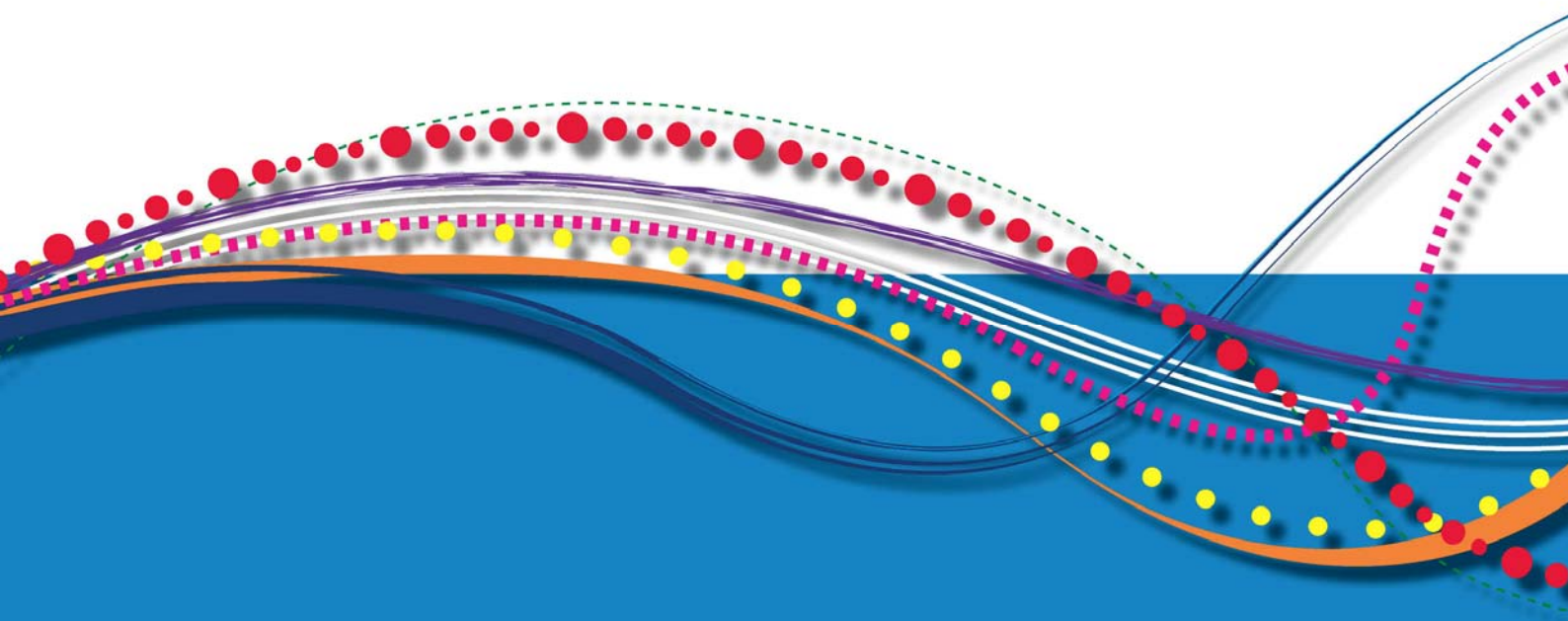


Queensland Health

Community Profiles for Health Care Providers



Acknowledgments

Community Profiles for Health Care Providers was produced for Queensland Health by Dr Samantha Abbato in 2011.

Queensland Health would like to thank the following people who provided valuable feedback during development of the cultural profiles:

- Dr Taher Forotan
- Dr Hay Thing
- Vasanthi Sivanathan
- Fazil Rostam
- Magdalena Kuyang
- Abel Sibonyio
- Azeb Mussie
- Nao Hirano
- Surendra Prasad
- Mary Wellington
- Rosina Randall
- Pastor John Ngatai
- Ianeta Tuia
- Paul Khieu
- Lingling Holloway
- Somphan Vang
- Phuong Nguyen
- Lemalu Felise
- Faimalotoa John Pale
- Vaáaoao Alofipo
- Charito Hassell



© State of Queensland (Queensland Health) 2011.

This document is licensed under a Creative Commons Attribution Non-Commercial 2.5 Australia licence. To view a copy of this licence, visit <http://creativecommons.org/licenses/by-nc/2.5/au>. You are free to copy, communicate and adapt the work for non-commercial purposes, as long as you attribute Queensland Health.

For permissions beyond the scope of this licence contact:

Intellectual Property Officer
Queensland Health
GPO Box 48
Brisbane Queensland 4001
email IP_Officer@health.qld.gov.au
phone 07 3234 1479

Suggested citation:

Abbato, S. *Community Profiles for Health Care Providers*. Division of the Chief Health Officer, Queensland Health. Brisbane 2011.

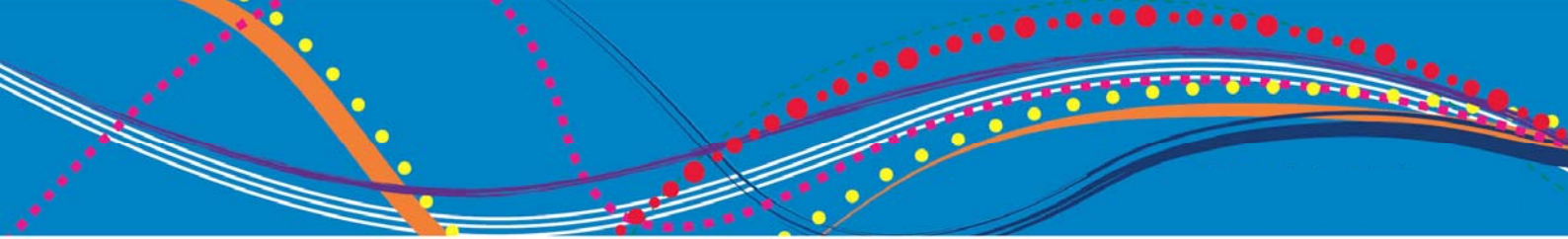


Table of contents

Acknowledgments.....	i
Table of contents	ii
Introduction	1
Afghan Australians.....	2
Australian South Sea Islander People	8
Burmese Australians.....	12
Burundian Australians	17
Cambodian Australians.....	21
Chinese Australians	26
Ethiopian Australians.....	31
Filipino Australians	37
Hmong Australians.....	42
Indian Australians	47
Iraqi Australians.....	54
Japanese Australians.....	60
Maori Australians.....	65
Papua New Guinean Australians	70
Samoan Australians	76
Sri Lankan Australians	80
Sudanese Australians	85
Vietnamese Australians	91

Introduction

Queensland is a culturally diverse state. At the 2006 Census, 40 percent of Queensland's population was born overseas or had a parent who was born overseas, and 7.8 percent spoke a language other than English at home. Queenslanders spoke more than 270 languages and about 50,000 people, or 1.2 percent of the population, were unable to speak English well, or not at all.

The increasing level of cultural diversity in the Queensland population means that to be safe, health services need to be culturally appropriate and responsive. Queensland Health's approach to building the cultural competency of the workforce is presented in [The Queensland Health Cross Cultural Learning and Development Strategy 2009-2012](#) and the [Queensland Health Cross Cultural Capabilities](#) documents. The Cross Cultural Capabilities define five areas where health care providers need to be capable to work effectively with a culturally diverse clientele and workforce.

[Practical tools and resources](#) are also available to assist health care providers to deliver culturally appropriate care. *Community Profiles for Health Care Providers* is one such practical tool that assists health care providers to better understand the health beliefs, pre-migration experiences, communication preferences and other aspects of their clients' culture.

However, it should be noted that people do not fit into a pre-determined cultural box or stereotype, and there are certain risks in summarising particular cultural issues and belief systems.

There is great diversity within the communities described, with sub-cultures, differences between rural and urban communities, and class groups apparent in all of these communities. As a result, the descriptions will not apply to all people from a particular cultural group.

These profiles should also be considered in the context of people's acculturation experiences. Both traditional health beliefs and the process of acculturation play an integral role in the health and well being of culturally diverse communities in Queensland.

These cultural profiles serve as a guide only, and provide an overview of some of the cultural and health issues that may concern particular communities. The profiles can be used as a pointer and may inform the health care provider of the issues that could be at play in the health care encounter. Health care providers should also consider their own cultural background and cultural beliefs as these are also at play in the health care encounter.

Afghan Australians

- The first Afghan people arrived in Australia in 1859 to drive camels in the Burke and Wills expedition².
- The number of Afghanistan-born people living in Australia in 1901 was 394 and there was a gradual decline in the population until the early 1980s².
- As a result of the 1979 invasion of Afghanistan by the Union of Soviet Socialist Republics (USSR) and subsequent civil war in the 1980s, many Afghan people (including educated professionals) sought refugee status in Australia.
- In the late 1990s, a number of Afghan people came to Australia fleeing the Taliban regime².
- After the United States and Britain initiated a North Atlantic Treaty Organization (NATO) supported war on the Taliban in October 2001, more Afghan people fled as refugees.
- Although the United Nations began repatriation of Afghan people from 2002⁴, the numbers of Afghan people settling in Australia peaked in 2005 and 2006 with more than 5000 Afghan refugees arriving in Australia during the two year period³.
- **Places of transition:** Pakistan and Iran.
- **Ethnicity:** The four main ethnic groups in Afghanistan are: Pashtuns (42 per cent), Tajiks (27 per cent), Hazaras (16 per cent) and Uzbeks (nine per cent)^{5,6}.
- **Language:** The main languages spoken in Afghanistan are: Dari (Afghan Persian) 50 per cent, Pashto 35 per cent and Turkic languages (primarily Uzbek and Turkmen) 11 per cent. Thirty other minor languages are spoken. Many people are bilingual⁷.

Population of Afghanistan-born people in Australia (2006 Census): 16,753¹

Population of Afghanistan-born people in Queensland: 840¹

Population in Afghanistan-born people in Brisbane¹: 725¹

Gender ratio (Queensland): 85.6 females per 100 males

Median age (Australia): The median age of Afghanistan-born people in Australia in 2006 was 28.9 years compared with 46.8 years for all overseas-born and 37.1 for the total Australian population²

Age distribution (Queensland)¹:

Age	Per cent
0-19	27%
20-39	47.7%
40-59	19.5%
60+	5.7%

Arrivals – past five years (Source – Settlement Reporting Database³)

Year	Australia	Queensland
2006	2568	117
2007	1862	92
2008	1602	101
2009	2345	166
2010	2665	233

- **Religion:** Islam is the official religion of Afghanistan and is practised by more than 99 per cent of Afghan people. Sunni Muslims make up 80 per cent, Shi'a Muslims make up 19 per cent and other religions one per cent or less^{5,7}.

Ancestry, language and religion in Australia (2006 Census for Afghanistan-born)²

- The top three ancestry responsesⁱⁱ of Afghanistan-born people in Australia were:
 - Afghan – 79 per cent
 - not stated – 6.6 per cent
 - Hazara – 4.5 per cent.
- The main languages spoken at home by Afghanistan-born people in Australia were:
 - Dari – 66.1 per cent
 - Persian (excluding Dari) – 16.2 per cent
 - Pashto – 7.6 per cent.
- The main religion of Afghanistan-born people in Australia was Islam (95.2 per cent).

Communication

- Hazaragi is a dialect of Dari spoken by the Hazara ethnic group of Afghanistan. Hazaras comprise between 16 to 20 per cent of the population of Afghanistanⁱⁱⁱ and they account for more than 50 per cent of the Afghan refugees who have arrived in Australia between 2006 and 2010⁶.
- The rates of education of Hazara people are lower than the other main ethnic groups of Afghanistan and many Hazaras are illiterate⁹. In many cases Hazaragi speakers (particularly those who have lived in rural areas) cannot understand Dari interpreters⁹. There is a shortage of Hazaragi interpreters in Australia^{6,8}.
- There is a fear in the Afghan Australian community that interpreters will not abide by confidentiality requirements⁸.
- Many Afghan Australian women wear a *burqa* (loose body covering) and *hijab* (head covering) in public.
- It is normal for people of the same gender (men/men, women/women) to shake hands, kiss on the cheek and hug (particularly among men) when greeting^{6,8}.

- Muslim men and women may be reluctant to shake hands with people of the opposite gender. It is advisable that in such situations it is left to the Muslim person to decide what is appropriate⁸.
- Afghan Australians may also greet by placing their hands over their heart and bowing slightly^{6,10}.
- Eye contact is generally avoided between men and women. Eye contact between men is acceptable but is usually only occasional, not prolonged¹⁰.
- An Afghan Australian elder's nod may merely be a social custom showing politeness and respect for authority rather than a sign that they understand or agree with what the healthcare provider is saying¹¹.
- As a sign of respect, Afghan Australians do not call older people by their given name⁸.
- Afghan Australians are likely to show their appreciation of a service provided to them by expressing words of blessing⁸.

Health in Australia

- Afghanistan has the fourth highest mortality rate and second highest infant mortality rate in the world, and a life expectancy of only 44.6 years (male 44.5, female 44.9)⁵.
- As a result of their experiences of war and displacement, and their experiences as refugees, which in many cases has included mandatory detention, Afghan refugees are at high risk of mental illness and emotional issues¹³.
- There is little research on the physical and mental health status of Afghanistan-born Australians and Afghan refugees in Australia. High rates of post traumatic stress disorder (PTSD), depression and anxiety have been found in Afghan asylum seekers and refugees living in the Netherlands¹⁴. Afghan women were shown to have higher rates of PTSD, depression and anxiety than men¹⁴.

- According to a 2002 population-based mental health survey in Afghanistan, women had significantly lower mental health status and poorer social functioning than men¹²:
 - The prevalence of depression was 73 per cent in women and 59 per cent in men
 - The prevalence of symptoms of anxiety was 84 per cent in women and 59 per cent in men
 - The prevalence of PTSD was 48 per cent in women and 32 per cent in men.

Health beliefs and practices

- Beliefs about preserving health include living in accordance with the precepts of Islam which strongly emphasises personal daily hygiene including washing before prayer. Regular exercise, eating fresh food and a balanced diet, staying warm, and getting enough rest are also seen as important for health¹⁵.
- Traditional Afghan causes of illness include: an imbalance of *hot* and *cold* forces in the body, not adhering to the principles of Islam and the will of God, possession by evil spirits called *jinn*, being given the *evil eye*, or sometimes witchcraft¹⁵. *Jinn*, the *evil eye* and witchcraft are mainly seen to cause mental illness⁶.
- Prayer is traditionally seen as important in healing illness¹⁵.
- Doctors are held in very high regard⁸.
- Financial hardship has meant a major lack of health care services in Afghanistan, especially in rural areas. As a result, there has been a reliance on the use of medicinal herbs and plants to treat various illnesses⁸.
- Older Afghan Australians may prefer traditional treatments to Australian medical treatments⁸.

- Older Afghan Australians have a strong preference for receiving care from same sex health care providers, particularly in nursing tasks such as assistance with personal care¹⁵.
- Religious rituals and customs at birth and death are important. A Muslim birth custom involves having an adult male be the first person to speak to a newborn infant. This male, who becomes a special person in the infant's life, whispers a secret blessing in the ear of the child¹⁶. This is usually the *Adhan*, or what is usually recited as a call for prayer⁶.
- Muslims may prefer to decrease sedation at the time of death so that the patient is able to hear the final part of the same blessing he or she heard at birth. The final part of the blessing, which is called the *Kalima* or confession of the faith, should be the last thing one hears at death¹⁶.
- For more information on Islamic beliefs affecting health care please refer to the [Health Care Providers' Handbook on Muslim Patients](#)¹⁷.
- A strong cultural stigma is attached to mental illness. Many mental health conditions such as depression may not be considered an illness. Afghan Australians may be reluctant to access mental health services⁸.
- There is a strong stigma attached to men having a mental illness as it is seen as a sign of weakness^{8,6}.

Social determinants of health

- Education and literacy^{iv} rates in Afghanistan are low. The overall literacy rate in 2000 in Afghanistan was 28.1 per cent^{5,7}. Female literacy was 12.6 per cent and male 43.1 per cent^{5,7}.
- Many Afghan women experienced severe restrictions to their movements under Taliban rule in Afghanistan. This includes being banned from attending educational institutions and foregoing medical treatment including attendance at pre and post natal clinics due to a fear of being in public and affordability issues^{18,19}.

