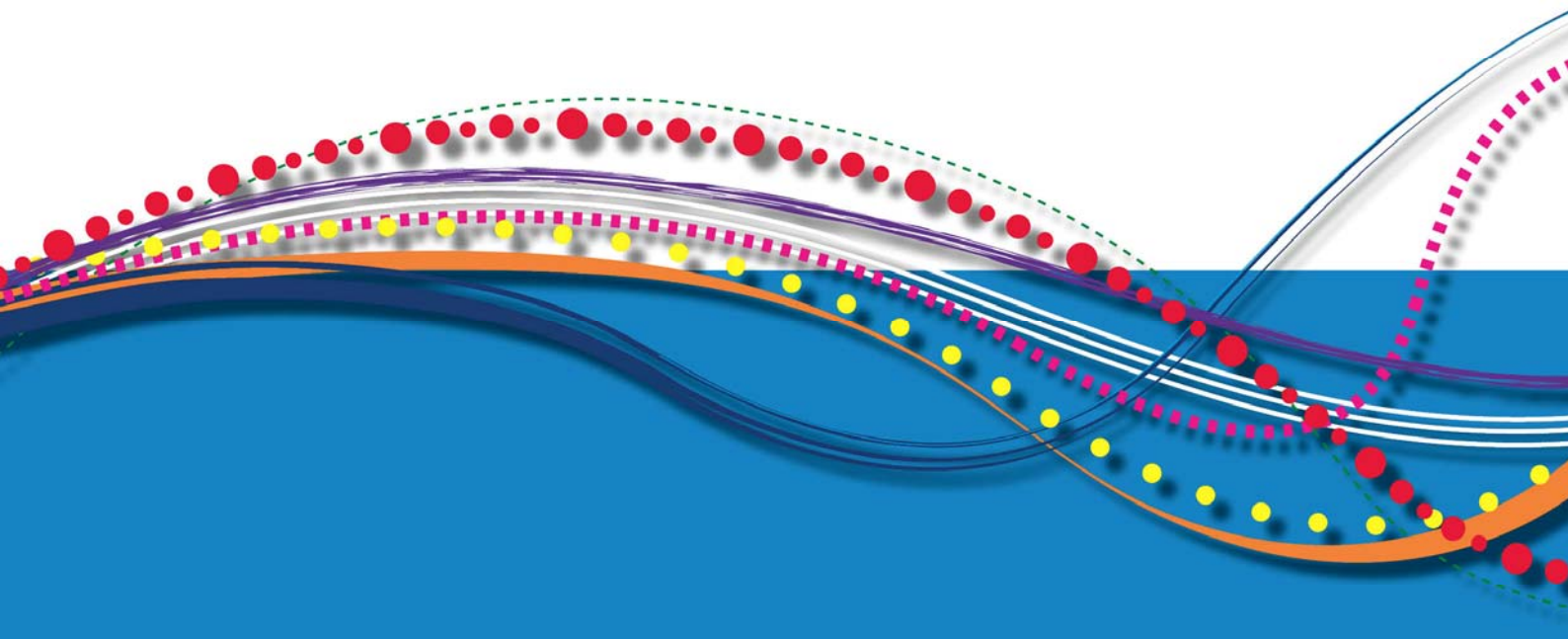
Queensland Health

Community Profiles
for Health Care Providers



Queensland Government

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
- Vasanthy 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

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

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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.

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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 expedition[2].
- 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 1980s[2].
- 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 regime[2].
- 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 2002[4], 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 period[3].
- **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 bilingual[7].

Population of Afghanistan-born people in Australia (2006 Census): 16,753[1]

Population of Afghanistan-born people in Queensland: 840[1]

Population in Afghanistan-born people in Brisbane[i]: 725[1]

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 population[2]

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 Database[3])

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 responses[ii] 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 Afghanistan[iii] and they account for more than 50 per cent of the Afghan refugees who have arrived in Australia between 2006 and 2010[6].
- The rates of education of Hazara people are lower than the other main ethnic groups of Afghanistan and many Hazaras are illiterate[9]. In many cases Hazaragi speakers (particularly those who have lived in rural areas) cannot understand Dari interpreters[9]. 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 requirements[8].
- 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 appropriate[8].
- 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 prolonged[10].
- 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 saying[11].
- As a sign of respect, Afghan Australians do not call older people by their given name[8].
- Afghan Australians are likely to show their appreciation of a service provided to them by expressing words of blessing[8].

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 issues[13].
- 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 Netherlands[14]. Afghan women were shown to have higher rates of PTSD, depression and anxiety than men[14].

- According to a 2002 population-based mental health survey in Afghanistan, women had significantly lower mental health status and poorer social functioning than men[12]:
  - 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 health[15].
- 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 witchcraft[15]. *Jinn*, the *evil eye* and witchcraft are mainly seen to cause mental illness[6].
- Prayer is traditionally seen as important in healing illness[15].
- Doctors are held in very high regard[8].
- 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 illnesses[8].
- Older Afghan Australians may prefer traditional treatments to Australian medical treatments[8].
- 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 care[15].
- 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 child[16]. This is usually the *Adhan*, or what is usually recited as a call for prayer[6].
- 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 death[16].
- 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 services[8].
- 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 killed[20]. In addition, many Afghans have experienced poverty, displacement, and the loss of social connections and social isolation before seeking refuge in countries such as Australia[20].
- The conditions in detention centres and the delay in the processing of refugee claims adds to the trauma which refugees have already experienced in Afghanistan[21].
- 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 population[2].
- 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 population[2]. The median weekly income for Afghanistan-born people in Australia aged 15 and older was $234 compared to $466 for the total Australian population[2].
- 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 qualifications[22].

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 system[13].

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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 farms[4-6].
- Australian South Sea Islander people came from 80 Pacific Islands, but most were primarily from Vanuatu and the Solomon Islands[5].
- Australian South Sea Islander people are not indigenous to Australia and are distinct from Australians born in the Pacific Islands[4]. They are their own unique cultural group[5].
- 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 Commission[7].
- 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 Queensland[6]. However, the 2001 Census reported only 3442 Australian South Sea Islander people based on ancestry[6].
- **Language:** Australian South Sea Islander people predominantly speak English[4].
- **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 gods[8]. 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 missions[8]. Today, Christianity is an integral part of what it means to be an Australian South Sea Islander person[8].

Population of Australian South Sea Islander people[i] in Australia (2006 Census): 4098[1]

Population of Australian South Sea Islander people in Queensland: 3030[2]

Gender ratio (Queensland): 84.1 males per 100 females[3]

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 surname[9]. This is particularly important when addressing older people[9]. 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 speaks[4].
- 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 provider[10].
- 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 patient[10].

- 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 discussions[4].
- 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 helpful[4].
- Many Australian South Sea Islander people operate on event time as opposed to clock time[10]. 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 appointments[10].
- Many Australian South Sea Islander people prefer a health provider of the same gender[10].

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 health[4].
- During times of illness, Australian South Sea Islander people often have a *special person* (either a relative or a friend) to provide assistance and care[4].
- Modesty is an important cultural value and Australian South Sea Islander people prefer not to be touched unnecessarily[4]. 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 emphasised[4].
- Australian South Sea Islander people who are seriously ill may have large numbers of visitors from their extended family[4]. Providing a separate room during visiting hours (if possible) may assist[4]. Alternatively, the nominated *special person* or a relative could be asked to assist with arranging a roster of visitors[4].
- Spirituality is important to Australian South Sea Islander people. When a person is dying, their relatives may wish to hold a bedside prayer vigil[4].

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 individual[4].
- Australian South Sea Islander people are an economically disadvantaged community. The community was recognised as a distinct and severely disadvantaged ethnic group in 1994[4].

- Poor education and employment opportunities have been the result of generations of poverty and discrimination[8].
- Studies have indicated significant literacy issues for Australian South Sea Islander people[8].
- Home ownership by Australian South Sea Islander people is lower than that of most other culturally and linguistically diverse communities in Australia[8].

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 entitled[4].
- A study in Mackay reported communication and cultural barriers between Australian South Sea Islander people and local hospital services[13]. 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 services[13].
- A tendency to be stoical when in pain has contributed to delayed presentation to health services[4].

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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.

[i] Population defined using Census Ancestry question.

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 Britain[2].
- 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 1972[2].
- Since 1972, the number of Burmese people settling in Australia has grown significantly through the Australian Government's Migration Refugee Special Humanitarian Programme[2].
- **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 Burma[4]. Other countries of transition are Malaysia and India[4].
- **Ethnicity:** Burma is one of the most ethnically diverse countries in the world[5]. The largest ethnic group, Burmans (or Bamar) form about 68 per cent of the population[6]. 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 Rohingyan[6].
- **Language:**
  - Burmese is the official language of Burma and is the main language spoken by Burmans[5]
  - Karen people speak several dialects of the Karen language including Sgaw Karen, Pwo Karen, Karenni and Pa-o[5]
  - Shan, Chin and Rohingyan people all have distinct languages and dialects within these language groups. In all, more than 100 languages are spoken in Burma[7].

