
- What have you been doing so far?
- What are the most important results you hope to get from treatment?
The organisation

> Time
  • Takes at least twice as long and usually even longer to see a refugee but using an interpreter does not double the time

> Finances
  • Decreased remuneration as doing the same work in twice the time

> Administrative support
  • Need to have cultural awareness training
  • Booking of interpreters

> Multi-disciplinary team
  • Best way to support patients with complex issues, multiple problems or big families
  • Home visits
  • Visits to supermarket

> Support for health professionals who are ‘burning out’ or stressed

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Why Use an Interpreter?

> Ensures accurate communication between people of different languages while taking into account cultural sensitivities and confidentiality.

> In times of crisis or in traumatic or emotionally-charged situations, second-language competency may decrease dramatically

> Because qualified interpreters are bound by the AUSIT (Australian Institute of Translators and Interpreters) Code of Ethics.

> They understand and practise impartiality, confidentiality and accuracy when interpreting and their conduct is professional.
Family members

> If you do not provide an interpreter when needed or use family members
  • You are not providing a good service
  • You risk serious consequence to your client's health/well being.
  • You will be in breach of privacy legislation

> If you use family members
  • They might filter the information to "protect" their parent, relative or friend
  • They might not be able to handle, or cope with things they will hear
  • They might use information for private advantage or gain
  • They cannot be expected to know the specialised terminology, and might make a serious or even fatal mistake.
  • They will not be impartial

Conclusion

> Dealing with nutrition and chronic health problems in CALD communities involves a wider range of potential issues, as well as an increased risk of some of the more familiar illnesses

> Interpreters, culturally appropriate education and management style are of the utmost importance

> Recognition that there are many factors that may influence adherence to management plans

> The health professional needs to be aware of the patient’s readiness for change

> A multidisciplinary team and a culturally aware workplace is probably the best place to deal with more complex chronic health problems.
References


> SA Health (2011) South Australia’s Culturally and Linguistically Diverse Population


Thank you