- Afghan refugees have been exposed to terror, destruction and loss from political violence. Many have experienced the destruction of homes, the disappearance or death of family members, sexual assault by armed combatants, arbitrary detention, torture and a chronic fear of being injured or killed²⁰. In addition, many Afghans have experienced poverty, displacement, and the loss of social connections and social isolation before seeking refuge in countries such as Australia²⁰.
- The conditions in detention centres and the delay in the processing of refugee claims adds to the trauma which refugees have already experienced in Afghanistan²¹.
- Proficiency in English^v in Australia (2006 Census)¹:
 - 72 per cent of Afghanistan-born men and 59 per cent of Afghanistan-born women reported that they spoke English well or very well
 - 19 per cent of men and 26 per cent of women reported that they didn't speak English well
 - 3 per cent of men and 11 per cent of women reported that they didn't speak English at all.
- At the time of the 2006 census, 33.7 per cent of Afghanistan-born people aged 15 years and older had some form of higher non school qualifications^{vi} compared to 52.5 per cent of the total Australian population².
- The participation rate in the workforce (2006 census) was 46 per cent and unemployment rate was 17.7 per cent compared to the corresponding values

of 64.6 per cent and 5.2 per cent in the total Australian population². The median weekly income for Afghanistan-born people in Australia aged 15 and older was \$234 compared to \$466 for the total Australian population².

- A 2009 large-scale audit discrimination study based on job applications using ethnically distinguishable names showed that people with names from the Middle East were subject to discrimination in applying for jobs. People with Middle Eastern sounding names had to apply for more jobs to receive the same number of interviews as people with Anglo-Saxon sounding names and those with names of more established migrant groups such as Italian, even if they had the same work history and qualifications²².

Utilisation of health services in Australia

- The use of hospital services among people born in refugee-source countries including Afghanistan is lower or similar to that of the Australia-born population^{23,24}.
- Identified barriers to accessing health care services in Australia include: services and procedures incompatible with Islamic beliefs, discrimination on the part of service providers, exclusion based on language (lack of translated information and insufficient numbers of professional interpreters), loneliness and insecurity based on the want of customary family support, alienation based on a sense of not belonging, and not being able to negotiate the health care system¹³.

References

1. Australian Bureau of Statistics. CDATA Census 2006. Available: <https://www.censusdata.abs.gov.au/CDATAOnline>. Accessed 07/12/2010, 2010.
2. Department of Immigration and Citizenship. *Community Information Summary: Afghanistan born*. Commonwealth of Australia; 2006. Available: <http://www.immi.gov.au/media/publications/statistics/comm-summ>.
3. Department of Immigration and Citizenship. Settlement reporting database. Available: <http://www.immi.gov.au/settlement>. Accessed 07/12/2010, 2010.
4. Pajhwok Afghan News (PAN). UNHCR hails Pakistan as an important partner. Nov 3 2002, 2007.
5. Central Intelligence Agency (CIA). *The world fact book*. CIA; 2010. Available: <https://www.cia.gov/library/publications/the-world-factbook/>.
6. Forotan T. *Review of Cultural Diversity Profile- Afghanistan*. Personal communication; 14 February 2011.
7. Daniel K. *SBS World Guide: The complete fact file on every country*. Sixteenth Edition ed. Prahan Victoria: Hardy Grant Books; 2008.
8. South Eastern Region Migrant Resource Centre. *Afghani Community Profile- Older people*. Melbourne; 2010.
9. South Eastern Region Migrant Resource Centre. *Afghan people in south east Melbourne: Perspectives of a migrant and refugee community*. Melbourne; 2009.
10. Kwintessential. Afghanistan- Language, Culture, Customs and Etiquette. Available: <http://www.kwintessential.co.uk/resources/global-etiquette/afghanistan.html>. Accessed 07/12/2010, 2010.
11. Crawley LM, Marshall PA, Lo B, Koenig BA. Strategies for culturally effective end-of-life care. *Annals of Internal Medicine* 2002;136:673-679.
12. Cardozo BL, Bilukha OO, Gotway CA, Wolfe MI, Gerber ML, Anderson M. Mental health of women in postwar Afghanistan. *Journal of Women's Health* 2005;14:285-293.
13. Omeri A, Lennings C, Raymond L. Beyond Asylum: Implications for nursing and health care delivery for Afghan refugees in Australia. *Journal of Transcultural Nursing* 2006;17:30-39.
14. Gerritsen A, Bramsen I, Deville W, van-Willigen LHM, Hovens JE, van-der-Ploeg KM. Physical and mental health of Afghan, Iranian and Somali asylum seekers and refugees living in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology* 2006;41:18-26.
15. Morioka-Douglas N, Sacks T, Yeo G. Issues in caring for Afghan American elders: insights from literature and a focus group. *Journal of Cross-Cultural Gerontology* 2004;19:27-40.
16. Davidson JE, Boyer ML, Casey D, Matsel SC, Walden CD. Gap analysis of cultural and religious needs of hospitalised patients. *Critical Care Nursing Quarterly* 2008;31:119-126.
17. Queensland Health and Islamic Council of Queensland. *Health Care Providers' handbook on Muslim patients Second Edition* Division of the Chief Health Officer, Queensland Health: Brisbane; 2010.
18. Ayotte B. Women's Health and Human Rights in Afghanistan: Continuing challenges. *Journal of Ambulatory Care Management* 2002;25:75-77.
19. Colville R. Afghanistan: The unending crisis- Afghanistan's women: A confused future. Vol UNHCR Refugees Magazine; 1997.
20. Miller KE, Omidian P, Rasmussen A, Yaqubi A, Daudzai H. Daily stressors, war experiences and mental health in Afghanistan. *Transcultural Psychiatry* 2008;45:611-638.
21. Steel Z, Sil DM. The mental health implications of detaining asylum seekers. *Medical Journal of Australia* 2001;175:596-604.
22. Booth A, Leigh A, Varganova E. *Does racial and ethnic discrimination vary across minority groups? Evidence from a field experiment*. Australian National University: Canberra; 2009.
23. Correa-Velez I, Ansari A, Sundarajan V, Brown K, Gifford SM. A six-year descriptive analysis of hospitalisations for ambulatory care sensitive conditions among people born in refugee source countries. *Population Health Metrics* 2007;5.
24. Correa-Velez I, Sundarajan V, Brown K, Gifford SM. Hospital utilisation among people born in refugee-source countries: An analysis of hospital admissions. *Medical Journal of Australia* 2007;186:577-580.



© State of Queensland (Queensland Health) 2011.

This document is licensed under a Creative Commons Attribution Non-Commercial 2.5 Australia licence. To view a copy of this licence, visit <http://creativecommons.org/licenses/by-nc/2.5/au>. You are free to copy, communicate and adapt the work for non-commercial purposes, as long as you attribute Queensland Health.

It should be noted that there is great diversity within communities and people do not fit into a pre-determined cultural box or stereotype. The information presented here will not apply to all Afghan Australians and this profile should be considered in the context of the acculturation process.

ⁱ Brisbane is defined as Local Government Area of Brisbane in ABS Census data.

ⁱⁱ At the 2006 Census up to two responses per person were allowed for the Ancestry question, count is therefore total responses not person count.

ⁱⁱⁱ Although some official estimates of the population size of Hazara in Afghanistan report it at 9 per cent (5.), the basis for this data is the successive Pashtun dominated governments who are believed to incorrectly represent the population of different Ethnic groups. Some Hazara leaders say that they are 30 per cent of the population. Many agree that the correct proportion is likely to be between 16 and 20 per cent.

^{iv} Literacy is defined as those aged 15 and older who can read and write.

^v Missing and not-stated responses to this question on the census were excluded from the analysis.

^{vi} Non-school qualifications are awarded for educational attainments other than those of pre-primary, primary or secondary education.

Australian South Sea Islander People

- Australian South Sea Islander people are the Australia-born descendants of the estimated 55,000 to 62,500 predominantly Melanesian people who were brought to Queensland and northern New South Wales between 1863 and 1904 to work as indentured labourers on sugar-cane and cotton farms⁴⁻⁶.
- Australian South Sea Islander people came from 80 Pacific Islands, but most were primarily from Vanuatu and the Solomon Islands⁵.
- Australian South Sea Islander people are not indigenous to Australia and are distinct from Australians born in the Pacific Islands⁴. They are their own unique cultural group⁵.
- The community was recognised by the Commonwealth Government as a unique minority group in 1994 following a report undertaken by the Human Rights and Equal Opportunity Commission⁷.
- The Human Rights and Equal Opportunity Commission's 1992 census estimated the Australian South Sea Islander population numbered between 10,000 and 12,000 people, with the majority (80 per cent) living in Queensland⁶. However, the 2001 Census reported only 3442 Australian South Sea Islander people based on ancestry⁶.
- **Language:** Australian South Sea Islander people predominantly speak English⁴.
- **Religion:** Most of the Australian South Sea Islander people who were brought to Queensland between 1863 and 1904 followed their own traditional religions, believing in the power of spirits, ancestors and one or more gods⁸. By the time recruitment to sugar-cane and cotton farms had ended in 1904, most Australian South Sea Islander people had converted to Christianity and many joined Australian churches or missions⁸. Today, Christianity is an integral part of what it means to be an Australian South Sea Islander person⁸.

Population of Australian South Sea Islander people¹ in Australia (2006 Census): 4098¹

Population of Australian South Sea Islander people in Queensland: 3030²

Gender ratio (Queensland): 84.1 males per 100 females³

Age distribution (Queensland)³:

Age	Per cent
0-19	38.8%
20-39	30.7%
40-59	22%
60+	8.4%

Communication

- In addressing others, Australian South Sea Islander people use the person's title (Mr, Mrs) followed by their surname⁹. This is particularly important when addressing older people⁹. In some cases, health professionals may be invited to use the respectful title of *Auntie* or *Uncle*⁹.
- Nonverbal communication is important, particularly eye contact and small gestures. Australian South Sea Islander people may be shy with strangers, particularly in one-on-one interviews, and will generally wait until the other person speaks⁴.
- Some Australian South Sea Islander people may use body language to communicate with each other nonverbally before responding to a question about health care. They may also read the body language of the health care provider¹⁰.
- Physical contact between people of the opposite sex such as touching or patting the head is best avoided. If it is essential for a patient to be touched during an

examination, it is recommended that the health care provider first explain the need to the patient¹⁰.

- Some Australian South Sea Islander people may be too shy or reluctant to ask questions or correct any misconceptions. Some people may say yes or nod simply to please or to avoid embarrassment, even if they do not understand. It may be necessary to check the person's understanding by asking questions or asking them to repeat important points from discussions⁴.
- Australian South Sea Islander people may find it easier to understand and retain information if healthcare providers use diagrams or models, and provide written notes on treatment plans or medication schedules. Australian South Sea Islander people may also find illustrated pamphlets on relevant topics helpful⁴.
- Many Australian South Sea Islander people operate on event time as opposed to clock time¹⁰. Scheduling appointments at event time, such as *around lunch time at 12:30pm* instead of scheduling a time that may have no event association, may assist clients to be on time for appointments¹⁰.
- Many Australian South Sea Islander people prefer a health provider of the same gender¹⁰.

Health in Australia

- There is little published research on the health of Australian South Sea Islander people.
- There is a high prevalence of diabetes, hypertension, heart disease and obesity in Australian South Sea Islander people compared to the overall Australian population^{8,11,12}. Diabetes rates have been shown to be three times higher than in the overall population^{4,8}.
- There is a higher incidence of smoking, as well as asthma^{8,11}.

Health beliefs and practices

- Australian South Sea Islander people may not be familiar with scientific explanations of health and disease⁴. In particular, older clients may have little knowledge of reproductive anatomy and health⁴.
- During times of illness, Australian South Sea Islander people often have a *special person* (either a relative or a friend) to provide assistance and care⁴.
- Modesty is an important cultural value and Australian South Sea Islander people prefer not to be touched unnecessarily⁴. There may be a preference for being bathed or dressed by a relative or nominated *special person*⁴.
- It is considered taboo to discuss reproductive and excretory functions due to the personal nature of the topics. If these subjects need to be raised, it is recommended that the importance of talking about these subjects is first emphasised⁴.
- Australian South Sea Islander people who are seriously ill may have large numbers of visitors from their extended family⁴. Providing a separate room during visiting hours (if possible) may assist⁴. Alternatively, the nominated *special person* or a relative could be asked to assist with arranging a roster of visitors⁴.
- Spirituality is important to Australian South Sea Islander people. When a person is dying, their relatives may wish to hold a bedside prayer vigil⁴.

Social determinants of health

- Australian South Sea Islander identity is based on a group culture, with group needs and decisions taking priority over those of an individual⁴.
- Australian South Sea Islander people are an economically disadvantaged community. The community was recognised as a distinct and severely disadvantaged ethnic group in 1994⁴.

- Poor education and employment opportunities have been the result of generations of poverty and discrimination⁸.
- Studies have indicated significant literacy issues for Australian South Sea Islander people⁸.
- Home ownership by Australian South Sea Islander people is lower than that of most other culturally and linguistically diverse communities in Australia⁸.

Utilisation of health services in Australia

- Australian South Sea Islander people have low access to health services. Reasons include limited knowledge of the services to which they are entitled, lack of transport in rural areas, and being mistaken for Indigenous people

and consequently referred to services to which they are not entitled⁴.

- A study in Mackay reported communication and cultural barriers between Australian South Sea Islander people and local hospital services¹³. The availability of Australian South Sea Islander health staff was an important factor in encouraging people to access the hospital, which was feared and seen as a place of death and suffering. Some respondents also expressed feelings of abandonment by health services, as their right to use Aboriginal and Torres Strait Islander health services was lost in 1989, and they did not feel welcomed at mainstream services¹³.
- A tendency to be stoical when in pain has contributed to delayed presentation to health services⁴.

References

1. Department of Immigration and Citizenship. *The people of Australia: Statistics from the 2006 Census*. Commonwealth of Australia: Canberra; 2008. Available: http://www.immi.gov.au/media/publications/research/_pdf/poa-2008.pdf.
2. Department of Immigration and Citizenship. *The people of Queensland: Statistics from the 2006 Census*. Commonwealth of Australia: Canberra; 2008. Available: <http://www.multicultural.qld.gov.au/services-resources/documents/People-of-QLD-Publication-Vol-1.pdf>.
3. Australian Bureau of Statistics. CDATA Census 2006. Available: <https://www.censusdata.abs.gov.au/CDATAOnline>. Accessed 07/12/2010, 2010.
4. Allotey P, Manderson L, Nikles J, Reidpath D, Sauvarin J. *Cultural diversity: A guide for health professionals*. Queensland Government Press: Brisbane; 1998.
5. Queensland Government. *Queensland Government action plan: Australian South Sea Islander Community*. Queensland Government Department of the Premier and Cabinet: Brisbane; 2001.
6. Australian Human Rights Commission: Flanagan T WM, Iuliano S,. Australian South Sea Islanders: A century of race discrimination under Australian law. Available: http://www.hreoc.gov.au/racial_discrimination/forum/Erace/south_sea.html.
7. Queensland Government MAQ. About Australian South Sea Islanders. Available: <http://www.multicultural.qld.gov.au/community/australian-south-sea-islanders/about.html>.
8. Queensland Government MAQ. *Australian South Sea Islanders: History*. Queensland Government, Multicultural Affairs Queensland: Brisbane; undated. Available: <http://www.multicultural.qld.gov.au/community/australian-south-sea-islanders/about.html>.
9. Queensland Health. *Australian South Sea Islanders: Defining cultures*. Queensland Health: Brisbane; undated. http://www.health.qld.gov.au/assi/docs/defining/com_strategies.pdf.
10. Queensland Health. *Australian South Sea Islanders: Building relationships*. Queensland Health: Brisbane; undated. Available: <http://www.health.qld.gov.au/assi/docs/building/reflections.pdf>.
11. Queensland Government QH. Australian South Sea Islanders: Foods and feasts. Available: http://www.health.qld.gov.au/assi/solutions/food_feasts.asp.
12. Hill P, Fa'afai E. The health of Australian South Sea Islanders in Mackay. *Pacific Health Dialog* 1996;3:28-35.
13. Kennedy RW. *Culture, identity, health: Australian South Sea Islanders in Mackay*. Melbourne, Deakin University; 2002.



© State of Queensland (Queensland Health) 2011.