Population of Burma-born people in Australia (2006 Census): 12,380[1]

Population of Burma-born people in Queensland: 730[1]

Population of Burma-born people in Brisbane[i]: 463[1]

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 population[2].

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 Database[3])

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

- **Religion:**
  - Burmans, Shan and Mon: Approximately 90 per cent are Theravada Buddhists[5]
  - Karen: About 70 per cent are Theravada Buddhist, Buddhist-animist or animist, and about 20-30 per cent are Christian[5]
  - Karenni (a subgroup of Karen): Most are animist[5]
  - Chin: A large number are Christians. Others continue to practice animism[5]
  - Rohingyan: Predominantly Muslim.

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

- The top four ancestry responses[ii] 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 dialects[5].
- Literacy rates among Karenni people are low[5].
- Traditionally Burmese people do not have family names. Therefore, all members of a family may have names that bear no obvious relationship to each other[5].
- It is customary to use titles (e.g. Mr and Mrs) when addressing people other than small children[5].
- The following communication issues are particularly important for Burmese Buddhists:
  - It is disrespectful for legs to be stretched out with feet pointed towards a person[5]
  - The head is considered the spiritually highest part of the body and sensitivity is advised if it is necessary to touch the head[5]
  - Using both hands to give and receive an object is a sign of respect, particularly with older people[5].
- These additional communication issues are relevant for Karen people:
  - Karen people normally walk behind those who are their seniors and elders[5]
  - Karen may answer a question with *no* to be modest when an affirmative answer may seem more appropriate[5].
- It is often not appropriate to establish direct eye contact with Chin people, especially seniors[5].
- 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 Burmese[5].

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 persecution[8].
- 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 strongyloidiasis[9].

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 meals[5].
- Theravada Buddhist health beliefs include:
  - Good and bad events can be attributed to actions committed in the past[5].
  - 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 disease [5]. 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 temperature[11]. *Hot* foods are generally those foods which are salty, sour or high in animal protein, while *cold* foods are generally sweet or bitter[11]. States of health seen as *hot* or *cold* are seen to require treatment with the opposite in medicine or foods[12].
  - Buddhist verses are important in curing illnesses, either being blown over the patient or recited over water for the patient to drink[13].
  - When a Buddhist is dying, a Buddhist monk or minister should be notified to provide chaplaincy services[14]. The monk will chant verses after the person has died to help release the person's good energies[14].
  - The state of mind at the time of death is important in determining the deceased person's next rebirth[14].
  - 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 flow[12].
- 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 illness[5].
- One way of keeping *kla* is by an elder or religious shaman tying sacred string around the wrist[5].
- The *kla* are said to leave the body at death and reappear in the form of the *kla* of a newly born child[5].
- Non-Christian Chins may ascribe some conditions that cannot be cured by Australian health care practices to *hnam*, an evil spirit that dwells within humans[5].
- 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 illnesses[5].

Social determinants of health

- Overall literacy[iii] 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 population[5]. The overall literacy rate in 2006 was 89.9 per cent[6]. Literacy of women was 86.4 per cent and men 93.9 per cent[6].
- 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 torture[15].
- 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 abuse[16].
- 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 population[2].
- 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 population[2]. The median weekly income for Burma-born people in Australia aged 15 and older was $432 compared to $466 for the total Australian population[2].

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-medication[19].

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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.

[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.

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 Tutsis[5]. As a result, an estimated 150,000 people were killed and tens of thousands of refugees fled to neighbouring countries[5].
- 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 2005[5].
- By 2006, there was only a relatively small intake of Burundian refugees into Australia with only 753 Burundi-born people recorded in the 2006 Census[2]. Since 2006, the Australian Burundi-born population has more than doubled with 1266 Burundi refugees settling in Australia between 2006 and 2010[3].
- **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 each[6].
- **Language:** The main and official languages are Kirundi and French[5,6]. Swahili is spoken in some areas[6].

Population of Burundi-born people in Australia (2006 Census)[i]: 753[2]

Population of Burundi-born people in Queensland: 188

Population of Burundi-born people in Brisbane[ii]: 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 Database[3])

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 animism[7]. Animists believe that inanimate and natural phenomena, as well as living creatures, have souls and

spirits[7]. Certain rituals are believed to control uncertainties and negative influences in life[7]

- 10 per cent of the population are Muslim[6].

Communication

- Handshakes are important to Burundians and the type of handshake varies by region[8]. For example, one handshake involves touching one's left hand to the other person's elbow[8]. Handshakes are often soft[9].
- People stand close together in conversation and often continue holding hands for several minutes after shaking[8].
- There is good to fair eye contact between people of equal stature but little eye contact otherwise[9]. Avoiding eye contact is a way to show respect for the elderly or important people[9].

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 Mantoux[iii] 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 Australia[12].

Health beliefs and practices

- Many Burundians use traditional remedies to treat diseases[7]. Potions made from leaves, roots, bark, fruit and herbs may be taken orally or rubbed on the skin[7]. 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 remedies[1].
- Animist rituals may be performed to cure a person who is ill[7].
- The health care system in Burundi is basic and medical facilities are limited, even in cities[7]. About two million people in Burundi (one third of the population) have no access to formal health care[7]. 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 departments[1].
- Burundian Australians are willing to access Australian medical treatments.
- Many Burundian Australians prefer injections to tablets[1].

Social determinants of health

- The literacy rate[iv] of Burundians, particularly female, is low[6]. 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 labour[13].

- About 60 per cent of the Burundian population lack access to safe drinking water[7].
- 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 lives[10]. Some Burundians have fled their country more than once[14]. 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 paranoia[10].
- Settlement is often impacted by changing family dynamics and concern for family members who remain in refugee camps[14].
- Proficiency in English (2006 Census)[v,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 sick[15]. 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 services[15].

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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 Census[1].

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

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

[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 1970s[2].
- 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 rein. 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 Australia[2].
- Between 1978 and 1991, more than 500,000 Cambodians sought refuge in refugee camps in Thailand[4].
- Between 1975 and 1986, 12,813 Cambodians came to Australia as refugees[2].
- 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 24,530[2].
- **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 more than 96 per cent of the population. Muslims comprise approximately two per cent of the population[6]. Less than two per cent of the population are affiliated with other religions[6].

Population of Cambodia-born people in Australia (2006 Census): 24,530[1]

Population of Cambodia-born people in Queensland: 1214[1]

Population of Cambodia-born people in Brisbane[i]: 1029[1]

Gender ratio (Queensland): 82.3 males per 100 females[1]

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 population[2].

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 Database[3])

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

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

- The top ancestry[ii] responses of Cambodia-born people in Australia were:
  - Khmer – 54.2 per cent
  - Chinese – 35.6 per cent
  - Not stated – 4.6 per cent[2].
- 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 strangers[8]. 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 name[8]. Some Cambodians have adopted the Australian style of naming and have changed the order of their names, placing their surnames last[8]. Children can take either their father's surname or a personal name[8].
- It is considered disrespectful to sit with the legs stretched out and the feet pointed towards a person[8].
- The head is considered the spiritually highest part of the body and sensitivity is advised if it is necessary to touch the head[8].
- 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 person[8].
- 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 treatment[8].
- Cambodian people rarely appear desperate or distressed, even when experiencing significant anxiety or pain[8].

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 eosinohilia[9].
- The blood diseases haemoglobin E and thalassemia minor have been observed in Cambodian refugees and migrants[8].
- Overseas research shows that other common diseases affecting Cambodian people include tuberculosis and hepatitis B[8].
- Dental problems including caries are common[8]. Some Cambodian Australians travel back to Cambodia for more affordable dental healthcare[10].
- 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 depression[4].

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* elements[8].
- 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* foods[8].
- 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 supernatural[8].
- 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 abuse[8].
- 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 vary[8].
- 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 treatment[8].
- 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 body[8].
- Medication is frequently taken only for as long as the individual feels ill. Compliance with medications for a chronic disease can be difficult[8].
- Many Cambodia-born women prefer to be examined by female health care providers[8].
- 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 necessary[8].
- When a Cambodian Buddhist is dying, a Buddhist monk or minister should be notified to provide chaplaincy services[12]. The monk will chant verses after the person has died to help release the person's *good* energies[12]. The state of mind at the time of death is considered important in determining the deceased person's next rebirth[12].

Social determinants of health

- The overall literacy[iii] 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 rein[4]. Cambodian people are considered the most traumatised of all South-East Asian people[13]. Many Cambodian people have experienced famine and starvation, witnessed death and destruction, and have spent long periods of time in refugee camps in Thailand[14].
- 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 refugees[4].

- 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 population[2].
- 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 population[2]. The median weekly income for Cambodia-born people in Australia aged 15 years or older was $328 compared to $466 for the total Australian population[2].
- 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 education[15].

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 illness[11].
- 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 utilisation[16].
- Cambodia-born women may avoid regular preventive pelvic and breast examinations because of embarrassment[8].

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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.

[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.

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 China[2]. Many China-born people were also attracted to Australia by the discovery of gold[2]. At the time of the 1861 Colonial Census, China-born people in Australia numbered 38,258 and comprised 3.4 per cent of the population[2].
- 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 6404[2]. By 1976, after the dismantling of the *White Australia Policy*, the number had risen to 19,971[2].
- 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 students[2].
- The term *Chinese* covers a diverse range of communities and individuals, sometimes having no more in common than ancestral heritage[4].
- **Ethnicity:** Han Chinese comprise 91.9 per cent of the population of China. Other ethnicities include: Zhuange, 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 Guandong province of the PRC, Vietnam, and among many people from Malaysia, Singapore and Christmas Island[4]. Other languages include: Shanghaiese (Wu), Fuzhou (Minbei), Hokkein-Taiwanese (Minnan), Xiang, Gan and Hakka dialects[5,6].

Population of China-born[i] people in Australia (2006 Census): 206,590[1], Chinese ancestry: 669,901[1]

Population of China-born people in Queensland: 15,059[1], Chinese ancestry: 71,139[1]

Population of China-born people in Brisbane[ii]: 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 population[2].

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 Database[3])

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

- **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 living[7]. Confucianism emphasises mercy, social order and fulfilment of responsibilities[7].

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 cent[2].
- 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 cent[2].

Communication

- Many distinct Chinese dialects are spoken by Chinese Australians[4]. It is recommended that health care providers seeking an interpreter for a patient should first find out the particular dialect spoken by the patient[8].
- Chinese Australians usually greet each other by shaking hands[9].
- For many China-born people, avoiding eye contact, shyness and passivity are cultural norms[4]. However, a smile, good eye contact and politeness are expressions of sincerity.
- Chinese Australians may avoid saying the word *no* because they consider it impolite[4].
- Chinese Australians may commonly mask discomfort or other unpleasant emotions by smiling[9].
- 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 names[9]. However some Chinese Australians have adopted the Australian style of naming and have changed the order of their names, placing their surnames last[10]. Chinese surnames usually only have one syllable[10].

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 people[11].
- The major causes of mortality for China-born people in Australia include ischaemic heart disease, cancer and cerebrovascular disease[11].
- Major cancers for China-born males in Australia include nasopyarynx, lung, intestines, rectum, stomach and liver[11]. Major cancers for China-born females in Australia include lung and stomach[11].
- Worldwide, Chinese women have higher rates of suicide than women of other nationalities[12].

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 health[7]. The classification of foods as *hot* or *cold* is unrelated to temperature and not always related to taste[10]. For example, seafood is classified as cold even if it served hot or with chilli[10].
- 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 body[7].

- 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 client[4].
- Chinese Australians emphasise the importance of the role of the family in liaising between health professionals and patients with cancer[13]. Chinese Australian patients with cancer prefer a confident and clear diagnosis and treatment recommendations[13].
- 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 used[4]. 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 treatments[4].
- Many Chinese Australians visiting a health care provider will expect tangible evidence of treatment, such as a prescription[4].
- Chinese people usually prefer to be examined by a doctor of the same sex; this is particularly true for women[4].

Social determinants of health

- The overall literacy[iii] 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 population[2].
- 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 population[2]. The median weekly income for China-born people in Australia aged 15 years or older was $242 compared to $466 for the total Australian population[2].
- 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 education[14].

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 Australians[15].
- Many Chinese Australians have a strong preference for Chinese-speaking general practitioners[15].
- 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 workers[15]. Health care professionals have observed that these barriers have decreased and health service access for Chinese Australians has improved since the 1990s[10].
- Chinese Australians have been shown to have low utilisation of mental health services[16].
- Barriers to accessing mental health services for Chinese Australians include low mental health literacy, communication difficulties, stigma, confidentiality concerns, service constraints and discrimination[16].

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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 countries[4].
- In the 1970s, drought, the Ogaden War with Somalia and an oppressive military regime caused the displacement of more than one million Ethiopians[4]. In the 1980s, Ethiopia experienced another prolonged drought and a consequent famine that continued into the 1990s displacing hundreds of thousands of people[4].
- 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 border[5].
- Ethiopia has itself provided refuge to displaced people from Sudan, Somalia and Eritrea who have fled war and famine in their own countries[6].
- The majority of Ethiopia-born people in Australia arrived after 1991, with over 3000 Ethiopian refugees settling in Australia between 2000 and 2005[4].
- 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 cent[4]. Between 2006 and 2010, more than 3000 Ethiopian refugees arrived in Australia[3].
- **Places of transition:** Somalia, Kenya, Sudan, Egypt and Djibouti[4].
- **Ethnicity:** Ethiopia is an ethnically complex and diverse country comprising more than 78 distinct ethnic groups[4]. 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
  - Sidama – 4 per cent
  - Guragie – 2.5 per cent
  - Welaita – 2.3 per cent[6].
  - Other ethnic groups make up the remaining 17.5 per cent of the population[6].

Population of Ethiopia-born people in Australia (2006 Census): 5635[1]

Population of Ethiopia-born people in Queensland: 435

Population of Ethiopia-born people in Brisbane[i]: 325

Gender ratio (Queensland): 95.9 females per 100 males[1]

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 population[2].

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 Database[3])

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

- **Language:** Consistent with the diversity of ethnicities, there are more than 84 languages spoken in Ethiopia[4]. Amharic (Amarigna) is the official language of Ethiopia and is spoken by 32.7 per cent of the population[6]. Oromigna, an official regional language, is spoken by 31.6 per cent of the population[6]. 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 Ethiopians[6].
- **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 Muslim[6]
  - Protestant: 18.6 per cent of the population are protestant[6]
  - Traditional beliefs: 2.6 per cent retain traditional beliefs[6].

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

- The top three ancestry responses[ii] of Ethiopia-born people in Australia were:
  - Ethiopian – 58.9 per cent
  - Not Stated – 8.9 per cent
  - Oromo – 5.5 per cent[2].
- 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 Amhara[7].
- 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 cent[2].
- 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 cent[2].

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 medicines[8].
- Ethiopians generally prefer interpreters of the same gender[8].
- 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 light[12].
- Ethiopians usually address others by their title and first name[12].
- 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 position[12].

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 disease[13]. Musculoskeletal and psychological problems were common in adults[13].
- 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 Mantoux[iii] test result requiring tuberculosis treatment – 28.9 per cent[14].

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 patients[15]. 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 Ethiopia[15]. Complications of FGM may include incontinence, obstructed miscarriage and childbirth, vaginal and perineal damage at childbirth, and sexual difficulties including non-consummation and painful intercourse[18]. Some families may want their daughters to undergo FGM, even if this means undertaking the operation outside Australia[19]. 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 uvuelectomy (to prevent suffocation during pharngitis in babies), the extraction of lower incisors (to prevent diarrhea), and the incision of eyelids (to prevent or cure conjunctivitis) are common[15].
- 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 abuse[20]. *Khat* is available and is not illegal in Australia[20].
- 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 tablets[15].
- 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 manner[21].

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 women[6]).
- 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 regime[17].
- 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 population[2].
- 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 population[2]. The median weekly income for Ethiopia-born people in Australia aged 15 and older was $342 compared to $466 for the total Australian population[2].

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 sick[24]. 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 services[24].
- 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 problems[25].

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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 ≥15mm.
[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 141[2].
- 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 Australia[4].
- From 1972 to 1981, the President of the Philippines Ferdinand Marcos imposed martial law which resulted in an increase in migration to Australia[2]. During the 1970s, many Philippines-born women migrated as spouses of Australian citizens[2]. Since that time, most Philippines-born people migrating to Australia have been sponsored by a family member[2].
- **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 population[5].

Population of Philippines-born people in Australia (2006 Census): 120,540[1]

Population of Philippines-born people in Queensland: 18,712[1]

Population of Philippines-born people in Brisbane[l]: 9869[1]

Gender ratio (Queensland): 34.7 males per 100 females[1]

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 population[2].

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 Database[3])

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 Pangasinan[5]. There are also more than 70 other regional dialects spoken in the Philippines[8].

- **Religion:** Catholics comprise 80.9 per cent of the Philippines population[5]. 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 cent[5]. Religion is deeply embedded in Filipino culture[9].

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

- The top three ancestry[ii] responses of Philippines-born people in Australia were:
  - Filipino – 80.9 per cent
  - Spanish – 5.8 per cent
  - Chinese – 3.5 per cent[2].
- 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 cent[2].
- 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 cent[2].

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 names[10].
- Older Filipino Australians prefer to be addressed by their title (e.g. Mr, Mrs) and surname[11]. People are familiar with using titles for professionals such as doctors in the Philippines and may be uncomfortable using first names[6].
- People of both sexes greet each other by bowing or shaking hands[8]. A firm handshake with a smile and eye-contact is appropriate[9].
- Filipinos take special care to avoid confrontation in any type of communication[8]. Filipino Australians may be reluctant to show disagreement and may say *yes* even when they do not agree[8]. 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 Australians[9].
- Although many Filipinos can communicate in English, many prefer to speak their native language, particularly when ill or when in other high stress situations[9]. 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 offended[9].
- 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 mellitus[9].
- 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 Americans[9]. Survival rates for cancers including breast, lung, colon , rectal, gastric and bladder cancer have been shown to be poor[9].
- Prevalence of mental illness and mental distress in Filipino Australians does not appear to be higher than in the Australia-born population[15].