This document is licensed under a Creative Commons Attribution Non-Commercial 2.5 Australia licence. To view a copy of this licence, visit <http://creativecommons.org/licenses/by-nc/2.5/au>. You are free to copy, communicate and adapt the work for non-commercial purposes, as long as you attribute Queensland Health.

ⁱ Population defined using Census Ancestry question.

It should be noted that there is great diversity within communities and people do not fit into a pre-determined cultural box or stereotype. The information presented here will not apply to all Australian South Sea Islander people and this profile should be considered in the context of the acculturation process.

Burmese Australians

- Approximately 3500 Burmese people sought refuge in Australia from 1947 to 1959 as a result of the rise of nationalism after Burmese independence from Britain².
- As a consequence of the military takeover of the Burmese government in 1962, a second wave of about 2500 Burmese settled in Australia between 1965 and 1972².
- Since 1972, the number of Burmese people settling in Australia has grown significantly through the Australian Government's Migration Refugee Special Humanitarian Programme².
- **Places of transition:** Since 1988, approximately one million Burmese people have fled to neighbouring countries, predominantly to nine main refugee camps on the border between Thailand and Burma⁴. Other countries of transition are Malaysia and India⁴.
- **Ethnicity:** Burma is one of the most ethnically diverse countries in the world⁵. The largest ethnic group, Burmans (or Bamar) form about 68 per cent of the population⁶. Other ethnic groups include:
 - Shan – 9 per cent
 - Karen (incl. Karenni) – 7 per cent
 - Rakhine – 4 per cent
 - Chinese – 3 per cent
 - Indian – 2 per cent
 - Mon – 2 per cent
 - Chin and Rohingya⁶.
- **Language:**
 - Burmese is the official language of Burma and is the main language spoken by Burmans⁵
 - Karen people speak several dialects of the Karen language including Sgaw Karen, Pwo Karen, Karenni and Pa-o⁵

Population of Burma-born people in Australia (2006 Census): 12,380¹

Population of Burma-born people in Queensland: 730¹

Population of Burma-born people in Brisbane¹: 463¹

Gender ratio (Queensland): 93.6 males per 100 females

Median age (Australia): The median age of Burma-born people in Australia in 2006 was 46.4 years compared with 46.8 years for all overseas born and 37.1 for the total Australian population².

Age distribution (Queensland)¹:

Age	Per cent
0-19	5.5%
20-39	26.5%
40-59	41.1%
60+	27%

Arrivals – past five years (Source – Settlement Reporting Database³)

Year	Australia	Queensland
2006	133	2
2007	32	5
2008	37	3
2009	2427	372
2010	1476	208

- Shan, Chin and Rohingya people all have distinct languages and dialects within these language groups. In all, more than 100 languages are spoken in Burma⁷.

- **Religion:**

- Burmans, Shan and Mon: Approximately 90 per cent are Theravada Buddhists⁵
- Karen: About 70 per cent are Theravada Buddhist, Buddhist-animist or animist, and about 20-30 per cent are Christian⁵
- Karenni (a subgroup of Karen): Most are animist⁵
- Chin: A large number are Christians. Others continue to practice animism⁵
- Rohingya: Predominantly Muslim.

Ancestry, language and religion in Australia (2006 census for Burma-born)²

- The top four ancestry responsesⁱⁱ of Burma-born people in Australia were:
 - Burmese – 50 per cent
 - English – 12 per cent
 - Chinese – 9.5 per cent
 - Karen – 3.7 per cent.
- The main languages spoken at home by Burma-born people in Australia were:
 - Burmese – 51.9 per cent
 - English – 33.5 per cent
 - Karen – 3.5 per cent
 - Mandarin – 2.9 per cent.
- The main religions of Burma-born people in Australia were:
 - Catholic – 34.3 per cent
 - Buddhist – 33.2 per cent
 - Baptist 11.1 per cent
 - Anglican – 6.7 per cent.

Communication

- Karen people who have travelled widely in the Karen State are usually able to speak a number of dialects of the Karen language. However, those people who have not travelled often have difficulty understanding other dialects⁵.

- Literacy rates among Karenni people are low⁵.
- Traditionally Burmese people do not have family names. Therefore, all members of a family may have names that bear no obvious relationship to each other⁵.
- It is customary to use titles (e.g. Mr and Mrs) when addressing people other than small children⁵.
- The following communication issues are particularly important for Burmese Buddhists:
 - It is disrespectful for legs to be stretched out with feet pointed towards a person⁵
 - The head is considered the spiritually highest part of the body and sensitivity is advised if it is necessary to touch the head⁵
 - Using both hands to give and receive an object is a sign of respect, particularly with older people⁵.
- These additional communication issues are relevant for Karen people:
 - Karen people normally walk behind those who are their seniors and elders⁵
 - Karen may answer a question with *no* to be modest when an affirmative answer may seem more appropriate⁵.
- It is often not appropriate to establish direct eye contact with Chin people, especially seniors⁵.
- Although the name Myanmar was adopted by the Burmese Military Government in 1989 and subsequently recognised by the United Nations, other international organisations, the business community and many Burmese expatriates who oppose the military government continue to use the old names, Burma and Burmese⁵.

Health in Australia

- Average life expectancy in Burma is 64.5 years (male 62.2, female 66.9) compared to 81.7 years for all people living in Australia (male 79.3, female 84.3)⁶.
- Karenni refugees living in Thai-Burmese border camps have been shown to have rates of depression, anxiety symptoms and post-traumatic stress disorder comparable to those of other communities affected by war and persecution⁸.
- Burmese refugees settling in Australia have been shown to have high rates of treatable infectious diseases including *Helicobacter pylori* infection, latent tuberculosis, vitamin D deficiency and strongyloidiasis⁹.

Health beliefs and practices

- Throughout Burma, rice is central to daily existence and is regarded as virtually synonymous with life itself. It is eaten at all meals⁵.
- Theravada Buddhist health beliefs include:
 - Good and bad events can be attributed to actions committed in the past⁵.
 - Aspects of mental illness are a result of one's past and current life actions (*karma*)¹⁰.
 - The health of a person is controlled by the four elements of fire, water, air and earth and any imbalance in these elements causes illness and disease⁵. Certain foods and medicines are classified as *hot* or *cold* and can adversely or positively affect health conditions and emotions. The classification of foods as *hot* or *cold* is unrelated to temperature¹¹. *Hot* foods are generally those foods which are salty, sour or high in animal protein, while *cold* foods are generally sweet or bitter¹¹. States of health seen as *hot* or *cold* are seen to require treatment with the opposite in medicine or foods¹².

- Buddhist verses are important in curing illnesses, either being blown over the patient or recited over water for the patient to drink¹³.
 - When a Buddhist is dying, a Buddhist monk or minister should be notified to provide chaplaincy services¹⁴. The monk will chant verses after the person has died to help release the person's good energies¹⁴.
 - The state of mind at the time of death is important in determining the deceased person's next rebirth¹⁴.
 - After childbirth, the mother's body is susceptible to illness because it is *cold* from blood loss. The mother may want her body warmed with external heat and warm drinks and may want to eat foods with *hot* properties. Sour and bitter foods are also seen as important to reduce blood flow¹².
- Many Karen and Karenni who have retained their animist belief system believe that a person possesses a number of souls called *kla* which might flee for various reasons (e.g. in connection with a mental breakdown)⁵. It is seen as vitally important to retain the *kla* and losing *kla* puts a person in danger of illness⁵.
 - One way of keeping *kla* is by an elder or religious shaman tying sacred string around the wrist⁵.
 - The *kla* are said to leave the body at death and reappear in the form of the *kla* of a newly born child⁵.
 - Non-Christian Chins may ascribe some conditions that cannot be cured by Australian health care practices to *hnam*, an evil spirit that dwells within humans⁵.
 - Belief in spells and black magic is thought to be widespread in Burma. When a person has an illness that cannot be cured by any kind of medicine, black magic is usually suspected, and a cure is sought from a healer experienced in dealing with illnesses⁵.

Social determinants of health

- Overall literacyⁱⁱⁱ rates in Burma are high as a result of the tradition of education in Buddhist monastery schools, as well as government campaigns to increase literacy throughout the population⁵. The overall literacy rate in 2006 was 89.9 per cent⁶. Literacy of women was 86.4 per cent and men 93.9 per cent⁶.
- Many Burmese refugees have experienced numerous traumatic events including the deaths of family members, prolonged separation from family, repressive measures and uncertainty about their future^{5,8}. In addition, they have been impacted in many cases by a lack of food and water and the widespread use of landmines^{5,8}.
- Burmese political dissidents have experienced traumatic events including interrogation, imprisonment, threats of deportation and torture¹⁵.
- Many Burmese refugees, particularly the Karen, Karenni, Mon and Shan people, were persecuted by the military regime in Burma, displaced and forced to live in refugee camps on the Thai border for extended periods of time, in some cases for decades^{5,8}.
- Burmese women are subject to numerous human rights abuses in Thailand due to their lack of legal status, including the denial of labour protections and health services, harsh living conditions, and sexual abuse¹⁶.
- Proficiency in English^{iv} in Australia (2006 Census)¹:
 - 82 per cent of Burma-born men and 76 per cent of Burma-born women reported that they spoke English very well or well
 - 16 per cent of men and 20 per cent of women reported that they did not speak English well
 - 2 per cent of men and 4 per cent of women reported that they did not speak English at all.
- At the time of the 2006 census, 53.9 per cent of Burma-born people aged 15 years and older had some form of higher non-school qualifications^v compared to 52.5 per cent of the total Australian population².
- The participation rate in the workforce (2006 census) was 59.3 per cent and the unemployment rate was 5.3 per cent compared to the corresponding values of 64.6 per cent and 5.2 per cent in the total Australian population². The median weekly income for Burma-born people in Australia aged 15 and older was \$432 compared to \$466 for the total Australian population².

Utilisation of health services in Australia

- The use of hospital services among people born in refugee-source countries including Burma is lower or similar to that of the Australia-born population^{17,18}.
- There is no published data on health service utilisation of Burma-born people in Australia.
- A United Kingdom study found that GP registration rate of Burmese migrants was high but GP service utilisation was low. Factors associated with lower use of primary health care services included being younger than 35 years, lacking prior overseas experience, having an unstable immigration status, having a shorter duration stay, and self-medication¹⁹.

References

1. Australian Bureau of Statistics. CDATA Census 2006. Available: <https://www.censusdata.abs.gov.au/CDATAOnline>. Accessed 07/12/2010, 2010.
2. Department of Immigration and Citizenship. *Community Information Summary: Burma (Myanmar) born*. Commonwealth of Australia: Canberra; 2010.
3. Department of Immigration and Citizenship. Settlement reporting database. Available: <http://www.immi.gov.au/settlement>. Accessed 07/12/2010, 2010.
4. Department of Immigration and Multicultural Affairs (DIMA). *Burmese: Community Profile*. Commonwealth of Australia: Canberra; 2006.
5. Barron S, Okell J, Yin SM, VanBik K, Swain A, Larkin E, et al. *Refugees from Burma: Their backgrounds and refugee experiences*. Center for Applied Linguistics: Washington DC; 2007.
6. Central Intelligence Agency (CIA). *The world fact book*. CIA; 2010. Available: <https://www.cia.gov/library/publications/the-world-factbook/>.
7. Daniel K. *SBS World Guide: The complete fact file on every country*. Sixteenth Edition ed. Prahan Victoria: Hardy Grant Books; 2008.
8. Cardozo BL, Talley L, Burton A, Crawford C. Karenni refugees living in Thai-Burmese border camps: Traumatic experiences, mental health outcomes and social functioning. *Social Science and Medicine* 2004;58:2637-2644.
9. Chaves NJ, Gibney KB, Leder K, O'Brien DP, Marshall C, Biggs B-A. Screening practices for infectious diseases among Burmese refugees in Australia. *Emerging Infectious Diseases* 2009;15:1769-1772.
10. Migrant Information Centre (MIC). *Home and personal care kit: Cultural and religious profiles to assist in providing culturally sensitive care and effective communication*. Migrant Information Centre: Melbourne; 2004.
11. Queensland Health. *Health care providers' handbook on Hindu patients 2011*. Division of the Chief Health Officer, Queensland Health: Brisbane; 2011.
12. Dziedzic C. *Karen-Burmese Refugees: An orientation for health workers and volunteers*. Community Nutrition Unit, Annerley Road Community Health. Queensland Health: Brisbane; 2010.
13. Everyculture.com. Countries and their cultures. Accessed 14/12/2010, 2010.
14. Matzo M, Sherman DW. *Palliative Care Nursing: Quality care to the end of life*. Springer Publishing Company; 2009.
15. Allden K, Poole C, Chantavanich S, Ohmar K, AUng NN, Mollica RF. Burmese political dissidents in Thailand: Trauma and survival among young adults in exile. *American Journal of Public Health* 1996;86:1561-1569.
16. Leiter K, Suwanvanichkij V, Tamm I, Iacopino V, Beyrer C. Human rights abuses and vulnerability to HIV/AIDS: The experiences of Burmese women in Thailand. *Health and Human Rights* 2006;9:88-111.
17. Correa-Velez I, Ansari A, Sundarajan V, Brown K, Gifford SM. A six-year descriptive analysis of hospitalisations for ambulatory care sensitive conditions among people born in refugee source countries. *Population Health Metrics* 2007;5.
18. Correa-Velez I, Sundarajan V, Brown K, Gifford SM. Hospital utilisation among people born in refugee-source countries: An analysis of hospital admissions. *Medical Journal of Australia* 2007;186:577-580.
19. Aung NC, Rechel B, Odermatt P. Access to and utilisation of GP services among Burmese migrants in London: a cross-sectional descriptive study. *BMC Health Services Research* 2010;10:285-296.



© State of Queensland (Queensland Health) 2011.

This document is licensed under a Creative Commons Attribution Non-Commercial 2.5 Australia licence. To view a copy of this licence, visit <http://creativecommons.org/licenses/by-nc/2.5/au>. You are free to copy, communicate and adapt the work for non-commercial purposes, as long as you attribute Queensland Health.

ⁱ Brisbane is defined as Local Government Area of Brisbane in ABS Census data.

ⁱⁱ At the 2006 Census up to two responses per person were allowed for the Ancestry question, count is therefore total responses not person count.

ⁱⁱⁱ Literacy is defined as those aged 15 and over who can read and write.

^{iv} Missing and not-stated responses to this question on the census were excluded from the analysis.

^v Non-school qualifications are awarded for educational attainments other than those of pre-primary, primary or secondary education.

It should be noted that there is great diversity within communities and people do not fit into a pre-determined cultural box or stereotype. The information presented here will not apply to all Burmese Australians and this profile should be considered in the context of the acculturation process.

Burundian Australians

- In 1972, conflict between the ruling Tutsis and the majority Hutu population resulted in approximately 200,000 deaths and 150,000 people seeking refuge in Tanzania, Rwanda and Zaire (now the Democratic Republic of Congo)⁴.
- In 1988, increasing tensions between the ruling Tutsis and the majority Hutus resulted in violent conflict between the army, the Hutu opposition and Tutsis⁵. As a result, an estimated 150,000 people were killed and tens of thousands of refugees fled to neighbouring countries⁵.
- In 1993, Burundi's first democratically elected Hutu president was assassinated leading to another wave of violence between the Tutsis and Hutus. This resulted in more than 100,000 deaths within a year, and another 100,000 more deaths and hundreds of thousands of refugees fleeing the country over the next 11 years^{5,6}. This civil war continued until 2005⁵.
- By 2006, there was only a relatively small intake of Burundian refugees into Australia with only 753 Burundi-born people recorded in the 2006 Census². Since 2006, the Australian Burundi-born population has more than doubled with 1266 Burundi refugees settling in Australia between 2006 and 2010³.
- **Places of transition:** Tanzania, Rwanda, Uganda, Zimbabwe, Malawi and the Democratic Republic of Congo.
- **Ethnicity:** There are two major ethnic groups in Burundi: Hutu (Bantu) (85 per cent) and Tutsi (Hamitic) (14 per cent). Twa (Pygmy) comprise about one per cent of the population and Europeans and South Asians number a few thousand each⁶.
- **Language:** The main and official languages are Kirundi and French^{5,6}. Swahili is spoken in some areas⁶.