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 medicial 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 medications[11].
- 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 faith[8]. *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 spirits[8].
- There is considerable variation in beliefs among Filipino Australians, including between earlier migrants and those who migrated more recently[9]. It is recommended that health practitioners acknowledge these variations and seek the preferences of patients and their families[9].
- Many Philippines-born people cope with illness with the help of family and friends, and by faith in God[9]. Filipino families can greatly influence a patient's decisions about health care[9].
- In general, Philippines-born people treat doctors and other health professionals with high levels of respect and authority[11].

Social determinants of health

- In 2000, the overall literacy[iii] 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 population[2].
- 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 population[2]. The median weekly income for Philippines-born people in Australia aged 15 years or older was $538 compared to $466 for the total Australian population[2].
- 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 education[16].
- 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 Filipinas[17].
- 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-employment[17].
- 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 providers[12].
- 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 risk[12].
- 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 people[19].

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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.

[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.

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 Laos[2-4].
- 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 Thailand[2].
- **Places of transition:** Thailand
- **Language:** Hmong was the main language spoken at home by 85.5 per cent of Hmong Australians in the 2006 census[5].
- **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 spirits[6].
- The main religion responses of Hmong Australians based on the 2006 census[5]:
  - 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): 2189[1]

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

Population of Hmong people in Brisbane[i] (2006 census): 690[1]

Gender ratio (Queensland): 94.4 females per 100 males[1]

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 verbally[7]. 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 inappropriate[7].
- 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 reply[7]. 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 children[9].

- Hmong people, particularly the elderly, may not speak English well, or at all, and may depend on their children or family members to communicate[2].
- Care may be required when explaining health care issues as many Hmong Australians have not completed any formal education[2].
- 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 health[11].

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 pancreas[8]. 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 distinct[13]. It primarily affects healthy young men in their mid-20s or 30s[13]. Research suggests the risk of SUNDS may be increased by a family history of SUNDS, a pre-existing cardiac abnormality, cadiomegaly 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 illnesses[8].

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 cases[15].
  - 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 illness[15].
- Non-Christian Hmong may consult a Shaman to diagnose and treat the causes of illness[16].

- 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 unhappy[15].
- Many Hmong people believe that surgery may interfere with reincarnation or may open access to the body for evil spirits to enter[17].
- Some Hmong people may fear anaesthesia and after a general anaesthetic may feel it is necessary to perform a soul calling ceremony[2].
- Many Hmong people believe that blood maintains balance in the body and that the body may be weakened if blood is withdrawn[17].
- Traditional Hmong believe that an autopsy may hinder the reincarnation of the deceased person[17].
- 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 mother[16].
- 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 placenta[2].
- 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 managed[12]. 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 support[2].
- 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 released[3]. Traditional healing techniques used to *dim pa* (release the pressure) include cupping, coining and massage[3].
  - 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 bruise[3].
  - 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 spoon[3].
  - Massage is used to loosen the body (muscles, tendons and veins) and promote better circulation[3].
- Hmong people may grow, import and use herbs and other organic substances for healing a variety of ailments[3].
- Same sex health care providers are preferred by Hmong Australians, particularly for women[2]. 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 checks[2].

Social determinants of health

- Many Hmong have not completed any formal education[8].
- 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 language[8].

- Many Hmong Australians may have spent several years in refugee camps before migrating to Australia, in addition to experiencing the trauma of war and repression[2].
- Clans are Hmong family groups and the clan name is the family name[16]. Hmong clans are a major source of social support for their members[16]. Traditionally, clans also provide economic assistance to their members[16].

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 option[2].
- 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 services[18].
- Cultural differences are major barriers to the use of mental health services by Hmong people[8]. The Hmong language has no words for mental illness, except for one word that means *crazy* in English[19]. Many Hmong consider self-disclosure and the open display of emotions to be signs of weakness and will not easily acknowledge mental health problems[8].

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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.

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

Indian Australians

- Indians were first brought to Australia from the early 1800s to work as labourers and domestic workers[3]. From the 1860s to the early 1900s, many Indians arrived to work as agricultural labourers, hawkers in country towns and to work in the gold fields[3].
- The number of Anglo-Indians and India-born British citizens migrating to Australia increased following India's independence in 1947[3]. The number of non-European Indian nationals migrating to Australia increased after 1966 and included many professionals such as doctors, teachers, computer programmers and engineers[3]. By 1981, the India-born population of Australia numbered 41,657[3].
- In 2001, there were 95,460 India-born people in Australia[3]. The 2006 Census recorded 147,110 India-born people in Australia, an increase of more than 50 per cent in five years[3]. In the five years from 2006 to 2010, 107,597 India-born people settled in Australia[4] including many skilled migrants and students[5].
- In addition to India, the three major countries of immigration of India-born people to Australia are Pakistan, Bangladesh and Sri Lanka[5]. Immigrants from an Indian background also migrate from Fiji, United Kingdom, United States, Canada, New Zealand, Singapore, Malaysia, Indonesia, Philippines, the Middle East, Mauritius, South Africa, East Africa, Madagascar and the Caribbean[5].
- **Ethnicity:** The two major ethnic groups of India are Indo-Aryan (72 per cent) and Dravidian (25 per cent)[6]. Other ethnicities, including Mongoloid, make up the remaining three per cent of the Indian population[6].
- **Language:** India has 15 official languages. Hindi is the most widely spoken and the primary language of 41 per cent of the population. However, more than 200 languages are spoken by people throughout India.

Population of India-born people in Australia (2006 Census): 147,105[1], Indian ancestry: 234,720[2]

Population of India-born people in Queensland: 10,974, Indian ancestry: 26,042[2]

Population of India-born people in Brisbane[i]: 7545, Indian ancestry: 19,218[1]

Gender ratio (Queensland): 82.1 females per 100 males[1]

Median Age (Australia): The median age of India-born in 2006 was 35.8 years compared with 46.8 years for all overseas born and 37.1 for the total Australian population[3].

Age distribution (Queensland)[1]:

Age	Per cent
0-19	9.8%
20-39	41.9%
40-59	28.6%
60+	19.6%

Arrivals – past five years (Source – Settlement Reporting Database[4])

Year	Australia	Queensland
2006	21,553	1469
2007	23,183	1776
2008	25,719	1866
2009	22,927	1875
2010	14,215	1086

- The 15 official languages of India are[6]:
  - Hindi – 41 per cent
  - Bengali – 8.1 per cent
  - Telugu – 7.2 per cent
  - Marathi – 7 per cent
  - Tamil – 5.9 per cent
  - Urdu – 5 per cent
  - Gujarati – 4.5 per cent
  - Kannada – 3.7 per cent
  - Malaylam – 3.2 per cent
  - Oriya – 3.2 per cent
  - Punjabi – 2.8 per cent
  - Assamese – 1.3 per cent
  - Kashmiri, Sindhi and Sanskrit – less than 1 per cent each.
- Maithili is a non-official language spoken by 1.2 per cent of the population[6]. English has the status of subsidiary official language of India[6].
- Many Indians grow up learning several languages at once[7].
- **Religion:** The majority of people in India are Hindu (80.5 per cent). Other religions include[6]:
  - Islam – 13.4 per cent
  - Christianity – 2.3 per cent
  - Sikhism – 1.9 per cent.
- More information on the religious beliefs of Hindu, Muslim and Sikh patients can be found in the series of Health Care Providers' Handbooks published by Queensland Health Multicultural Services[8-10].

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

- The top three ancestry[ii] responses of India-born people in Australia were:
  - Indian – 70.1 per cent
  - English – 10.2 per cent
  - Anglo-Indian – 4.3 per cent[3].
- The main languages spoken at home by India-born people in Australia were:
  - English – 34.4 per cent
  - Hindi – 19.9 per cent
  - Punjabi – 10.3 per cent
  - Tamil – 6.5 per cent.
- The main religions of India-born people in Australia were:
  - Hindu – 44.2 per cent
  - Catholic – 23.5 per cent
  - Sikh – 11.2 per cent
  - Anglican – 5.1 per cent.

Communication

- Indian Australians usually greet each other with the word *namaste* and a slight bow with the palms of the hands together. Greetings are usually formal and respectful.
- Some Indian Australians may be uncomfortable with physical contact with strangers[7]. In most cases, a handshake is appropriate. However, it is usually not appropriate to shake hands with the opposite sex[11]. Handshakes are usually gentle, rather than firm[12].
- Naming conventions vary across India[12]. Many Indians do not use surnames. People are usually referred to by their title (e.g. Mr, Mrs) and their first name[7]. However, many Indian Australians have adopted Australian naming conventions[12]. It is advisable to request permission to use an Indian Australian patient's first name[13].
- Sikh people use given names followed by either *Singh* (for men) or *Kaur* (for women). Muslim people are known by their given name followed by *bin* (son of) or *binto* (daughter of) followed by their father's given name[7,9]. For older Hindus, the term *ji* (for both men and women) or *da* (meaning big brother for men) is added to the end of a person's name or title to indicate respect (e.g. *Anita-ji* or *Basu-da*)[8,13].