Population of Burundi-born people in Australia (2006 Census)¹: 753²

Population of Burundi-born people in Queensland: 188

Population of Burundi-born people in Brisbaneⁱⁱ: 166

Gender ratio (Queensland): 89.9 females per 100 males

Age distribution (Queensland)²:

Age	Per cent
0-19	37.8%
20-39	46.8%
40-59	15.4%
60+	0%

Arrivals – past five years (Source – Settlement Reporting Database³)

Year	Australia	Queensland
2006	380	118
2007	417	142
2008	180	41
2009	184	69
2010	105	16

- **Religion:**
 - The majority of Burundians are Christian (67 per cent), of which most are Catholic (62 per cent) and some Protestant (5 per cent)
 - About 23 per cent of Burundians, including most of the Twa and some Christians, have maintained traditional beliefs which include forms of animism⁷. Animists believe that inanimate and natural phenomena, as well as living creatures, have souls and

spirits⁷. Certain rituals are believed to control uncertainties and negative influences in life⁷

- 10 per cent of the population are Muslim⁶.

Communication

- Handshakes are important to Burundians and the type of handshake varies by region⁸. For example, one handshake involves touching one's left hand to the other person's elbow⁸. Handshakes are often soft⁹.
- People stand close together in conversation and often continue holding hands for several minutes after shaking⁸.
- There is good to fair eye contact between people of equal stature but little eye contact otherwise⁹. Avoiding eye contact is a way to show respect for the elderly or important people⁹.

Health in Australia

- Average life expectancy in Burundi is 58.3 years (male 56.7, female 60) compared to 81.7 years for all people living in Australia (male 79.3, female 84.3)⁶.
- The prevalence of serious mental health problems in Burundian refugees living in Tanzanian refugee camps has been found to be very high (50 per cent using the General Health Questionnaire as a screening instrument)¹⁰.
- A Western Australia infectious disease screening study of 2111 refugees and humanitarian entrants (2003-2004) reported a high prevalence of infectious diseases in sub-Saharan Africans including: hepatitis B (6.4 per cent carrier state, 56.7 per cent exposed), syphilis (6.8 per cent), malaria (8 per cent), intestinal infections (*giardia intestinalis* – 13 per cent, *schistosoma mansoni* – 7 per cent, *stongyloides stercoralis* – 2 per cent, *hymenolepis nana* – 3 per cent, *salmonella* – 1 per cent and Hookworm – 5 per cent), a Mantouxⁱⁱⁱ test result requiring tuberculosis treatment (28.9 per cent)¹¹.

- The prevalence of non-communicable diseases such as diabetes and hypertension is increasing in Tanzania, a major source country for Burundian refugees arriving in Australia¹².

Health beliefs and practices

- Many Burundians use traditional remedies to treat diseases⁷. Potions made from leaves, roots, bark, fruit and herbs may be taken orally or rubbed on the skin⁷. Many Burundian Australians are unable to use traditional remedies in Australia because of the unavailability of ingredients. Some people travel to Burundi to access traditional remedies¹.
- Animist rituals may be performed to cure a person who is ill⁷.
- The health care system in Burundi is basic and medical facilities are limited, even in cities⁷. About two million people in Burundi (one third of the population) have no access to formal health care⁷. Burundian Australians unfamiliar with the health care system may benefit from orientation to the system, including how to make a health appointment, the importance of regular health checks and immunisation, and how to access emergency departments¹.
- Burundian Australians are willing to access Australian medical treatments.
- Many Burundian Australians prefer injections to tablets¹.

Social determinants of health

- The literacy rate^{iv} of Burundians, particularly female, is low⁶. In 2000, the overall literacy rate for Burundi was 59.3 per cent (male 67.3 per cent, female 52.2 per cent)⁶.
- Many Burundians have experienced traumatic and life threatening experiences including prolonged pre-trial detention, harsh and life threatening prison conditions, torture and beatings, witnessing killings, kidnap, rape, extortion, and forced labour¹³.

- About 60 per cent of the Burundian population lack access to safe drinking water⁷.
- Thousands of Burundian refugees have spent years in refugee camps in neighbouring countries such as Tanzania, many for longer than a decade and some for almost their entire lives¹⁰. Some Burundians have fled their country more than once¹⁴. Living conditions in these overcrowded camps are primitive, water and sanitation inadequate, infectious diseases a continued threat and, with a mix of ethnicities and political orientations, many people have experienced insecurity and paranoia¹⁰.
- Settlement is often impacted by changing family dynamics and concern for family members who remain in refugee camps¹⁴.
- Proficiency in English (2006 Census)^{11,2}:
 - 36 per cent of Burundi-born males and 19 per cent of Burundi-born females reported that they spoke English well or very well
 - 46 per cent of males and 49 per cent of females reported that they did not speak English well
 - 18 per cent of males and 32 per cent of females reported that they did not speak English at all.

Utilisation of health services in Australia

- A small study of sub-Saharan refugees in Sydney showed evidence of difficulties in accessing health care, including at times when a family member was sick¹⁵. Barriers to health care access included: language barriers, lower levels of education and literacy, financial disadvantage, lack of health information, and a poor understanding of how to access health services¹⁵.

References

1. Sibonyio A. *Review of Cultural Diversity Profile- Burundi*. Personal communication; 18 March 2011.
2. Australian Bureau of Statistics. CDATA Census 2006. Available: <https://www.censusdata.abs.gov.au/CDATAOnline>. Accessed 07/12/2010, 2010.
3. Department of Immigration and Citizenship. Settlement reporting database. Available: <http://www.immi.gov.au/settlement>. Accessed 07/12/2010, 2010.
4. Cultural Orientation Resource Centre. *The 1972 Burundians. COR Centre Refugee Backgrounder No.2*. 2007. Available: <http://www.wrapsnet.org/LinkClick.aspx?fileticket=2ZpkAuy3Fag%3D&tabid=180&mid=605&language=es-ES>.
5. World Vision. Country profile- Burundi. Available: http://www.worldvision.com.au/Libraries/3_1_2_Country_Profiles_-_Africa/Burundi.sflb.ashx.
6. Central Intelligence Agency (CIA). *The world fact book*. CIA; 2010. Available: <https://www.cia.gov/library/publications/the-world-factbook/>.
7. Anti-Racism MaNIACR, I., *Burundi: A cultural profile*. Anti-Racism, Multiculturalism and Native Issues (AMNI) Centre, Faculty of Social Work, University of Toronto: Toronto; 2001. <http://www.cp-pc.ca/english/burundi/index.html>.
8. Everyculture.com. Countries and their cultures: Burundi. Available: <http://www.everyculture.com/Bo-Co/Burundi.html>.
9. Palls BP. *Cultural portraits: A synoptic guide, Second Edition*. Clearwater Beach, Florida: B&B Educational Consultants; 2010.
10. deJong JP, scholte WF, Koeter M, Hart A. The prevalence of mental health problems in Rwandan and Burundese refugee camps. *Acta Psychiatrica Scandinavica* 2000;102:171-177.
11. Martin JA, Mak DB. Changing faces: a review of infectious disease screening of refugees by the Migrant Health Unit, Western Australia in 2003 and 2004. *Medical Journal of Australia* 2006;185:607-610.
12. Unwhin N, Setel P, Rashid S, Mugusi F, Mbanya J-C, Kitange H, et al. Noncommunicable diseases in sub-saharan Africa: where do they feature in the health research agenda. *Bulletin of the World Health Organisation* 2001;79:947-953.
13. Home Office UK Border Agency. *Country of origin information key documents: Burundi*. Home Office UK Border Agency; Croydon, United Kingdom; 2009.
14. US Committee for refugees and immigrants. Burundian refugee resettlement from Tanzania: Supporting the successful integration of Burundian refugees. Available: http://www.powershow.com/view/429c-MmEzN/Burundian_Refugee_Resettlement_From_Tanzania.
15. Sheikh-Mohammed M, MacIntyre CR, Wood NJ, Leask J, Isaacs D. Barriers to access to health care for newly resettled sub-Saharan refugees in Australia. *Medical Journal of Australia* 2006;185:594-597.



© State of Queensland (Queensland Health) 2011.

This document is licensed under a Creative Commons Attribution Non-Commercial 2.5 Australia licence. To view a copy of this licence, visit <http://creativecommons.org/licenses/by-nc/2.5/au>. You are free to copy, communicate and adapt the work for non-commercial purposes, as long as you attribute Queensland Health.

It should be noted that people do not fit into a pre-determined cultural box or stereotype and there is great diversity within communities. The information presented will not apply to all Burundian Australians and this profile should be considered in the context of the acculturation process.

ⁱ According to community representatives it is likely that the Census numbers of Burundi-born people underestimate the actual number of Burundi-born people in Australia, Queensland and Brisbane as a result of Burundian Australians' lack of familiarity with and low participation in the Census¹.

ⁱⁱ Brisbane is defined as Local Government Area of Brisbane in ABS Census data

ⁱⁱⁱ Defined as a positive Mantoux test result of ≥ 15 mm.

^{iv} Definition of literacy- age over 15 years can read and write.

^v Missing and not-stated responses to this question on the census were excluded from the analysis.

Cambodian Australians

- Cambodian people first came to Australia as students from the 1950s to 1970s².
- After a coup in Burma in 1970, a civil war began that led to a Communist Khmer Rouge takeover from 1975 to 1979. An invasion by Vietnam in 1979 ended the Khmer Rouge reign, but civil war continued until United Nations troops enforced a cease-fire in late 1991^{2,4,5}.
- Of an estimated population of 7.1 million people in 1975, approximately two million Cambodians were killed during the four year Khmer Rouge reign. Approximately one million people were killed in the civil wars before and after this period^{2,4,5}.
- From 1975, Cambodian people began to seek refuge in other countries including Australia².
- Between 1978 and 1991, more than 500,000 Cambodians sought refuge in refugee camps in Thailand⁴.
- Between 1975 and 1986, 12,813 Cambodians came to Australia as refugees².
- By 2001, there were 23,000 Cambodia-born people in Australia. Between 2001 and 2006, the number of Cambodia-born people in Australia increased by 6.7 per cent to 24,530².
- **Places of transition:** Thailand
- **Ethnicity:** The main ethnic group in Cambodia is Khmer (90 per cent)^{6,7}. Smaller ethnic groups include Vietnamese (five per cent) and Chinese (one per cent)^{6,7}.
- **Language:** Khmer is the official language and is spoken by 95 per cent of the population^{6,7}. Other languages include French and English^{6,7}.
- **Religion:** Buddhism is the official religion of Cambodia and is practiced by

Population of Cambodia-born people in Australia (2006 Census): 24,530¹

Population of Cambodia-born people in Queensland: 1214¹

Population of Cambodia-born people in Brisbane¹: 1029¹

Gender ratio (Queensland): 82.3 males per 100 females¹

Median age (Australia): The median age of Cambodia-born people in Australia in 2006 was 40.3 years compared with 46.8 years for all overseas born and 37.1 for the total Australian population².

Age distribution (Queensland)¹:

Age	Per cent
0-19	7.6%
20-39	39.6%
40-59	39.5%
60+	13.2%

Arrivals – past five years (Source – Settlement Reporting Database³)

Year	Australia	Queensland
2006	699	46
2007	724	46
2008	694	29
2009	940	48
2010	663	48

more than 96 per cent of the population. Muslims comprise approximately two per cent of the population⁶. Less than two per cent of the population are affiliated with other religions⁶.

Ancestry, language and religion in Australia (2006 Census for Cambodia-born)

- The top ancestryⁱⁱ responses of Cambodia-born people in Australia were:
 - Khmer – 54.2 per cent
 - Chinese – 35.6 per cent
 - Not stated – 4.6 per cent².
- The main languages spoken at home by Cambodia-born people in Australia were:
 - Khmer – 65 per cent
 - Cantonese – 10.6 per cent
 - Teochew – 6 per cent.
- The main religion of Cambodia-born people in Australia was Buddhism (79.8 per cent).

Communication

- Traditionally, Cambodians do not address each other by name, but according to relationship (e.g. brother or uncle)⁸.
- The titles *Sir* and *Madam* are used for strangers⁸. It is advisable to use a person's title when addressing a Cambodian person directly (e.g. Mr, Mrs, Doctor)⁸.
- In Cambodia, names are usually written with the person's surname first followed by their given name⁸. Some Cambodians have adopted the Australian style of naming and have changed the order of their names, placing their surnames last⁸. Children can take either their father's surname or a personal name⁸.
- It is considered disrespectful to sit with the legs stretched out and the feet pointed towards a person⁸.
- The head is considered the spiritually highest part of the body and sensitivity is advised if it is necessary to touch the head⁸.
- Cambodian people may consider direct eye contact to be inappropriate. Some people may be reluctant to maintain eye contact with people seen as deserving of respect, such as a senior person⁸.

- A response of *yes* does not necessarily indicate agreement. The word *yes* is sometimes used to indicate that the listener is paying attention. It is important to obtain feedback from the person to ensure understanding, especially when gaining consent to treatment⁸.
- Cambodian people rarely appear desperate or distressed, even when experiencing significant anxiety or pain⁸.

Health in Australia

- Average life expectancy in Cambodia is 62.7 years (male 60.3, female 65.1) compared to 81.7 years for all people living in Australia (male 79.3, female 84.3)⁶.
- There is little research on the physical and mental health status of Cambodia-born Australians.
- Intestinal parasites are a common health problem among Cambodian Australians. A cross-sectional survey showed that 42 per cent of Cambodian Australians had a positive or equivocal serology for *S. stercoralis* and 17 per cent had eosinophilia⁹.
- The blood diseases haemoglobin E and thalassemia minor have been observed in Cambodian refugees and migrants⁸.
- Overseas research shows that other common diseases affecting Cambodian people include tuberculosis and hepatitis B⁸.
- Dental problems including caries are common⁸. Some Cambodian Australians travel back to Cambodia for more affordable dental healthcare¹⁰.
- It has been shown that two decades after seeking refuge in the United States, the Cambodian population continues to have high rates of psychiatric disorders associated with trauma including post traumatic stress disorder (PTSD) and depression⁴.

Health beliefs and practices

- A belief in the *hot* and *cold* qualities of food and medicine is common. The body is seen as operating in a delicate balance between these two opposing elements. For example, diarrhoea is thought to be due to an excess of *cold* elements and skin rashes to an excess of *hot* elements⁸.
- Many Cambodian people believe that the body of a woman is made *cold* by labour. Women who have recently given birth may want to be kept very warm and may not want to shower post partum for up to three days, or may prefer a sponge bath. New mothers are often kept warm by being fed *hot* foods⁸.
- Spiritual healers may be sought for mental illnesses such as depression, and chronic diseases such as diabetes and hypertension, as these illnesses are thought to be caused by spirits^{8,10}.
- Cambodian people may explain the causes of illnesses in terms of both the natural and supernatural⁸.
- Traditional healing can include cupping, pinching or rubbing (also known as coining). In cupping, a cup is heated and then placed on the skin, usually on the forehead or abdomen, which creates a vacuum. These treatments can often leave some redness or bruising. The marks resulting from cupping and other traditional treatments have sometimes been mistaken by healthcare providers for signs of a more serious illness or domestic abuse⁸.
- Many Cambodian people use complementary and alternative medicines in conjunction with prescription medications to deal with physical or mental illness^{8,11}.
- Attitudes and beliefs about Australian medical practices may vary⁸.
- Some Cambodian people may resist surgery or other invasive techniques. When such procedures are required, it may be necessary to explain the need for such treatment⁸.

- Cambodian people may have a fear of blood tests. Blood is thought to be replenished slowly, if at all, with any loss of blood seen as weakening the body⁸.
- Medication is frequently taken only for as long as the individual feels ill. Compliance with medications for a chronic disease can be difficult⁸.
- Many Cambodia-born women prefer to be examined by female health care providers⁸.
- Some Cambodian people may expect to receive medications for every illness, and injections are often seen as more effective than oral medications. It may be necessary to carefully explain why medication is not necessary⁸.
- When a Cambodian Buddhist is dying, a Buddhist monk or minister should be notified to provide chaplaincy services¹². The monk will chant verses after the person has died to help release the person's *good* energies¹². The state of mind at the time of death is considered important in determining the deceased person's next rebirth¹².

Social determinants of health

- The overall literacyⁱⁱⁱ rate in 2004 in Cambodia was 73.6 per cent (men 84.7 per cent, women 64.1 per cent)⁶.
- Cambodian people were subjected to an extremely traumatic period during the four year Khmer Rouge rein⁴. Cambodian people are considered the most traumatised of all South-East Asian people¹³. Many Cambodian people have experienced famine and starvation, witnessed death and destruction, and have spent long periods of time in refugee camps in Thailand¹⁴.
- Poor English proficiency, unemployment, older age, being retired or disabled, and living in poverty have been shown to be associated with higher rates of PTSD and major depression in Cambodian refugees⁴.

- Proficiency in English^{iv} in Australia (2006 Census)¹:
 - 63 per cent of Cambodia-born men and 76 per cent of Cambodia-born women reported that they spoke English well or very well
 - 32 per cent of men and 20 per cent of women reported that they did not speak English well
 - 5 per cent of men and 4 per cent of women reported that they did not speak English at all^v.
- At the time of the 2006 census, 27.1 per cent of Cambodia-born people aged 15 years and older had some form of higher non-school qualifications^{vi} compared to 52.5 per cent of the total Australian population².
- The participation rate in the workforce (2006 census) was 59.1 per cent and unemployment rate was 11.4 per cent compared to the corresponding values of 64.6 per cent and 5.2 per cent in the total Australian population². The median weekly income for Cambodia-born people in Australia aged 15 years or older was \$328 compared to \$466 for the total Australian population².
- A 2009 large-scale audit discrimination study based on job applications using ethnically distinguishable names showed that people with Asian sounding names were subject to discrimination in applying for jobs. People with Asian sounding names have to apply for more jobs to receive

the same number of interviews as people with Anglo-Saxon sounding names and those with names of more established migrant groups such as Italian, even if they have the same work history and education¹⁵.

Utilisation of health services in Australia

- There is little research in Australia on the utilisation of health services by Cambodian Australians.
- Research in the United States showed that a high proportion of Cambodian Americans used American medicine for PTSD and major depression. Only a small percentage used complementary and alternative medicine exclusively. Utilisation of complementary medicine did not inhibit utilisation of American medicine, but was positively associated with seeking American medicine for mental illness¹¹.
- Cost and language issues have been shown to be the major barriers to health care access for Cambodian refugees in the United States, including mental health care utilisation¹⁶.
- Cambodia-born women may avoid regular preventive pelvic and breast examinations because of embarrassment⁸.

References

1. Australian Bureau of Statistics. CDATE Census 2006. Available: <https://www.censusdata.abs.gov.au/CDATAOnline>. Accessed 07/12/2010, 2010.
2. Department of Immigration and Citizenship. *Community Information Summary: Cambodia-born*. Commonwealth of Australia: Canberra; 2006.
3. Department of Immigration and Citizenship. Settlement reporting database. Available: <http://www.immi.gov.au/settlement>. Accessed 07/12/2010, 2010.
4. Marshall GN, Schell TL, Elliott MN, Berthold SM, Chun C. Mental health of Cambodian refugees 2 decades after resettlement in the United States. *Journal of the American Medical Association* 2005;294:571-579.
5. Rummel RJ. *Death by Government*. New Brunswick, NJ: Transaction Publishers; 1994.
6. Central Intelligence Agency (CIA). *The world fact book*. CIA; 2010. Available: <https://www.cia.gov/library/publications/the-world-factbook/>.
7. Daniel K. *SBS World Guide: The complete fact file on every country*. Sixteenth Edition ed. Prahan Victoria: Hardy Grant Books; 2008.
8. Allotey P, Manderson L, Nikles J, Reidpath D, Sauvarin J. *Cultural diversity: A guide for health professionals*. Queensland Government Press: Brisbane; 1998.
9. Caruana SR, Kelly HA, Ngeow JY, Ryan NJ, Bennett CM, Chea L, et al. Undiagnosed and potentially lethal parasitic infections among immigrants and refugees in Australia. *Journal of Travel Medicine* 2006;13:233-239.
10. Khieu P. *Review of Cultural Diversity Profile- Cambodian Australians*. Personal communication; 8 May 2011.
11. Berthold SM, Wong BC, Schell TL, Marshall GN, Elliott MN, Takeuchi D, et al. U.S Cambodian refugees' use of complementary and alternative medicine for mental health problems. *Psychiatric Services* 2007;58:1212-1218.
12. Matzo M, Sherman DW. *Palliative Care Nursing: Quality care to the end of life*. Springer Publishing Company; 2009.
13. Kinzie J, Fleck J. Psychotherapy with severely traumatised refugees. *American Journal of Psychotherapy* 1987;75:1080-1084.
14. Strumpff NE, Glicksman A, Goldberg-Glen RS, Fox RC, Logue EH. Caregiver and elder experiences of Cambodian, Vietnamese, Soviet Jewish, and Ukrainian refugees. *International Journal of Aging and Human Development* 2001;53:233-252.
15. Booth A, Leigh A, Varganova E. *Does racial and ethnic discrimination vary across minority groups? Evidence from a field experiment*. Australian National University: Canberra; 2009.
16. Wong EC, Marshall GN, Schell TL, Elliott MN, Hambarsoomians K, Chun C, et al. Barriers to mental health care utilisation for US Cambodian refugees. *Journal of Consulting and Clinical Psychology* 2006;74:1116-1120.



© State of Queensland (Queensland Health) 2011.

This document is licensed under a Creative Commons Attribution Non-Commercial 2.5 Australia licence. To view a copy of this licence, visit <http://creativecommons.org/licenses/by-nc/2.5/au>. You are free to copy, communicate and adapt the work for non-commercial purposes, as long as you attribute Queensland Health.

ⁱ Brisbane is defined as Local Government Area of Brisbane in ABS Census data

ⁱⁱ At the 2006 Census up to two responses per person were allowed for the Ancestry question, count is therefore total responses not person count.

ⁱⁱⁱ Literacy is defined as those aged 15 and over who can read and write.

^{iv} Missing and not-stated responses to this question on the census were excluded from the analysis.

^v Community representatives state that the prevalence of people who cannot speak English is considerably higher than that reported by the Census and that there is error in census information resulting from children in the household completing the census on behalf of the family.

^{vi} Non-school qualifications are awarded for educational attainments other than those of pre-primary, primary or secondary education.

It should be noted that there is great diversity within communities and people do not fit into a pre-determined cultural box or stereotype. The information presented here will not apply to all Cambodian Australians and this profile should be considered in the context of the acculturation process.

Chinese Australians

- In the last half of the 19th Century, a large number of China-born people came to Australia fleeing civil disorder, famine and floods in southern China². Many China-born people were also attracted to Australia by the discovery of gold². At the time of the 1861 Colonial Census, China-born people in Australia numbered 38,258 and comprised 3.4 per cent of the population².
- From 1901 to 1973, during the period of the *White Australia Policy*, the immigration of China-born people to Australia declined. By 1947, the number of China-born people in Australia numbered only 6404². By 1976, after the dismantling of the *White Australia Policy*, the number had risen to 19,971².
- During the past 30 years, Chinese people have arrived in Australia from Malaysia, Singapore, Hong Kong, Vietnam and elsewhere in Indochina. More recently, immigrants have arrived from Taiwan and the People's Republic of China (PRC)⁴. At the time of the 2006 Census, the number of China-born people in Australia had risen to 206,590 and included a number of China-born overseas students².
- The term *Chinese* covers a diverse range of communities and individuals, sometimes having no more in common than ancestral heritage⁴.
- **Ethnicity:** Han Chinese comprise 91.9 per cent of the population of China. Other ethnicities include: Zhuang, Uygur, Hui, Yi, Tibetan, Miao, Manchu, Mongol, Buyi and Korean^{5,6}.
- **Language:** Mandarin is the official language of China and is widely spoken in the PRC and Taiwan^{4,6}. Cantonese (Yue) is spoken and widely understood in Hong Kong, the Guangdong province of the PRC, Vietnam, and among many people

Population of China-born¹ people in Australia (2006 Census): 206,590¹, Chinese ancestry: 669,901¹

Population of China-born people in Queensland: 15,059¹, Chinese ancestry: 71,139¹

Population of China-born people in Brisbane¹: 11,419

Gender ratio (Queensland): 81.9 males per 100 females

Median age (Australia): The median age of China-born people in 2006 was 39.3 years compared with 46.8 years for all overseas-born and 37.1 for the total Australian population².

Age distribution (Queensland)¹:

Age	Per cent
0-19	7.2%
20-39	45%
40-59	30.5%
60+	17.3%

Arrivals – past five years (Source – Settlement Reporting Database³)

Year	Australia	Queensland
2006	21,866	1858
2007	22,707	1813
2008	23,176	1728
2009	23,561	1744
2010	16,220	1032

from Malaysia, Singapore and Christmas Island⁴. Other languages include: Shanghaiese (Wu), Fuzhou (Minbei), Hokkein-Taiwanese (Minnan), Xiang, Gan and Hakka dialects^{5,6}.

- **Religion:** China is officially atheist^{5,6}. Ancestor worship is widely practiced^{5,6}. A small percentage of the population are Daoist (Taoist), Buddhist, Muslim and Christian^{5,6}. Confucianism, although not strictly a religion, has an important role in the Chinese way of living⁷. Confucianism emphasises mercy, social order and fulfilment of responsibilities⁷.

Language and religion in Australia (2006 Census for China-born)

- The main languages spoken at home by China-born people in Australia were:
 - Mandarin – 59.4 per cent
 - Cantonese – 29.3 per cent².
- The main religions of China-born people in Australia were:
 - No religion – 57.8 per cent
 - Buddhism – 17.6 per cent
 - Catholic – 3.8 per cent².

Communication

- Many distinct Chinese dialects are spoken by Chinese Australians⁴. It is recommended that health care providers seeking an interpreter for a patient should first find out the particular dialect spoken by the patient⁸.
- Chinese Australians usually greet each other by shaking hands⁹.
- For many China-born people, avoiding eye contact, shyness and passivity are cultural norms⁴. However, a smile, good eye contact and politeness are expressions of sincerity.
- Chinese Australians may avoid saying the word *no* because they consider it impolite⁴.
- Chinese Australians may commonly mask discomfort or other unpleasant emotions by smiling⁹.
- Chinese Australians may be accustomed to being addressed by their title and surname (e.g. Mr or Mrs), job title (e.g. Manager), professional qualification (e.g. Engineer) or educational qualification (e.g. Bachelor).

- In many cases, family names are generally placed before first names⁹. However some Chinese Australians have adopted the Australian style of naming and have changed the order of their names, placing their surnames last¹⁰. Chinese surnames usually only have one syllable¹⁰.

Health in Australia

- Average life expectancy in China is 74.7 years (male 72.7, female 76.9) compared to 81.7 years for all people living in Australia (male 79.3, female 84.3)⁵.
- China-born males in Australia have been shown to have a higher overall mortality and China-born females a slightly lower overall mortality than Australia-born people¹¹.
- The major causes of mortality for China-born people in Australia include ischaemic heart disease, cancer and cerebrovascular disease¹¹.
- Major cancers for China-born males in Australia include nasopharynx, lung, intestines, rectum, stomach and liver¹¹. Major cancers for China-born females in Australia include lung and stomach¹¹.
- Worldwide, Chinese women have higher rates of suicide than women of other nationalities¹².

Health beliefs and practices

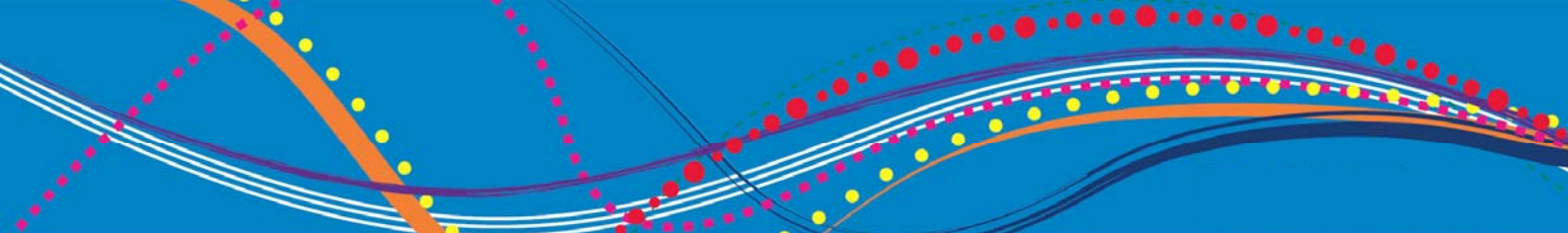
- Many Chinese Australians classify food, illness and medications as *hot* or *cold* according to the perceived effects on the body. A proper balance of these elements is required to maintain good health⁷. The classification of foods as *hot* or *cold* is unrelated to temperature and not always related to taste¹⁰. For example, seafood is classified as cold even if it served hot or with chilli¹⁰.
- Illness is believed to result from an imbalance of *Yang* (male, positive energy, hot) and *Yin* (female, negative energy, cold) forces in the body. *Chi* refers to the life force or energy in the body⁷.

- Some Chinese Australians may attribute illness to:
 - disharmony of body elements (e.g. an excess of *hot* or *cold* foods)
 - moral retribution by ancestors or deities for misdeeds or negligence
 - cosmic disharmony which may occur if a person's combination of year of birth, month of birth, day of birth and time of birth (the *eight characters*) clash with those of someone in their family
 - interference from evil forces such as malevolent ghosts and spirits, or impersonal evil forces
 - poor *Feng Shui* (i.e. the impact of the natural and built environment on the fortune and wellbeing of inhabitants)⁴.
- Many Chinese people assume a *sick role* when they are ill or pregnant in which they depend heavily on others for assistance. As a result, health care providers may be seen as uncaring if they encourage independence rather than catering directly to the wishes of the client⁴.
- Chinese Australians emphasise the importance of the role of the family in liaising between health professionals and patients with cancer¹³. Chinese Australian patients with cancer prefer a confident and clear diagnosis and treatment recommendations¹³.
- Many Chinese Australians will use traditional Chinese medical treatments including acupuncture, acupressure and Chinese herbs. Dietary therapy and supernatural healing (through a fortune teller, *Feng Shui* practitioner or temple medium) may also be used⁴. Modern versions of traditional medicines are widely available in all major Australian cities.
- Many Chinese Australians use traditional Chinese medicine in conjunction with Australian medical treatments⁴.

- Many Chinese Australians visiting a health care provider will expect tangible evidence of treatment, such as a prescription⁴.
- Chinese people usually prefer to be examined by a doctor of the same sex; this is particularly true for women⁴.

Social determinants of health

- The overall literacyⁱⁱⁱ rate in 2007 in China was 91.6 per cent (men 95.7 per cent, women 87.6 per cent)⁵.
- Proficiency in English^{iv} in Australia (2006 Census)¹:
 - 68 per cent of China-born men and 63 per cent of China-born women reported that they spoke English well or very well
 - 24 per cent of China-born men and 26 per cent of China-born women reported that they did not speak English well
 - eight per cent of men and 11 per cent of women reported that they did not speak English at all.
- At the time of the 2006 Census, 55 per cent of China-born people aged 15 years or older had some form of higher non-school qualification^v compared to 52.5 per cent of the total Australian population².
- The participation rate in the workforce (2006 Census) was 56.3 per cent and the unemployment rate was 11.2 per cent compared to the corresponding values of 64.6 per cent and 5.2 per cent in the total Australian population². The median weekly income for China-born people in Australia aged 15 years or older was \$242 compared to \$466 for the total Australian population².
- A 2009 large-scale audit discrimination study based on job applications using ethnically distinguishable names showed that people with Asian sounding names were subject to discrimination in applying for jobs. People with Asian sounding names have to apply for more jobs to receive the same number of interviews as



people with Anglo-Saxon sounding names and those with names of more established migrant groups such as Italian, even if they have the same work history and education¹⁴.

Utilisation of health services in Australia

- There is little research in Australia on the utilisation of health services by Chinese Australians. There is some evidence that the use of hospital and public health services and general practitioners is low in Chinese Australians¹⁵.
- Many Chinese Australians have a strong preference for Chinese-speaking general practitioners¹⁵.
- Research in the 1990s identified barriers to health service usage for Chinese Australians. Barriers included insufficient interpreter services, low use of preventative services such as pap smears and breast screening, and a lack of knowledge about the existence and role of ethnic health workers¹⁵. Health care professionals have observed that these barriers have decreased and health service access for Chinese Australians has improved since the 1990s¹⁰.
- Chinese Australians have been shown to have low utilisation of mental health services¹⁶.
- Barriers to accessing mental health services for Chinese Australians include low mental health literacy, communication difficulties, stigma, confidentiality concerns, service constraints and discrimination¹⁶.