- Indian Australians usually prefer minimal eye contact and in India it is considered rude to look someone directly in the eye, especially where they feel deference or respect[11,14].
- In many cases Indian Australians will often avoid saying *no* and may prefer to avoid conflict by giving an answer such as *I will try*[7]. In some circumstances, shaking of the head may indicate agreement[12].
- Indian Australians may say *yes* in order to please a health professional, even if they do not understand the medical concept or treatment plan[5]. It is advisable that health professionals ensure that the patient understands all instructions[5].
- Indian Australians may avoid the words *please* and *thank you,* believing that actions are performed from a sense of duty and do not require these courtesies[7].
- Older Indian Australians may expect respectful and deferential treatment[13]. In turn, they often treat doctors with respect and deference and try to closely follow the doctor's recommendations[13].

Health in Australia

- Average life expectancy in India is 66.5 years (male 65.5, female 67.6) compared to 81.7 years for all people in Australia (male 79.3, female 84.3)[6].
- There is limited research on the health of Indian Australians.
- Cancer rates for India-born Australians are lower than for people born in Australia, but higher than rates in India[17]. The most common cancers among Indian migrants in the United States are prostate, lung and colorectal in men, and breast, genital and colorectal in women[18].
- United States studies have shown that people from an Indian background are at high risk of insulin resistance and Type II diabetes[15,16].
- Vitamin D deficiency is a common health problem and Indian-born women living in the United States are at high risk for osteoporosis[13].
- A United States study has shown that lactose intolerance is very common in older people of Indian background[13].
- Cardiovascular disease is higher in Indian migrants in the United States[13].
- Other health problems of importance among Indian migrants to the United States include hypertension, nutritional deficits, tuberculosis, malaria, filariasis, protosoal and other parasitic infections, hepatitis A, dental caries and periodontal disease, and sickle cell disease[13].
- Worldwide, Indian women have higher rates of suicide than women of other nationalities[19].

Health beliefs and practices

- Many Indian Australians use Australian medicine in conjunction with traditional remedies including traditional medicine and spiritual practices such as Ayurveda, Siddha, Unani, Tibbi, homeopathy, naturopathy and acupressure[12,13]. Ayuveda places emphasis on herbal medicines, aromatherapy, nutrition, massage and meditation to create a balance between the mind and body[13,20].
- The involvement of family members in major and minor medical decisions is crucial for many Indian Australians[14]. Disclosing a serious or terminal diagnosis is best undertaken with great care and with the consultation and help of family members. It may be appropriate to ask a patient his or her wishes about confidentiality and privacy before discussion of any sensitive issues[14].
- Many Indian Australian women, particularly older Hindus, may prefer to be examined by health professionals of the same gender[13]. Having a female relative in attendance when examining an older Hindu woman is recommended as it may facilitate a more open interaction[13].

- An Indian cultural practice that may influence health care is the designation of left and right hands for specific tasks. The right hand is typically used for sanitary tasks such as eating while the left hand is reserved for unsanitary tasks[14]. This may affect a patient's comfort with the use of one arm or the other for drawing blood or for the insertion of an IV[14].
- Mental illness has severe negative connotations, especially among the older Hindu population[13,14]. Some believe that mental illness is due to possession of the *evil eye*[13]. Shame and denial are typical responses to any suggestion of mental illness[14]. Because mental illness is concealed, it is often presented to a doctor as somatic complaints such as headaches or stomach pain rather than as anxiety or depression[13].
- Married Hindu women of Indian background often wear the *Mangalsutra* (a sacred necklace) around their necks[13]. Some Hindu men wear a sacred thread around their torso[13]. Ritualistic armbands are also worn by Hindu men and women[13]. These items are sacred and it is important that they are not cut or removed without the consent of the family[8,9,13].
- Certain days of the month based on the Hindu lunar calendar are considered auspicious and Hindus may request surgical procedures to occur on these days[13].
- Some Indian families may wish for sedation to be decreased for a dying patient because it is considered important that the person is as conscious as possible at the time of death[13]. Many people believe that individuals should be thinking about God at the time of death and that the nature of one's thoughts determines the destination of the departing soul[13].
- At the time of death, family members may request that the body be positioned in a specific direction[8,13]. They may wish to drop water from the River Ganges or place a holy basil leaf in the mouth of the patient and to audibly chant Vedic hymns[8,9,13]. It is very important for family members to be at the bedside of a dying patient[8,9,13].
- More information on the health beliefs and practices of Hindu, Muslim and Sikh patients can be found the series of Health Care Providers' Handbooks published by Queensland Health Multicultural Services[8-10].

Social determinants of health

- Literacy[iii] rates in India are low, particularly for women[6]. The overall rate is 61 per cent based on a 2001 census[6]. Literacy of women is 47.8 per cent and men 73.4 per cent[6]. However, the population of Indian Australians have relatively high levels of education compared to the total Australian population[3].
- Proficiency in English in Australia (2006 census)[iv,1]:
  - 97 per cent of India-born men and 92 per cent of India-born women reported that they spoke English well or very well
  - three per cent of men and six per cent of women reported that they did not speak English well
  - Less than one per cent of men and two per cent of women reported that they did not speak English at all.
- At the time of the 2006 Census, 76.1 per cent of the India-born population aged 15 years and over had some form of higher non-school qualifications[v] compared to 52.5 per cent of the total Australian population[3].
- The participation rate in the workforce (2006 Census) was 72.3 per cent and unemployment rate 7.2 per cent compared to the corresponding values of 64.6 per cent and 5.2 per cent in the total Australian population[3]. The median weekly income for India-born people in Australia aged 15 and over was $543 compared to $466 for the total Australian population[3].

- 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 education[21].
- A United States study of young Asian immigrants, including those of Indian background, showed major sources of stress included pressure to meet parental expectations of high academic achievement, difficulty in balancing two cultures and communicating with parents, family obligations based on strong family values, and discrimination and isolation due to racial or cultural background[22].
- From 2007 to 2010 there were reports of racially motivated attacks on Indian Australians, including Indian students, which resulted in protests by Indian Australians and Indian students[23].

Utilisation of health services in Australia

- Overseas studies show lower rates of usage of health services and greater expectation of, and reliance on, family support among Indian migrants, especially older people, when compared to those born in the destination country[24].
- A United States study has shown that a lower level of English proficiency in older Indian migrants is associated with the use of traditional medicines in preference to accessing doctors and hospitals[25].
- Due to negative attitudes towards mental illness, seeking help for mental health problems usually only occurs in severe cases and may start with the pursuit of traditional treatment options[14]. Sometimes a patient will agree to treatment by a family physician or a psychologist in a primary health care setting, but will refuse to go to an outside psychiatrist or mental health clinic because of the severe stigma involved[14].
- Individuals who immigrated before 10 years of age show a more positive attitude towards psychological counselling than those who immigrated at a later age[26].
- Young migrants from India tend not to seek professional help for mental health problems and instead use personal support networks including close friends and the religious community[22].

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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 Indian 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] 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.

Iraqi Australians

- Since the early 1980s Iraq has experienced successive wars, oppression, and political and economic sanctions resulting in the displacement of at least nine million people, with approximately seven million people leaving the country and two million being displaced within Iraq[4].
- The humanitarian crisis in Iraq has included sectarian violence between the two main Muslim groups, the Sunni and the Shi'a, and ethnic cleansing perpetrated against non-Muslim religious minorities including the Yazidis, the Chaldean-Assyrians, Iraqi Christians, Kurds and the Mandaeans (a small pre-Christian sect)5.
- In 1976, the Iraq-born population in Australia was 2273 and by 1986 this had almost doubled to 4516[2]. Since the 1991 Gulf War, thousands of Iraqis have found refuge in Australia with the 2006 census recording 32,520 Iraq-born people in Australia[2]. At that time, 89.6 per cent of the Iraq-born population were living in New South Wales and Victoria with only a relatively small percentage (2.2 per cent) settling in Queensland[2]. This trend has continued with less than six per cent of Iraqi refugees arriving in Australia settling in Queensland in the five years since 2006[3].
- **Places of transition:** Syria, Jordan and Iran.
- **Ethnicity:** There are two major ethnic groups in Iraq: Arabs (75-80 per cent) and Kurdish (15-20 per cent)[6]. The Kurds are a distinct group who live in an area in the north located at the intersection of Turkey, Iraq, Iran, Syria and Armenia[4]. Turkomans comprise less than three per cent of the population and Assyrians less than two per cent[4,6].
- **Language:**
  - Almost all Iraqis speak Arabic, the official language of Iraq
  - Kurdish (official in Kurdish regions) is spoken in northern Iraq
  - The Turkomans speak Turkish
  - The Assyrians speak Aramaic
  - Farsi is spoken by some groups in Iraq[4,6].

Population of Iraq-born people in Australia (2006 Census): 32,520[1]

Population of Iraq-born people in Queensland: 723

Population of Iraq-born people in Brisbane[i]: 535

Gender ratio (Queensland): 62.1 females per 100 males[1]

Median age (Australia): The median age of Iraq-born people in Australia in 2006 was 35.7 years compared with 46.8 years for all overseas born and 37.1 for the total Australian population[2].

Age distribution (Queensland)[1]:

Age	Per cent
0-19	19.8%
20-39	40.8%
40-59	32.2%
60+	7.2%

Arrivals – past five years (Source – Settlement Reporting Database[3])

Year	Australia	Queensland
2006	2586	64
2007	2143	48
2008	3547	194
2009	3719	102
2010	2092	113

- **Religion:**
  - About 95 per cent of Iraq's population is Muslim, but split between Sunnis (32-37 per cent) and Shi'ites (60-65 per cent)[4,6]. Although the two groups are similar, there are some differences[7].
  - Prior to the 2003 US-led invasion of Iraq, Christians made up nearly four per cent of the population of Iraq[4]. Chaldeans form the majority of Iraq's Christians. The Chaldean community is a very old Catholic sect who traditionally lived in what is modern Iraq[8]. Other Christian communities include the Assyrian (or Nestorian), Mandaean (or Sabaean) and Armenian[9].

Ancestry, language and religion in Australia (2006 Census for Iraq-born)[2]:

- The top three ancestry responses[ii] of Iraq-born people settled in Australia were:
  - Assyrian/Chaldean – 37.7 per cent
  - Iraqi – 31.7 per cent
  - Arab – 9.1 per cent.
- The main languages spoken at home by Iraq-born people in Australia were:
  - Arabic – 48.6 per cent
  - Assyrian (Aramaic) – 38.9 per cent
  - Other – 4.8 per cent
  - English – 3.9 per cent
  - Kurdish – 3.8 per cent.
- The main religions of Iraq-born people in Australia were:
  - Catholic – 37.6 per cent
  - Muslim – 30.9 per cent
  - Assyrian Apostolic – 13.2 per cent.

Communication

- The most common form of greeting is a handshake coupled with direct eye contact and a smile. Handshakes may be prolonged[7]. It is normal for people of the same gender (men/men, women/women) to kiss on the cheek as well as shake hands when greeting.
- For some Iraqi Australians, it is disrespectful for a man to offer his hand to a woman unless she extends it first[7]. However, this is usually not the case for Christians and Kurds[10].
- A single, downward nod is the most common expression for yes[9].
- Many Iraqi Australians view outward signs of emotions in a negative manner because of the need to save face and protect honour[7].
- Many Iraqi Australian women who are Muslim wear a *hijab* (head covering) or *jilbab* (full body covering) in public.
- It is recommended that gender is considered when matching a patient with a health worker or interpreter[11].
- Both male and female Iraqi Australian patients have a preference for a male doctor. For pregnancy or gynaecological needs, most women prefer to be seen by a female doctor[12].

Health in Australia

- Average life expectancy in Iraq is 70.3 years (male 68.9, female 71.7) compared to 81.7 years for all people living in Australia (male 79.3, female 84.3)[6].
- Chronic conditions including obesity, hypertension and latent tuberculosis infection have been shown to be prevalent in Iraqi refugees[13].
- Iraqi refugees have been shown to have higher rates of untreated tooth decay than the Australia-born population[14,15]. A small study found that only 15 percent had no untreated decayed teeth and more than 10 percent had high decay levels[15].
- Iraqi refugees have been shown to have high rates of post-traumatic stress disorder (PTSD), anxiety and depression[5,16].

Health beliefs and practices

- Many Iraq-born people place a high value on Australian health care practices and have confidence in the medical profession[12].

- It is common for a family member to stay with the patient and to help answer questions[12,17]. Many Iraq-born people expect information about a patient's diagnosis and prognosis to be first filtered through the family with the family deciding whether or not to tell the patient[17].
- For Iraqi Muslims:
  - Iraqi Muslims may be reluctant to disclose personal information and may be embarrassed by personal questions, including their sexual relationships. Patients may not provide enough information for a comprehensive diagnosis[12].
  - It may be stressful for Muslim women to expose their bodies in front of male health care providers, or to even discuss sensitive topics related to women's health[18].
  - It is expected that decision making regarding procedures such as a tubal ligation or hysterectomy involve the woman's husband[17].
  - 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 new born infant. This male, who becomes a special person in the infant's life, whispers a blessing in the infant's ear[19]. This is usually the *Adhan* or what is usually recited as a call for prayer.
  - 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 blessing, which is the *Kalima* or confession of the faith, should be the last thing one hears at death[19].
  - Muslims are required to pray five times a day and this may be particularly important when they are ill[17].
  - For more information on Islamic beliefs affecting health care refer to the Health Care Providers' Handbook on Muslim Patients[21].
- Some rural Iraqis have ancient traditional health beliefs and practices that can include supernatural agents such as *evil eye*, *jinni*, witchcraft, sin, envy and bad luck and often seek traditional healers[22]. These beliefs may delay patients and their families from seeking medical advice[22].
- Mental illness is often stigmatised. A person with mental health problems may not seek advice from professionals or even family members[23].

Social determinants of health

- The literacy rate[iii] for females in Iraq in 2000 was low (64.2 per cent) compared with males (84.1 per cent)[6]. The overall literacy rate was 74.1 per cent[6].
- Many Iraqi refugees have experienced traumatic and life threatening experiences before fleeing Iraq[5,16]. Common traumatic experiences include living in a combat or war zone, imprisonment and torture (especially common for Iraqi men), and the experience of an accident, fire or explosion[16]. The fear of genocide has a major impact on the health of Kurds and non-Muslim minorities from Iraq[5].
- Iraqi Australians continue to be impacted by fears for family members still living in Iraq. A study of Mandaean refugees living in Sydney showed that those people with immediate family still in Iraq had higher levels of symptoms of PTSD and depression, and greater mental health related disability compared to those without family in Iraq[5].
- Proficiency in English (2006 Census)[iv,1]:
  - 78 per cent of Iraq-born men and 65 per cent of Iraq-born women in Australia reported that they spoke English well or very well
  - 18 per cent of men and 26 per cent of women reported that they did not speak English well
  - four per cent of men and nine per cent of women reported that they did not speak English at all.

- At the time of the 2006 Census, 36.9 per cent of Iraq-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 population[2].
- The participation rate in the workforce (2006 census) was 40.7 per cent and unemployment rate was 22.3 per cent compared to the corresponding values of 64.6 per cent and 5.2 per cent in the total Australian population[2]. The median weekly income for Iraq-born people in Australia aged 15 and older was $228 compared to $466 for the total Australian population[2].
- 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 qualifications[25].

Utilisation of health services in Australia

- The use of hospital services among people born in refugee-source countries including Iraq is lower or similar to that of the Australia-born population[26,27].
- Barriers to utilisation of health services include language barriers, cultural barriers related to modesty, gender preferences in seeking and accepting health care from male or female providers, strong values relating to family privacy, values of honour and shame, and barriers related to refugee factors and the stresses of migration[28].

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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 Iraqi 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] Definition of literacy- Age over 15 years 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.

Japanese Australians

- Japanese people first migrated to Australia in the late 1800s. Most migrants were men who came to Australia to work in the pearling industry in Broome and Thursday Island, and in the sugar industry in Queensland[2]. The 1911 Census recorded 3281 Japanese males and 208 females in Australia[2].
- By the end of the World War II, only 74 Japan-born people and their children were allowed to stay in Australia[2]. However, within five years about 500 Japanese *war brides* had entered Australia[4].
- The end of the *White Australia Policy*[i] in 1973 saw more Japan-born people arrive in Australia to study and for business[4]. The 2001 Census showed there were 25,480 Japan-born people living in Australia[2]. By 2006, the population had increased by more than 20 per cent to 30,780[2].
- **Ethnicity:** Japanese comprise 98.5 per cent of the population of Japan and are the only main ethnic group. Koreans and Chinese combined account for less than one per cent of the population[5].
- **Language:** Japanese is the official language and is spoken by the majority of the population[5].
- **Religion:**
  - The main religions of Japan are Shintoism and Buddhism, and many Japanese people belong to both religions. About two per cent of the population are Christian and eight per cent follow other religions[5].
  - Shintoism is an ancient indigenous religion of Japan existing before the introduction of Buddhism[6]. It lacks formal dogma and is characterised by a veneration of nature spirits and ancestors[6]. In Shintoism, the wind, sun, moon, water, mountains and trees are all spirits (*Kami*)[6].