References

1. Australian Bureau of Statistics. CDATE Census 2006. Available: <https://www.censusdata.abs.gov.au/CDATAOnline>. Accessed 07/12/2010, 2010.
2. Department of Immigration and Citizenship. *Community Information Summary:China-born*. Commonwealth of Australia: Canberra; 2006.
3. Department of Immigration and Citizenship. Settlement reporting database. Available: <http://www.immi.gov.au/settlement>. Accessed 07/12/2010, 2010.
4. Allotey P, Manderson L, Nikles J, Reidpath D, Sauvarin J. *Cultural diversity: A guide for health professionals*. Queensland Government Press: Brisbane; 1998.
5. Central Intelligence Agency (CIA). *The world fact book*. CIA; 2010. Available: <https://www.cia.gov/library/publications/the-world-factbook/>.
6. Daniel K. *SBS World Guide: The complete fact file on every country*. Sixteenth Edition ed. Prahan Victoria: Hardy Grant Books; 2008.
7. Stokes SC, Pan C. *Health and health care of Chinese American older adults*. eCampus Geriatrics in the Division of General Internal Medicine, Stanford School of Medicine: Stanford; 2010. Available: <http://geriatrics.stanford.edu>.
8. Shapiro ME. *Asian culture brief: China*. University of Hawaii, Center on Disability Studies: Manoa; 2000.
9. Anti-Racism MaNIACC, E, Mayers, M, Williams, E, Vemuri, S. *China: A cultural profile*. Anti-Racism, Multiculturalism and Native Issues (AMNI) Centre, Faculty of Social Work, University of Toronto: Toronto; 2001. <http://www.cp-pc.ca/english/china/index.html>.
10. Holloway L. *Review of Cultural Diversity Profile- Chinese Australians*. Personal communication; 16 May 2011.
11. Zhang YQ, MacLennan R, Berry G. Mortality of Chinese in New South Wales, 1969-1978. *International Journal of Epidemiology* 1984;13:188-192.
12. Brockington I. Suicide in women. *International Clinical Psychopharmacology* 2001;16:s7-s19.
13. Huang X, Meiser P, Butow P, Goldstein D. Attitudes and information needs of Chinese migrant cancer patients and their relatives. *Australian and New Zealand Journal of Medicine* 1999;29:207-213.
14. Booth A, Leigh A, Varganova E. *Does racial and ethnic discrimination vary across minority groups? Evidence from a field experiment*. Australian National University: Canberra; 2009.
15. Chan YF, Quine S. Utilisation of Australian health care services by ethnic Chinese. *Australian Health Review* 1997;20:64-77.
16. Blignault I, Ponzio V, Rong Y, Eisenbruch M. A qualitative study of barriers to mental health services utilisation among migrants from mainland China in south-east Sydney. *International Journal of Social Psychiatry* 2008;54:180-190.



© State of Queensland (Queensland Health) 2011.

This document is licensed under a Creative Commons Attribution Non-Commercial 2.5 Australia licence. To view a copy of this licence, visit <http://creativecommons.org/licenses/by-nc/2.5/au>. You are free to copy, communicate and adapt the work for non-commercial purposes, as long as you attribute Queensland Health.

It should be noted that there is great diversity within communities and people do not fit into a pre-determined cultural box or stereotype. The information presented here will not apply to all Chinese Australians and this profile should be considered in the context of the acculturation process.

ⁱ China-born population statistics excludes those from the Special Administrative Region (SARs) and Taiwan.

ⁱⁱ Brisbane is defined as Local Government Area of Brisbane in ABS Census data.

ⁱⁱⁱ Literacy is defined as those aged 15 and over who can read and write.

^{iv} Missing and not-stated responses to this question on the census were excluded from the analysis.

^v Non-school qualifications are awarded for educational attainments other than those of pre-primary, primary or secondary education.

Ethiopian Australians

- Ethiopia is located in the horn of Africa, a region that has experienced decades of natural disasters, political unrest, war, drought and famine. This has forced millions of Ethiopians to seek refuge within their own and in other countries⁴.
- In the 1970s, drought, the Ogaden War with Somalia and an oppressive military regime caused the displacement of more than one million Ethiopians⁴. In the 1980s, Ethiopia experienced another prolonged drought and a consequent famine that continued into the 1990s displacing hundreds of thousands of people⁴.
- From 1998-2000, Ethiopia and Eritrea fought a war that killed more than 70,000 people and displaced more than 600,000 people from areas near the border⁵.
- Ethiopia has itself provided refuge to displaced people from Sudan, Somalia and Eritrea who have fled war and famine in their own countries⁶.
- The majority of Ethiopia-born people in Australia arrived after 1991, with over 3000 Ethiopian refugees settling in Australia between 2000 and 2005⁴.
- At the time of the 2001 Census, there were 3600 Ethiopia-born people in Australia. By the 2006 Census this number had increased to 5640; an increase of 56.7 per cent⁴. Between 2006 and 2010, more than 3000 Ethiopian refugees arrived in Australia³.
- **Places of transition:** Somalia, Kenya, Sudan, Egypt and Djibouti⁴.
- **Ethnicity:** Ethiopia is an ethnically complex and diverse country comprising more than 78 distinct ethnic groups⁴. The seven largest ethnic groups are:
 - Oromo – 34.5 per cent
 - Amhara – 26.9 per cent
 - Somali – 6.2 per cent
 - Tigraway – 6.1 per cent

Population of Ethiopia-born people in Australia (2006 Census): 5635¹

Population of Ethiopia-born people in Queensland: 435

Population of Ethiopia-born people in Brisbane¹: 325

Gender ratio (Queensland): 95.9 females per 100 males¹

Median age (Australia): The median age of Ethiopia-born people in 2006 was 33.8 years compared with 46.8 years for all overseas born and 37.1 for the total Australian population².

Age distribution (Queensland)¹:

Age	Per cent
0-19	42.5%
20-39	30.1%
40-59	23.8%
60+	3.5%

Arrivals – past five years (Source – Settlement Reporting Database³)

Year	Australia	Queensland
2006	504	55
2007	589	54
2008	555	45
2009	814	102
2010	721	66

- Sidama – 4 per cent
- Guragie – 2.5 per cent
- Welaita – 2.3 per cent⁶.
- Other ethnic groups make up the remaining 17.5 per cent of the population⁶.

- **Language:** Consistent with the diversity of ethnicities, there are more than 84 languages spoken in Ethiopia⁴. Amharic (Amarigna) is the official language of Ethiopia and is spoken by 32.7 per cent of the population⁶. Oromigna, an official regional language, is spoken by 31.6 per cent of the population⁶. Other major languages of Ethiopia include:
 - Tigrinya (a second official regional language) – 6.1 per cent
 - Somaligna – 6 per cent
 - Guaragigna – 3.5 per cent
 - Sidamigna – 3.5 per cent
 - Hadiyigna – 1.7 per cent
 - English and Arabic are also official languages spoken by a small percentage of Ethiopians⁶.
- **Religion:**
 - Ethiopian Orthodox: About 43.5 per cent of the population identify with this unique Coptic form of Christianity which has been practiced in Ethiopia since the fourth century AD^{4,6}.
 - Muslim: 33.9 per cent of the population are Muslim⁶
 - Protestant: 18.6 per cent of the population are protestant⁶
 - Traditional beliefs: 2.6 per cent retain traditional beliefs⁶.

Ancestry, language and religion in Australia (2006 Census for Ethiopia-born)²

- The top three ancestry responsesⁱⁱ of Ethiopia-born people in Australia were:
 - Ethiopian – 58.9 per cent
 - Not Stated – 8.9 per cent
 - Oromo – 5.5 per cent².
- From 2006 to 2010, 20.9 per cent of Ethiopia-born people settling in Australia identified themselves as Oromo and 13 per cent identified as Amhara⁷.

- The main languages spoken at home by Ethiopia-born people in Australia were:
 - Amharic – 38.8 per cent
 - English – 14.8 per cent
 - Oromo – 12.2 per cent
 - Tigrinya – 8.3 per cent².
- The main religions of Ethiopia-born people in Australia were:
 - Islam – 22.2 per cent
 - Oriental Orthodox (Christian) – 21.9 per cent
 - Eastern Orthodox (Christian) – 21.6 per cent
 - Catholic – 6.7 per cent².

Communication

- Ethiopians may be uncomfortable with interpreters because of ethnic and political differences. As a result they may not openly express all of their health needs or trust prescribed medicines⁸.
- Ethiopians generally prefer interpreters of the same gender⁸.
- Many Ethiopian Australians may be unfamiliar with the use of a surname. Most people have their own personal name and use their father's name in place of a surname^{9,10}. As a result, members of the same family may not have the same surname.
- Ethiopians are generally formal and courteous in their greetings^{11,12}. The most common form of greeting is a handshake with direct eye contact^{11,12}. Handshakes are generally light¹².
- Ethiopians usually address others by their title and first name¹².
- Elders are highly respected in Ethiopia and it is customary for Ethiopians to greet elders first and to bow when introduced to someone who is older or holds a more senior position¹².

Health in Australia

- Average life expectancy in Ethiopia is 55.8 years (male 53.3, female 58.4) compared to 81.7 years for all people in Australia (male 79.3, female 84.3)⁶.
- In a study of common medical conditions diagnosed in newly arrived African refugees in Melbourne, the major health issues included lack of immunity to common vaccine-preventable diseases, vitamin D deficiency or insufficiency, infectious diseases (gastrointestinal infections, schistosomiasis and latent tuberculosis), and dental disease¹³. Musculoskeletal and psychological problems were common in adults¹³.
- A 2003-2004 Western Australian infectious disease screening study of 2111 refugees and humanitarian entrants reported a high prevalence of infectious diseases in sub-Saharan Africans including:
 - Hepatitis B – 6.4 per cent carrier state, 56.7 per cent exposed
 - Syphilis – 6.8 per cent
 - Malaria – 8 per cent
 - Intestinal infections (giardia intestinalis – 13 per cent, schistosoma mansoni – 7 per cent, hookworm – 5 per cent, hymenolepis nana – 3 per cent, stongyloides stercoralis – 2 per cent, salmonella – 1 per cent)
 - A Mantouxⁱⁱⁱ test result requiring tuberculosis treatment – 28.9 per cent¹⁴.

Health beliefs and practices

- Many Ethiopians practice herbal and traditional health remedies. However, the practice is limited in Australia due to a lack of availability of herbs and a lack of traditional healers and other specialists to prepare remedies and treat patients¹⁵. Some Ethiopian Australians may use traditional remedies in combination with Australian medical treatments, for

related or unrelated health conditions, without informing their doctor^{16,17}.

- Female genital mutilation (FGM) is practiced in Ethiopia¹⁵. Complications of FGM may include incontinence, obstructed miscarriage and childbirth, vaginal and perineal damage at childbirth, and sexual difficulties including non-consummation and painful intercourse¹⁸. Some families may want their daughters to undergo FGM, even if this means undertaking the operation outside Australia¹⁹. FGM is illegal in Queensland and all Queensland Health employees are obligated to report FGM, or the risk of FGM, to the Department of Communities (Child Safety). It is also illegal to remove a child from Queensland with the intention of having FGM performed.
- In Ethiopia, children commonly undergo uvulectomy (to prevent suffocation during pharyngitis in babies), the extraction of lower incisors (to prevent diarrhea), and the incision of eyelids (to prevent or cure conjunctivitis) are common¹⁵.
- Many Ethiopia-born people chew *khat*, a plant that contains an amphetamine-like stimulant that can produce mild to moderate psychological dependence and has been classified by the World Health Organisation (WHO) as a drug of abuse²⁰. *Khat* is available and is not illegal in Australia²⁰.
- The use of prayer for spiritual healing is an important part of treatment for illness for many Ethiopians^{9,17}.
- Ethiopians may prefer injections to tablets¹⁵.
- In Ethiopia, bad news such as a terminal prognosis is first given to the patient's family or close friends and not directly to the patient themselves. This is done to maintain the patient's hope and avoid sudden shock that is seen as harmful to health^{15,21}. A family member or close friend will inform the patient in a culturally appropriate manner²¹.

Social determinants of health

- The overall literacy rate^{iv} in Ethiopia is low, especially among women. In 2003, the literacy rate was 42.7 per cent for the total population (50.3 per cent for men and 35.1 per cent for women⁶).
- Prior to seeking refuge, many Ethiopian Australians experienced persecution, harassment, torture, political imprisonment, death or disappearance of family members, threats to safety, lack of freedom of expression and will, and coercion to support the ruling political regime¹⁷.
- Proficiency in English (2006 Census)^{v2}:
 - 90 per cent of Ethiopia-born men and 78 per cent of Ethiopia-born women reported that they spoke English well or very well
 - 10 per cent of men and 18 per cent of women reported that they did not speak English well
 - Less than one per cent of men and four per cent of women reported that they did not speak English at all.
- At the time of the 2006 census, 48.8 per cent of Ethiopia-born Australians aged 15 years and older had some form of higher non-school qualifications^{vi} compared to 52.5 per cent for the total Australian population².
- The participation rate in the workforce (2006 Census) was 59.4 per cent and the unemployment rate was 13.7 per cent compared to the corresponding rates of 64.6 per cent and 5.2 per cent

in the total Australian population². The median weekly income for Ethiopia-born people in Australia aged 15 and older was \$342 compared to \$466 for the total Australian population².

Utilisation of health services in Australia

- The use of hospital services among people born in refugee-source countries, including Ethiopia, is lower or similar to that of the Australia-born population^{22,23}.
- A small study of sub-Saharan refugees in Sydney showed evidence of difficulties in accessing health care, including at times when a family member was sick²⁴. Barriers to health care access included language barriers, lower levels of education and literacy, financial disadvantage, lack of health information, not knowing where to seek help, and poor understanding of how to access health services²⁴.
- Overseas studies have shown that Ethiopian refugees use fewer mental health care services from health care professionals than the general population and are more likely to consult traditional healers for mental health problems²⁵.

References

1. Australian Bureau of Statistics. CDATE Census 2006. Available: <https://www.censusdata.abs.gov.au/CDATAOnline>. Accessed 07/12/2010, 2010.
2. Department of Immigration and Citizenship. *Community Information Summary: Ethiopia-born*. Commonwealth of Australia; 2006.
3. Department of Immigration and Citizenship. Settlement reporting database. Available: <http://www.immi.gov.au/settlement>. Accessed 07/12/2010, 2010.
4. Department of Immigration and Multicultural Affairs (DIMA). *Ethiopian: Community Profile*. Commonwealth of Australia: Canberra; 2006.
5. International Rescue Committee. *The health of asylees from Ethiopia and Eritrea*. International Rescue Committee,; 2009. http://www.cal.org/co/email_discussion/Attachments/IRC-Ethiopia-Eritrea_Health_FactSheet.pdf.
6. Central Intelligence Agency (CIA). *The world fact book*. CIA; 2010. Available: <https://www.cia.gov/library/publications/the-world-factbook/>.
7. Department of Immigration and Citizenship. *Settlement Data Report January 1 2006- December 31 2010*. Personal Communication; 2011.
8. The Cross Cultural Health Care Program. *Voices of the Ethiopian community*. The Cross Cultural Health Care Program: Seattle, Washington; 1996. www.xculture.org.
9. EthnoMed. Ethiopian cultural profile. Available: http://ethnomed.org/culture/ethiopian/copy_of_ethiopian-cultural-profile. Accessed 11/02/2011, 2011.
10. Mussie A. *Review of Cultural Diversity Profile- Ethiopian Australians*. Personal communication; 11 March 2011.
11. Anti-Racism MaNIACB, B, Vemuri, S. *Ethiopia: A cultural profile*. Anti-Racism, Multiculturalism and Native Issues (AMNI) Centre, Faculty of Social Work, University of Toronto: Toronto; 2001. <http://www.cp-pc.ca/english/ethiopia/index.html>.
12. Kwintessential. Ethiopia- Language, Culture, Customs and Etiquette. Available: <http://www.kwintessential.co.uk/resources/global-etiquette/ethiopia.html>.
13. Tiong ACD, Patel MS, Gardiner J, Ryan R, Linton KS, Walker KA, et al. Health issues in newly arrived African refugees attending general practice clinics in Melbourne. *Medical Journal of Australia* 2006;185:602-606.
14. Martin JA, Mak DB. Changing faces: a review of infectious disease screening of refugees by the Migran Health Unit, Western Australia in 2003 and 2004. *Medical Journal of Australia* 2006;185:607-610.
15. Hodes RM. Cross-cultural medicine and diverse health beliefs- Ethiopians abroad. *Western Journal of Medicine* 1997;166:29-36.
16. Ethnomed: Gall A, Shenkute, Z,. *Ethiopian traditional and herbal medications and their interactions with conventional drugs*. EthnoMed; 2009. <http://ethnomed.org/clinical/pharmacy/ethiopian-herb-drug-interactions>
17. Papadopoulos R, Lay M, Lees S, Gebehiwot A. The impact of migration on health beliefs and behaviours: The case of Ethiopian refugees in the UK. *Contemporary Nurse* 2003;15:210-222.
18. The Royal Australian College of Obstetricians and Gynaecologists. *Female Genital Mutilation: Information for Australian Health Professionals*. Melbourne; 1997.
19. Victorian Foundation for Survivors of Torture Inc. *Promoting refugee health:A guide for doctors and other health care providers caring for people from refugee backgrounds*. Victorian Foundation for Survivors of Torture Inc.; Melbourne; 2007.
20. Drug info clearinghouse. *Fact sheet: Khat*. Australian Drug Foundation: Melbourne; 2005. Available: http://www.druginfo.adf.org.au/downloads/fact_sheets/Khat_English.pdf.
21. Beyene Y. Medical disclosure and refugees: Telling bad news to Ethiopian patients. *Cross-Cultural Medicine - A Decade Later* 1992;157:328-332.
22. Correa-Velez I, Ansari A, Sundarajan V, Brown K, Gifford SM. A six-year descriptive analysis of hospitalisations for ambulatory care sensitive conditions among people born in refugee source countries. *Population Health Metrics* 2007;5.
23. Correa-Velez I, Sundarajan V, Brown K, Gifford SM. Hospital utilisation among people born in refugee-source countries: An analysis of hospital admissions. *Medical Journal of Australia* 2007;186:577-580.
24. Sheikh-Mohammed M, MacIntyre CR, Wood NJ, Leask J, Isaacs D. Barriers to access to health care for newly resettled sub-Saharan refugees in Australia. *Medical Journal of Australia* 2006;185:594-597.
25. Fenta H, HYman I, Noh S. Mental health service utilisation by Ethiopian immigrants and refugees in Toronto. *The Journal of Nervous and Mental Disease* 2006;194:925-934.



© State of Queensland (Queensland Health) 2011.

This document is licensed under a Creative Commons Attribution Non-Commercial 2.5 Australia licence. To view a copy of this licence, visit <http://creativecommons.org/licenses/by-nc/2.5/au>. You are free to copy, communicate and adapt the work for non-commercial purposes, as long as you attribute Queensland Health.

It should be noted that there is great diversity within communities and people do not fit into a pre-determined cultural box or stereotype. The information presented here will not apply to all Ethiopian Australians and this profile should be considered in the context of the acculturation process.

ⁱ Brisbane is defined as Local Government Area of Brisbane in ABS Census data

ⁱⁱ At the 2006 Census up to two responses per person were allowed for the Ancestry question, count is therefore total responses not person count.

ⁱⁱⁱ Defined as a positive Mantoux test result of ≥ 15 mm.

^{iv} Definition of literacy- Age over 15 years can read and write.

^v Missing and not-stated responses to this question on the census were excluded from the analysis.

^{vi} Non-school qualifications are awarded for educational attainments other than those of pre-primary, primary or secondary education.

Filipino Australians

- At the turn of the 20th century, there were approximately 700 Philippines-born people in Australia. By 1947, during the period of the *White Australia Policy*, the number of Philippines-born people in Australia had decreased to 141².
- In the 1950s, the population of Philippines-born people in Australia began to increase due to the arrival of significant numbers of students and skilled workers.
- From the 1960s to the 1990s, the Philippines-born population was one of the fastest growing overseas-born populations in Australia, with the population doubling between each Census (every five years)². By 1991, there were 73,673 Philippines-born people in Australia⁴.
- From 1972 to 1981, the President of the Philippines Ferdinand Marcos imposed martial law which resulted in an increase in migration to Australia². During the 1970s, many Philippines-born women migrated as spouses of Australian citizens². Since that time, most Philippines-born people migrating to Australia have been sponsored by a family member².
- **Ethnicity:** The main ethnic groups in the Philippines based on a 2000 census are:
 - Tagalog – 28.1 per cent
 - Cebuano/Bisaya/Binisaya – 20.7 per cent
 - Ilocano – 9 per cent
 - Hiligaynon Ilonggo – 7.5 per cent
 - Bikol – 6 per cent
 - Waray – 3.4 per cent^{5,6}.
 - Other ethnic groups make up the remaining 25.3 per cent of the population⁵.

Population of Philippines-born people in Australia (2006 Census): 120,540¹

Population of Philippines-born people in Queensland: 18,712¹

Population of Philippines-born people in Brisbane¹: 9869¹

Gender ratio (Queensland): 34.7 males per 100 females¹

Median age (Australia): The median age of Philippines-born people in 2006 was 40.3 years compared with 46.8 years for all overseas born and 37.1 for the total Australian population².

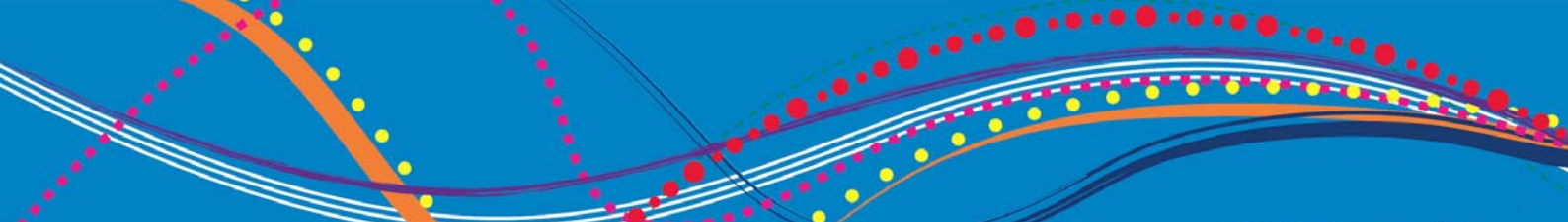
Age distribution (Queensland)¹:

Age	Per cent
0-19	12.4%
20-39	34.9%
40-59	44.9%
60+	7.8%

Arrivals – past five years (Source – Settlement Reporting Database³)

Year	Australia	Queensland
2006	6405	971
2007	7763	1301
2008	9139	1625
2009	9037	1581
2010	5568	946

- **Language:** Filipino and English are the official languages of the Philippines and both are spoken by many in the Philippines^{5,7}. Filipino is based on the language Tagalog which is a South-



Asian language influenced by Spanish, Chinese, Malay and Arabic^{5,7,8}. In addition, there are eight major dialects spoken: Tagalog, Cebuano, Ilocano, Hiligaynon or Ilonggo, Bicol, Waray, Pampango, and Pangasinan⁵. There are also more than 70 other regional dialects spoken in the Philippines⁸.

- **Religion:** Catholics comprise 80.9 per cent of the Philippines population⁵. Muslims make up 5 per cent of the population, Evangelical 2.8 per cent, Iglesia ni Kristo 2.3 per cent, Aglipayan 2 per cent and other Christians, 4 per cent⁵. Religion is deeply embedded in Filipino culture⁹.

Ancestry, language and religion in Australia (2006 Census for Philippines-born)²

- The top three ancestryⁱⁱ responses of Philippines-born people in Australia were:
 - Filipino – 80.9 per cent
 - Spanish – 5.8 per cent
 - Chinese – 3.5 per cent².
- The main languages spoken at home by Philippines-born people in Australia were:
 - Tagalog – 38.8 per cent
 - Filipino – 28.7 per cent
 - English – 27.0 per cent².
- The main religions of Philippines-born people in Australia were:
 - Catholic – 80.1 per cent
 - Christian – 2.6 per cent
 - Pentecost – 2.6 per cent
 - Baptist – 2.5 per cent².

Communication

- The word *Filipina* refers to a woman from the Philippines; *Filipino* may refer to a person from the Philippines in general, or a man from the Philippines.
- Nicknames are common and may be very different from Christian names¹⁰.
- Older Filipino Australians prefer to be addressed by their title (e.g. Mr, Mrs)

and surname¹¹. People are familiar with using titles for professionals such as doctors in the Philippines and may be uncomfortable using first names⁶.

- People of both sexes greet each other by bowing or shaking hands⁸. A firm handshake with a smile and eye-contact is appropriate⁹.
- Filipinos take special care to avoid confrontation in any type of communication⁸. Filipino Australians may be reluctant to show disagreement and may say *yes* even when they do not agree⁸. They may maintain a smile when disagreeing or when feeling embarrassed and may say *maybe* or *I don't know* when they really mean *no* or *I can't*⁸.
- Prolonged eye contact can be considered rude and provocative, especially if it involves people of different status or occurs between a man and a woman^{8,12}. Brief and frequent eye contact is recommended between health care providers and Filipino Australians⁹.
- Although many Filipinos can communicate in English, many prefer to speak their native language, particularly when ill or when in other high stress situations⁹. However, sensitivity is required in introducing the need for an interpreter as many Filipinos take pride in their ability to speak, read and write English and may feel offended⁹.
- An important cultural value of Filipinos is *hiya*, which can be roughly translated as embarrassment, shame or face. It has been described as a kind of anxiety, a fear of being left exposed, unprotected and unaccepted. Having *hiya* means that people may feel very sensitive to social slight and as a result are very careful of the feelings of others^{10,12}.
- Questions such as *Do you understand?* or *Do you follow?* may be considered disrespectful. It is more appropriate to ask *Do you have any questions?*^{9,10}.

Health in Australia

- Average life expectancy in the Philippines is 71.7 years (male 68.7, female 74.7) compared to 81.7 years for all people living in Australia (male 79.3, female 84.3)⁵.
- There is limited research on the health of Filipino Australians.
- Major illnesses and causes of death of Filipino American adults include cardiovascular disease, cancer, stroke, chronic lower respiratory disease and asthma, and diabetes mellitus⁹.
- Filipino Americans have been shown to have a higher incidence of diabetes and hypertension compared to Caucasian Americans^{9,13,14}.
- Rates of breast, lung and liver cancer have been shown to be higher for Filipino Americans⁹. Survival rates for cancers including breast, lung, colon, rectal, gastric and bladder cancer have been shown to be poor⁹.
- Prevalence of mental illness and mental distress in Filipino Australians does not appear to be higher than in the Australia-born population¹⁵.

Health beliefs and practices

- Filipino Australians originating from rural areas in the Philippines are often knowledgeable about home remedies, traditional healing techniques and faith healers^{9,11}.
- Filipino Australians originating from urban areas may be more likely to rely on Australian medical treatments and over-the-counter medicines^{9,11}.
- Traditional therapies such as *hilot* (traditional therapeutic massage), herbals, nutritional supplements and home remedies may be used in conjunction with Australian medical treatments and prescribed medications¹¹.
- Filipino Australians may classify and explain illnesses using concepts of *hot* and *cold*. Foods, medicines and temperature/weather conditions are classified according to their heating or

cooling quality and their effects on the body. Sudden changes in body temperature may be perceived as harmful. Beliefs about the relationship of water and bathing to health differ substantially. Bathing can be associated with a draining of strength from the body, particularly if a person is already ill^{9,12}.

- Filipino Australians may believe in *anitos* (spirits) alongside their Christian faith⁸. *Anitos* are sometimes seen as the cause of illness and, in certain areas of the Philippines, healers may be consulted to perform rituals to appease the invading spirits⁸.
- There is considerable variation in beliefs among Filipino Australians, including between earlier migrants and those who migrated more recently⁹. It is recommended that health practitioners acknowledge these variations and seek the preferences of patients and their families⁹.
- Many Philippines-born people cope with illness with the help of family and friends, and by faith in God⁹. Filipino families can greatly influence a patient's decisions about health care⁹.
- In general, Philippines-born people treat doctors and other health professionals with high levels of respect and authority¹¹.

Social determinants of health

- In 2000, the overall literacyⁱⁱⁱ rate in the Philippines was 92.6 per cent (men 92.5 per cent, women 92.7 per cent)⁵.
- Proficiency in English^{iv} in Australia (2006 Census)¹:
 - 97 per cent of Philippines-born men and women reported that they spoke English well or very well
 - 3 per cent of Philippines-born men and women reported that they did not speak English well
 - Less than 1 per cent of Philippines-born men and women reported that they did not speak English at all.

- At the time of the 2006 Census, 64.9 per cent of Philippines-born people aged 15 years or older had some form of higher non-school qualification compared to 52.5 per cent of the total Australian population².
- The participation rate in the workforce (2006 Census) was 73.1 per cent and unemployment rate was 5.2 per cent compared to the corresponding values of 64.6 per cent and 5.2 per cent in the total Australian population². The median weekly income for Philippines-born people in Australia aged 15 years or older was \$538 compared to \$466 for the total Australian population².
- A 2009 large-scale audit discrimination study based on job applications using ethnically distinguishable names showed that people with Asian sounding names were subject to discrimination in applying for jobs. People with Asian sounding names have to apply for more jobs to receive the same number of interviews as people with Anglo-Saxon sounding names and those with names of more established migrant groups such as Italian, even if they have the same work history and education¹⁶.
- A Queensland study has shown that the loss of close family ties and the transition from a collectivist to an individualist society are related to emotional distress in Filipinas¹⁷.
- Filipinas in Queensland have been shown to experience financial stresses including the loss of income associated with full time study to achieve recognition of overseas qualifications, financial pressure of remittances and under-employment¹⁷.
- Power imbalances in relationships can in some cases escalate to domestic violence^{12,18}. Catholic beliefs and values may influence some women's decisions to remain in abusive relationships despite personal cost^{12,18}. Women's options for domestic violence services are limited in many parts of Queensland^{12,18}. In addition, women may be reluctant to seek help if they think that other Filipinas will find out about their marital difficulties, and they may not feel comfortable discussing issues of domestic violence with service providers^{12,18}.

Utilisation of health services in Australia

- Filipinos generally expect their families to care for them and to be with them when they are sick. Fear of isolation from families is one reason for delayed presentation to hospitals and health care providers¹².
- Other barriers to accessing health services may include difficulties making the initial contact, cultural issues associated with asking questions, practical constraints and differing perceptions of health risk¹².
- Many Filipino Australians may not be willing to accept a diagnosis of mental illness. This can lead to the avoidance and underutilisation of mental health services because of the associated stigma and shame^{9,11,17}. The use of traditional practices and healing methods have been shown to be an additional barrier to the use of mental health services by Philippines-born people¹⁹.