Population of Japan-born people in Australia (2006 Census): 30,776[1]

Population of Japan-born people in Queensland: 8592

Population of Japan-born people in Brisbane: 3297

Population of Japan-born people in Gold Coast: 3125

Population of Japan-born people in Cairns: 1252

Gender ratio (Queensland): 51.3 males per 100 females[1]

Median age (Australia): The median age of Japan-born people in Australia in 2006 was 33.9 years compared with 46.8 years for all overseas born and 37.1 for the total Australian population[2].

Age distribution (Queensland)[1]:

Age	Per cent
0-19	16.4%
20-39	52.3%
40-59	23.9%
60+	7.4%

Arrivals- past five years (Source- Settlement Reporting Database[3])

Year	Australia	Queensland
2006	2,146	681
2007	2,011	643
2008	1,940	631
2009	1,549	508
2010	693	181

- Confucianism as a code of ethics has an influence on the lives of many Japanese people. High importance is placed on family values and social order[7].

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

- The top three ancestry responses[ii] of Japan-born people in Australia were: Japanese (84.0 per cent), Australian (4.4 per cent) and English (2.7 per cent)[2].
- More than three in four (79.2 per cent) Japan-born people reported that Japanese was the main language they spoke at home, with 17.4 per cent speaking English as the main language at home[2].
- Almost half of all Japan-born people in Australia (49.2 per cent) reported they had no religious affiliation[2], with 28.1 per cent reporting they were Buddhists and four per cent Catholic. An additional 11.6 per cent indicated they followed another religion and 7.2 per cent did not state their religion[2].

Communication

- Japanese people bow as a greeting, and to show respect and gratitude[6]. The depth of the bow depends on the occasion and social status of the individuals involved[6].
- The Japanese smile can be difficult to interpret as it can be used to convey happiness, anger, confusion, embarrassment, sadness or disappointment[6].
- Japanese people nod their heads to show either agreement or concentration during a conversation[6].
- Japanese people make considerable effort to maintain harmony and may do so by expressing agreement, regardless of level of comprehension or genuine agreement, or simply by following instructions or recommendations[8].
- A negative response is signalled by holding a hand in front of the face and waving it backwards and forwards[6].
- It is usual to address Japanese people by their family names[6]. Given names are used only for children or between close friends[6]. *Sensei* or *san* may be added to the end of a name to indicate rank or position. *San* is the equivalent of the title Mr or Mrs[6]. *Sensei* is generally used for teachers or doctors[9].
- An older Japanese person may not volunteer information, so respectful inquiry may be helpful to elicit pertinent clinical information[7].
- It is advisable to avoid direct eye contact with a Japanese patient when discussing their illness, including diagnosis and prognosis[10]. Japanese people focus on the other person's forehead when they are talking[9].

Health in Australia

- Average life expectancy in Japan is 82.2 years (male 78.9, female 85.7) compared to 81.7 years for all people in Australia (male 79.3, female 84.3)[5].
- Although there is a scarcity of studies of the health of Japan-born people in Australia, United States studies have shown that Japanese American men have lower rates of many chronic diseases including cardiovascular disease and stroke compared with other American men[7].
- Type II diabetes is a disease shown to have higher prevalence among Japanese Americans. Prevalence rates of 20 per cent (twice the rate in comparable populations) have been reported among Japanese American men aged 45-74[7].

Health beliefs and practices

- Japanese Australians may combine traditional therapies with Australian medicine. It is advisable to ask patients if they are using any other therapies for their medical conditions[7].
- Common traditional health practices include Kampo, Moxibustion, Shiatsu and Acupuncture[7]:

- Kampo uses herbal medicines which originated in China around the 7th Century[7]. The herbs are usually in powdered or granular form[7].
- Moxibustion involves burning dried mugwort on specialised points of the skin to stimulate life energy and blood flow[7]. This can cause bruising on the skin[7].
- Cupping uses round glass cups which contain a lit taper and are pressed into the skin to stimulate circulation.
- Shiatsu is a form of massage therapy concentrating on pressure points of the body to redirect or re-establish energy flow and restore balance[7].
- Acupuncture involves inserting needles into specific points on the body to eliminate toxins and relieve pain[7].

- Japanese Australian patients may find it awkward if sensitive medical information is given to them directly[10]. Japanese Australian patients may not want to hear the name of their illness directly from a doctor and may prefer to be informed indirectly before their appointment so they can be prepared when speaking with the doctor[10]. In Japan, medical information is usually shared with the family. The doctor may tell close family members about the situation first[10].
- In many cases, Japanese Australian patients may not want their doctor to know that they are mentally upset by hearing bad news about their illness. Offering comfort to a Japanese patient who has broken down with grief could be very embarrassing for the patient[10].
- In Shintoism, the state of health is associated with purity[7]. Japanese Australian patients may want to wash their hands frequently and use wet towels instead of washing[8].
- In Japan, it is a common saying that Japanese people are born Shinto but die Buddhist[7].
- In Shintoism, there is an emphasis on purity and cleanliness[7]. Terminal illness, dying and death are considered *negative* and *impure*[7]. Therefore, frank and open discussions about death and dying may be difficult[7].
- Many Japanese people embrace Buddhism later in life. For Buddhists, death is a natural process where life continues in the form of rebirth[7]. Japanese Australians who are Buddhists may be more open to discussion about death and dying[7].

- A number of Japanese Australians are Christians and embrace a Christian view of the meaning of death, dying and end of life issues.
- Many Japanese people believe that weakness of character is a cause for mental illness and may be reluctant to openly discuss disturbances of mood as these are considered to be indicative of personal weakness rather than treatable medical conditions[11,12].

Social determinants of health

- Literacy rates[iii] in Japan are high and equivalent to Australian rates at 99 per cent overall (99 per cent for both men and women based on a 2002 census in Japan)[5].
- Most Japan-born people currently living in Australia have migrated by choice for work or study[2].
- Proficiency in English (2006 Census)[iv,1]:
  - 72.9 per cent of Japan-born men and 78.1 per cent of Japan-born women in Australia reported that they spoke English well or very well
  - 23.7 per cent of men and 19.8 per cent of women reported that they did not speak English well
  - 3.4 per cent of men and 2.2 per cent of women reported that they did not speak English at all.

- At the time of the 2006 Census, 65 per cent of Japan-born people in Australia aged 15 years and older had some form of higher non-school qualifications[v] compared to 52.5 per cent of the total Australian population[2].
- The participation rate in the workforce (2006 Census) was 56.8 per cent and unemployment rate was 6.2 per cent compared to the corresponding values of 64.6 per cent and 5.2 per cent in the total Australian population[2]. The median income for Japan-born people in Australia aged 15 and older was $315 compared to $466 for the total Australian population[2].
- 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 education[13].

Utilisation of health services in Australia

- Barriers to health service access and utilisation including mental health services include language, cultural differences, lack of appropriate information, communication and stigma[14].
- There is a general stigma associated with mental illnesses among Japanese people and as a result some people may not seek psychiatric care or psychological counselling[7,15]. In traditional Japanese society, mental illness in a family member could bring embarrassment or shame upon the family name[7].

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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 Japanese Australians and this profile should be considered in the context of the acculturation process.

[i] A phrase used to describe the restrictive immigration policies of the colonial and Australian Governments from the 1850s until the 1970s that aimed to maintain a predominantly white population in Australia.
[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] Definition of literacy – Age over 15 years 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.

Māori Australians

- Māori began travelling to Australia to trade, acquire skills and learn new ideas soon after British settlement in the late 18th century[3,ii]. Māori were exempt from the *White Australia Policy*[iii]. Significant migration began in the 1960s with increased numbers of Māori looking for employment opportunities in Australia[2,3].
- The Māori population is now the largest Pacific Islander population in Queensland. The population grew by 44 per cent in the five years between the 2001 and 2006 Censuses[2].
- Māori migration to Australia has followed the pattern of overall migration from New Zealand with Māori drawn to Australia by economic opportunities, lifestyle, and to join family and community already settled in Australia[3].
- Māori comprise 14 per cent of the total population of New Zealand[5].
- **Language:** Māori or *te reo Māori* is commonly known as *te reo* and is the native language of Māori and an official language of New Zealand[6]. The *White Assimilation Policy* of New Zealand affected up to three generations of Māori with many not being able to speak or understand *te reo*[7]. According to the 2006 New Zealand Census, 23.7 per cent of the New Zealand Māori population spoke *te reo*[8].
- **Religion:**
  - In the early 19th Century many Māori embraced Christianity. The concepts of Christianity were combined with traditional Māori religion[9].
  - There are now several Māori religions that combine aspects of Christianity with traditional and non-traditional Māori philosophies[9]. These include: Ratana, Ringatū, Pia Marire, Hauhau and the church of the Seven Rules of Jehovah. Of these, Ratana is the most practiced with 50,565 people stating this as their religion in the 2006 New Zealand Census[9].
  - Large numbers of Māori joined the Church of England and the Catholic Church and both religions are highly influential in Māori society[9].
  - Today, many Māori public gatherings begin and end with Christian prayer[9]. Many Māori bless their *kai* (food) before eating and pray at the beginning and end of the day[7].

Population of people with Māori ancestry[i] in Australia (2006 Census): 92,912[1,2]

Total number estimated at between 115,000 and 125,000[3].