References

1. Australian Bureau of Statistics. CDATA Census 2006. Available: <https://www.censusdata.abs.gov.au/CDATAOnline>. Accessed 20/05/2011, 2010.
2. Department of Immigration and Citizenship. *Community Information Summary: Philippines-born*. Commonwealth of Australia: Canberra; 2006.
3. Department of Immigration and Citizenship. Settlement reporting database. Available: <http://www.immi.gov.au/settlement>. Accessed 07/12/2010, 2010.
4. Migrant Resource Centre. *Philippines born*. Migrant Resource Centre: Melbourne; 2004. Available: www.vtput.org.au/.../Philippines%20born%20profile-%20NW%20MRC.doc.
5. Central Intelligence Agency (CIA). *The world fact book*. CIA; 2010. Available: <https://www.cia.gov/library/publications/the-world-factbook/>.
6. Hassell C. *Review of Cultural Diversity Profile- Filipino Australians*. Personal communication; 25 May 2011.
7. Daniel K. *SBS World Guide: The complete fact file on every country*. Sixteenth Edition ed. Prahan Victoria: Hardy Grant Books; 2008.
8. Anti-Racism MaNIACV, O M, Vemuri, S. *Philippines: A cultural profile*. Anti-Racism, Multiculturalism and Native Issues (AMNI) Centre, Faculty of Social Work, University of Toronto: Toronto; 2002. <http://www.cp-pc.ca/english/philippines/index.html>.
9. Dela-Cruz MT, Periyakoil VJ. *Health and health care of Filipino American older adults*. eCampus Geriatrics, Stanford University School of Medicine, Department of Medicine: Stanford, CA; 2010. Available: <http://geriatrics.stanford.edu>.
10. Centre for Philippine Concerns Australia. *We are Filipino: A practical guide to promoting HACC services to Filipino seniors*. Centre for Philippine Concerns Australia: Melbourne; 2003. Available: www.miceastmelb.com.au/documents/pdaproject/PilipinoKami.pdf.
11. South Eastern Migrant Resource Centre. *Filipino cultural profile- older people*. South Eastern Migrant Resource Centre: Melbourne; 2010. Available: www.sermrc.org.au/.../Filipino%20Cultural%20Profile%202011-06-10.pdf.
12. Allotey P, Manderson L, Nikles J, Reidpath D, Sauvarin J. *Cultural diversity: A guide for health professionals*. Queensland Government Press: Brisbane; 1998.
13. Araneta MR, Wingard DL, Barrett-Connor E. Type 2 diabeters and metabolic syndrome in Filipina-American women: A high-risk nonobese population. *Diabetes Care* 2002;25:494-499.
14. Cuasay LC, Lee ES, Orlander PP, Steffen-Batey L, Hanis CL. Prevalence and determinants of type 2 diabetes among Filipino-Americans in the Houston, Texas metropolitan statistical area. *Diabetes Care* 2001;24:2054-2058.
15. Thompson S, Hartel G, Manderson L, Woelz-Stirling N, Kelaher M. The mental health status of Filipinas in Queensland. *Australian and New Zealand Journal of Psychiatry* 2002;36:674-680.
16. Booth A, Leigh A, Varganova E. *Does racial and ethnic discrimination vary across minority groups? Evidence from a field experiment*. Australian National University: Canberra; 2009.
17. Thompson S, Manderson L, Woelz-Stirling N, Cahill A, Kelaher M. The social and cultural context of the mental health of Filipinas in Queensland. *Australian and New Zealand Journal of Psychiatry* 2002;36:681-687.
18. Woelz-Stirling NA, Kelaher M, Manderson L. Power and the politics of abuse: Rethinking violence in Filipina-Australian marriages. *Health Care for Women International* 1998;19:289-301.
19. Sanchez F, Gaw A. Mental health care of Filipino Americans. *Psychiatric Services* 2007;58:810-815.



© State of Queensland (Queensland Health) 2011.

This document is licensed under a Creative Commons Attribution Non-Commercial 2.5 Australia licence. To view a copy of this licence, visit <http://creativecommons.org/licenses/by-nc/2.5/au>. You are free to copy, communicate and adapt the work for non-commercial purposes, as long as you attribute Queensland Health.

ⁱ Brisbane is defined as Local Government Area of Brisbane in ABS Census data

ⁱⁱ At the 2006 Census up to two responses per person were allowed for the Ancestry question, count is therefore total responses not person count.

ⁱⁱⁱ Literacy is defined as those aged 15 and over who can read and write.

^{iv} Missing and not-stated responses to this question on the census were excluded from the analysis.

It should be noted that there is great diversity within communities and people do not fit into a pre-determined cultural box or stereotype. The information presented here will not apply to all Filipino Australians and this profile should be considered in the context of the acculturation process.

Hmong Australians

- The Hmong are a highland group from southern China, and resident in Laos, North Vietnam and Thailand. The Hmong have migrated from their homeland since the end of the Vietnam War in 1975 when they faced persecution or death from the communist movement in Laos²⁻⁴.
- From 1975 to 1997, approximately 138,000 Hmong escaped by crossing the hazardous Mekong River to refugee camps in Thailand. It is estimated that between 50,000 to 100,000 Hmong people died from fighting, disease and starvation^{3,4}. Many of the Hmong seeking refuge in Australia transitioned through a refugee camp in Thailand².
- **Places of transition:** Thailand
- **Language:** Hmong was the main language spoken at home by 85.5 per cent of Hmong Australians in the 2006 census⁵.
- **Religion:** Hmong religion is comprised of a cult of spirits, shamanism and ancestor worship. It is a pantheistic religion teaching that there are spirits residing in all things. According to Hmong religious beliefs there are two distinct worlds, the invisible world of *yeeb ceeb*, which holds the spirits, and the visible world of *yaj ceeb*, which holds humans, material objects and nature. The shaman is an important person because he has the ability to make contact with the world of the spirits⁶.
- The main religion responses of Hmong Australians based on the 2006 census⁵:
 - No religion or not stated – 42 per cent
 - Buddhism – 21.8 per cent
 - Ancestor veneration – 10 per cent
 - Animism – 8.9 per cent
 - Christian – 3.8 per cent
 - Catholic – 3 per cent.

Population of Hmong people in Australia (2006 census): 2189¹

Population of Hmong people in Queensland (2006 census): 14471

Population of Hmong people in Brisbane (2006 census): 690¹

Gender ratio (Queensland): 94.4 females per 100 males¹

Age distribution (Queensland)¹:

Age	Per cent
0-19	55%
20-39	27%
40-59	13.7%
60+	4.2%

Communication

- Hmong people greet each other verbally⁷. Older Hmong people and women may be unfamiliar with the practice of shaking hands.
- Hmong people may be reluctant to make direct eye contact. Traditionally, looking directly into the face of a Hmong person or making direct eye contact is considered rude and inappropriate⁷.
- Hmong people tend to be reserved and may not wish to show or express their true emotions in front of other people. They may say *maybe* or *I will try* instead of giving a definite positive or negative reply⁷. If they feel pressured, they may say *ok* or *yes* when they actually mean *no*^{8,9}.
- Due to religious beliefs and personal values, many traditional Hmong elders, especially men, may object to a stranger touching their heads, or those of their children⁹.

- Hmong people, particularly the elderly, may not speak English well, or at all, and may depend on their children or family members to communicate².
- Care may be required when explaining health care issues as many Hmong Australians have not completed any formal education².
- There are two distinct dialects of Hmong language: White Hmong (*Hmong Der* dialect) and Green Hmong (*Mong Leng* dialect)^{8,10}. The names of the languages originate from the colours traditionally used for women's clothing by the different groups^{8,10}. Although some Hmong people report difficulty in understanding speakers of another dialect, in general speakers of White and Green Hmong can understand each other^{8,10}.
- Hmong patients often prefer for health care providers to take some time to discuss family or other pleasantries before asking direct questions about their physical health¹¹.

Health in Australia

- Little data are available on the health of Hmong people in Australia. The health information presented here is based on data on Hmong in the United States.
- Hmong people have been shown to have relatively high rates of tuberculosis (approximately 12 per cent of Hmong people who arrived in the United States between 2004 and 2006 had latent tuberculosis infection) and hepatitis B (approximately 10 per cent of Hmong people who arrived between 2004 and 2006 carried chronic hepatitis B infection)^{3,8}.
- Studies show that Hmong people are at increased risk of cardiovascular disease, diabetes mellitus, hypertension and end-stage renal disease^{3,8,12}.
- There is evidence to indicate that Hmong people have an elevated risk for cancers of the stomach, liver, cervix and pancreas⁸. Hmong people have a

35 times higher risk for nasopharyngeal cancer and a relatively high risk of leukemia and non-Hodgkins lymphoma^{3,8}.

- A health issue that is of particular concern for Hmong men is Sudden Unexplained Nocturnal Death Syndrome (SUNDS)⁸. This is a regional phenomenon within Asia and occurs in populations that are culturally and genetically distinct¹³. It primarily affects healthy young men in their mid-20s or 30s¹³. Research suggests the risk of SUNDS may be increased by a family history of SUNDS, a pre-existing cardiac abnormality, cardiomegaly and post-traumatic stress disorder (PTSD)^{13,14}.
- The trauma and stress of war, extended periods of time spent in refugee camps, and experiences of repression have contributed to high rates of depression, PTSD, and other psychological illnesses⁸.

Health beliefs and practices

- Hmong beliefs about the causes of illness can be divided into three basic categories^{3,15}:
 - Natural causes: This includes imbalances of metaphysical forces (similar to the concept of *yin/yang*), changes in weather, bad food, heredity, aging and bacteria. The Hmong understanding of bacteria is similar to that of Australian medicine^{3,15}.
 - Spiritual or religious causes: Ancestors, nature and evil spirits are all thought to be able to cause illness to people in some cases¹⁵.
 - Other causes: There is a broad range of other causes of illness. For example, it is a common traditional Hmong belief that a person who has been wronged by another has the power to curse that person and bring about illness¹⁵.
- Non-Christian Hmong may consult a Shaman to diagnose and treat the causes of illness¹⁶.

- Many Hmong people believe that illness can result from an individual losing one or more of the twelve souls that are thought to dwell in the human body. For good health, all twelve souls must remain intact in the body. Many aches and pains, depression and symptoms of mental illness are believed to be caused by a person having lost souls. Souls may be lost in a variety of ways including a sudden fright, excessive fear or grief, capture by an evil spirit, or a soul transferring to another being because they are unhappy¹⁵.
- Many Hmong people believe that surgery may interfere with reincarnation or may open access to the body for evil spirits to enter¹⁷.
- Some Hmong people may fear anaesthesia and after a general anaesthetic may feel it is necessary to perform a soul calling ceremony².
- Many Hmong people believe that blood maintains balance in the body and that the body may be weakened if blood is withdrawn¹⁷.
- Traditional Hmong believe that an autopsy may hinder the reincarnation of the deceased person¹⁷.
- Many Hmong believe that after childbirth the mother's body is susceptible to illness because it is *cold* from blood loss. It is believed that the new mother should follow a special diet for 30 days that includes *hot* as opposed to *cold* foods. The father and his mother will often cook these foods for the new mother¹⁶.
- Hmong believe the placenta is required for reincarnation and is usually buried at the place of birth. In Australia, Hmong women may wish to bury the placenta².
- Hmong may have a limited understanding of the concept of chronic illness and may have a consistent impression that these illnesses can be cured rather than managed¹². Adherence to long-term sustained treatment regimes may be low. Careful explanation to the decision maker in the family may be required to gain their support².
- Headaches, muscle aches, swelling, tingling, back pains, chest pains and abdominal pains are often interpreted as being caused by a build-up of pressure in the body that must be released³. Traditional healing techniques used to *dim pa* (release the pressure) include cupping, coining and massage³.
 - Cupping uses round glass cups, bamboo jars or water buffalo horns. These objects are placed on the location of the pain and a vacuum is applied to the skin by heat or mouth suction. Cupping can cause a bruise³.
 - Coining or spooning involves applying medicated oil or balm and then rubbing the skin with a flat edged object such as a silver coin or a spoon³.
 - Massage is used to loosen the body (muscles, tendons and veins) and promote better circulation³.
- Hmong people may grow, import and use herbs and other organic substances for healing a variety of ailments³.
- Same sex health care providers are preferred by Hmong Australians, particularly for women². Hmong women may refuse vaginal examinations, especially by male doctors. This may be a reason for late presentation for antenatal care and non-attendance at post partum checks².

Social determinants of health

- Many Hmong have not completed any formal education⁸.
- The written form of Hmong language was only developed in the 1950s. Because of this recent development of the written language, many older Hmong Australians may be illiterate in the Hmong language⁸.

- Many Hmong Australians may have spent several years in refugee camps before migrating to Australia, in addition to experiencing the trauma of war and repression².
- Clans are Hmong family groups and the clan name is the family name¹⁶. Hmong clans are a major source of social support for their members¹⁶. Traditionally, clans also provide economic assistance to their members¹⁶.

Utilisation of health services in Australia

- There is no published data on health service utilisation by Hmong Australians.
- Hmong Australians believe Australian medicine to be beneficial, but traditional herbal and spiritual

diagnosis and treatment may preferred as a first option².

- A United States study found that consultation with traditional practitioners such as herbalists and shaman, and lower socioeconomic position were two major barriers to utilisation of health services¹⁸.
- Cultural differences are major barriers to the use of mental health services by Hmong people⁸. The Hmong language has no words for mental illness, except for one word that means *crazy* in English¹⁹. Many Hmong consider self-disclosure and the open display of emotions to be signs of weakness and will not easily acknowledge mental health problems⁸.

References

1. Department of Immigration and Citizenship. *The people of Queensland: Statistics from the 2006 Census*. Commonwealth of Australia: Canberra; 2008. Available: <http://www.multicultural.qld.gov.au/services-resources/documents/People-of-QLD-Publication-Vol-1.pdf>.
2. Allotey P, Manderson L, Nikles J, Reidpath D, Sauvarin J. *Cultural diversity: A guide for health professionals*. Queensland Government Press: Brisbane; 1998.
3. Gerdner LA. *Health and health care of Hmong American older adults*. eCampus Geriatrics in the Division of General Internal Medicine, Stanford School of Medicine: Stanford; 2010. Available: <http://geriatrics.stanford.edu>.
4. Robinson WC. *Terms of refuge: The Indochinese exodus and the international response*. United Nations High Commissioner for Refugees: New York, NY; 1998.
5. Australian Bureau of Statistics. CDATA Census 2006. Available: <https://www.censusdata.abs.gov.au/CDATAOnline>. Accessed 07/12/2010, 2010.
6. Everyculture.com. Countries and their cultures: Hmong Americans. Available: <http://www.everyculture.com/multi/Ha-La/Hmong-Americans.html>.
7. Vital Aging Network. Cultural Etiquette for Interacting with Traditional Hmong. Available: http://www.vital-aging-network.org/Resources_for_Vital_Living/Cultural_Diversity/130/Cultural_Etiquette_for_Interacting_with_Traditional_Hmong_.html.
8. Centres for Disease Control and Prevention. *Promoting Cultural Sensitivity: A practical guide for tuberculosis programs that provide services to Hmong persons from Laos*. U.S. Department of Health and Human Services: Atlanta, GA; 2008.
9. Hmong Cultural Center. Etiquette for interacting with the Hmong. Available: <http://hmongcc.org/BuildingBridgesGeneralPresentation2007Version.ppt>. Accessed 5 April 2011, 2011.
10. Duffy J, Harmon R, Ranard DA, Thao B, Yang K. *The Hmong: An introduction to their history and culture*. Baltimore, MD: Centre for Applied Linguistics, Cultural Orientation Resource Centre; 2004.
11. Barrett B, Shadick K, Schilling R, Spencer L, Rosario Sd, Moua K. Hmong/medicine interactions: Improving cross-cultural health care. *Family Medicine* 1998;30:179-184.
12. Hessel D, Mochel M, Bauer R. Chronic illness and Hmong shamans. *Journal of Transcultural Nursing* 2005;16:150-154.
13. Munger R. Sudden death in sleep of Laotian-Hmong refugees in Thailand: A case-control study. *American Journal of Public Health* 1987;77:1187-1190.
14. Kirschner R, Eckner F, Barron R. The cardiac pathology of sudden unexplained nocturnal death in Southeast Asian refugees. *Journal of the American Medical Association* 1986;256:2700-2705.
15. Bliatout BT. Hmong beliefs about health and illness. *Hmong Forum* 1990;1:41-45.
16. Lee TP, Pfeifer M. *Building bridges: Teaching about the Hmong in our communities*. Hmong Cultural Center: Saint Paul, MN; 2007.
17. Cha D. *Hmong American concepts of health, healing and illness and their experience with conventional medicine*. Boulder, University of Colorado; 2000.
18. Baker DL, Dang MT, Ying M, Diaz R. Perception of barriers to immunisation among parents of Hmong origin in California. *American Journal of Public Health* 2010;100:839-845.
19. Lipson JG, Dibble SL. *Providing culturally appropriate health care. Culture and Clinical Care*. San Francisco: UCSF Nursing Press; 2005.



© State of Queensland (Queensland Health) 2011.

This document is licensed under a Creative Commons Attribution Non-Commercial 2.5 Australia licence. To view a copy of this licence, visit <http://creativecommons.org/licenses/by-nc/2.5/au>. You are free to copy, communicate and adapt the work for non-commercial purposes, as long as you attribute Queensland Health.

ⁱ Brisbane is defined as Local Government Area of Brisbane in ABS Census data

It should be noted that there is great diversity within communities and people do not fit into a pre-determined cultural box or stereotype. The information presented here will not apply to all Hmong Australians and this profile should be considered in the context of the acculturation process.