Population of people with Māori ancestry in Queensland: 31,076 Queenslanders[1,2]

Population of people with Māori ancestry in Brisbane: 7096[4]

Population of people with Māori ancestry in Gold Coast: 6891[4]

Population of people with Māori ancestry in Logan: 4105[4]

Gender ratio: 99.6 males per 100 females (2006 Census cited in [2])

Age distribution Māori in Queensland (2006 Census)[1]:

Age	Per cent
0-19	35%
20-39	36%
40-59	24%
60+	5%

Language and religion in Australia (2006 Census for Māori ancestry)

- About 6.1 per cent of Māori living in Queensland speak *te reo* at home (2006 Census cited in [2]).
- About three per cent of Māori living in Queensland are affiliated with the Ratana (Māori) religion (2006 Census cited in [2]).

Communication

- A traditional Māori form of greeting is the *hongi*. The *hongi* involves touching the forehead and nose to another person's forehead and nose long enough so that the breath is shared. It is symbolic of sharing everything with one another and showing respect.
- When meeting and when leaving, a firm handshake with good eye contact is suggested. Men generally wait for a woman to be the first to extend their hand. Women do shake hands with other women.
- It is appropriate to address a person using their title (Mr, Mrs, Miss), followed by their full name.

Health in Australia

- There is little data available on the health of the Māori population in Australia[2].
- From 2005 to 2007 in New Zealand, life expectancy at birth was 79 years for non-Māori males and 70.4 years for Māori males. Life expectancy at birth was 83 years for non-Māori females and 75.1 years for Māori females.
- In New Zealand, Māori have slightly higher rates of cancer than non-Māori people, but their all-cancer mortality rates are twice as high[10]. The leading causes of cancer death in women are lung, breast, colorectal, stomach and cervical[10]. The leading causes of cancer death in men are lung, prostate, colorectal, stomach and liver[10].
- Māori have higher rates of heart attack, diabetes and chronic obstructive pulmonary disease than the total New Zealand population[11].
- The prevalence of smoking in Māori in New Zealand is about 50 per cent, which is double that of non-Māori population[12].
- Māori are 50 per cent more likely to be obese and almost three times as likely to be obese smokers compared to the non-Māori population in New Zealand[13].
- The Māori population of New Zealand have been shown to have a greater prevalence of mental health problems, suicide and attempted suicide compared to the non-Māori population[14,15].

Health beliefs and practices

- Good health is seen as a balance between mental (*hinengaro*), physical (*tinana*), family/social (*whānau*) and spiritual (*wairua*) dimensions[16].
- Māori tend to see their health connected to the health of their family and larger social group. Doing *one's own thing* is seen as unhealthy. Wellbeing is seen to be a function of participating in the Māori world[5].
- Extended family (*whānau*) involvement in the care of the ill is seen as crucial and visitors are actively encouraged to stay with a sick relative[2].
- Prayer is conducted openly and family are encouraged to be present for prayers with the ill[2].
- Nursing staff who have cared for a Māori person during a period of illness become kin by association[17].
- Some Māori use traditional medicine (*rongoa*) and therapeutic massage (*mirimiri*) to complement Australian medicine[2].

Social determinants of health

- The concept of family (or *whānau*) is central to Māori social structure. *Whānau* refers to family and extended family. The *whānau* is a member of a social group (*hapū*) which in turn is a member of the larger social group (*iwi*). About 20 per cent of Māori live in private dwellings with extended family and about half have three generations of family under one roof[18].

- Māori are have a high degree of reliance on people from within the Māori community for support – the *whānau*, the *hapū* and the *iwi*[2].
- The use and knowledge of the *te reo* language has been shown to be steadily declining among Māori in Australia[3].
- Like other indigenous peoples, Māori have been impacted by a history of colonisation resulting in a loss of culture, land, voice, population, dignity, and health and wellbeing[5].
- Some Māori leave New Zealand because of negative experiences with gangs, drugs and crime, domestic violence and abuse, negative stereotyping and media coverage of Māori, and negative attitudes towards success within their own families[3].
- **Education:** Based on the 2006 Census, the Queensland Māori population had a lower level of higher non-school qualification than the total Queensland population – only three per cent of the Māori population had a bachelor or post-graduate level qualification compared to 18 per cent of the total Queensland population[2].
- **Employment:** In a study on Māori living in Australia, the majority of respondents indicated that they moved to Australia seeking better employment opportunities and higher income. Of those who answered the question, 74 per cent said that they had *much better* employment since migration and 13 per cent said it was *a bit better*[3].
- Based on country of birth, there is evidence that Māori may be over-represented in Australian prisons[3,19].
- In Queensland, relatively high numbers of Māori live in lower socio-economic suburbs[3].

Utilisation of health services in Australia

- Collectivist cultures such as Māori have a high reliance on their own social group for care and support and this may delay their use of health services. Minor health issues are often expected to be cared for within the family or social unit and health services used only if emergency care is required[20].
- Barriers to health (including mental health) service access and utilisation include language, cultural differences, lack of appropriate information, communication and stigma[21].

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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 Māori Australians and this profile should be considered in the context of the acculturation process.

[i] This may be an underestimation of the population with Māori ancestry as one study found that more than 14 per cent said that they would not indicate they had Māori ancestry in the Australian Census

[ii] Some Māori believe that their ancestors had contact with Aborigines prior to British settlement.

[iii] A phrase used to describe the restrictive immigration policies of the colonial and Australian Governments from the 1850s until the 1970s that aimed to maintain a predominantly white population in Australia.

Papua New Guinean Australians

- Papua New Guineans have travelled to Australia for thousands of years. In 1978, a treaty was signed enabling the coastal people of Papua New Guinea to carry on their traditional way of life travelling without restriction across the Torres Strait between Papua New Guinea and Australia within defined boundaries[4].
- In the 1880s approximately 5000 Papua New Guineans were trafficked illegally to Queensland to work in the sugarcane industry. Many of the workers died soon after their arrival in Queensland[5]. An average of 450 Papua New Guineans came to Australia each year between 1905 and 1910 to work in the pearling industry. This number declined to around 350 by 1928[2].
- While the 1954 Census showed only 1523 Papua New Guinea-born people in Australia[2], by the time of the 1976 Census, there were 15,562 Papua New Guinea-born people living in Australia. However, many were the children of Australians working in Papua New Guinea when Australia was responsible for administering either the Australian Territory of Papua or the Territory of Papua and New Guinea[2].
- An average of around 350 Papua New Guineans settled in Australia each year over the five years from 2006 to 2010 with more than half settling in Queensland[3].
- **Ethnicity:** Papua New Guinea is one of the most ethnically diverse and complex countries on earth. There are more than 700 ethnic groups which are often separated into two major divisions, Papuans (84 per cent) and Melanesians (15 per cent). In addition, Negritos, Micronesians, Polynesians and other ethnicities comprise the remaining one per cent.

Population of Papua New Guinea-born people in Australia (2006 Census): 24,022[1]

Population of Papua New Guinea-born people in Queensland: 12,590

Population of Papua New Guinea-born people in Brisbane: 6703

Population of Papua New Guinea-born people in Cairns: 1426

Population of Papua New Guinea-born people in Gold Coast: 971

Gender ratio (Queensland): 77.7 males per 100 females[1]

Median age (Australia): The median age of Papua New Guinea-born people in 2006 was 37.8 years compared with 46.8 years for all overseas-born and 37.1 for the total Australian population[2].

Age distribution (Queensland)[1]:

Age	Per cent
0-19	12.5%
20-39	44.5%
40-59	35.3%
60+	7.7%

Arrivals – past five years (Source – Settlement Reporting Database[3])

Year	Australia	Queensland
2006	357	217
2007	357	224
2008	449	243
2009	407	205
2010	198	134

- **Language:** There are more than 830 indigenous languages of Papua New Guinea[6]. The three official languages are English, Tok Pisin (Pidgin) and Hiri Motu (spoken mainly on the south coast)[6,7]. Other languages include Chinese, and languages of the Philippines and India which are spoken by Papua New Guineans of these Asian backgrounds[6,8].
- **Religion:**
  - Catholic – 27 per cent
  - Evangelical Lutheran – 19.5 per cent
  - United Church – 11.5 per cent
  - Seventh-Day Adventist – 10 per cent
  - Pentecostal – 8.6 per cent
  - Evangelical Alliance – 5.2 per cent
  - Anglican – 3.2 per cent
  - Baptist – 2.5 per cent
  - Other Protestant – 8.9 per cent
  - Bahai – 0.3 per cent
  - Indigenous beliefs and other – 3.3 per cent[9].

Ancestry, language and religion in Australia (2006 Census for Papua New Guinea-born)[2]

- The top four ancestry responses[i] of Papua New Guinea-born people in Australia were:
  - Australian – 23 per cent
  - Papua New Guinean – 20.6 per cent
  - English – 17.1 per cent
  - Chinese – 8.5 per cent[2].
- The main languages spoken at home by Papua New Guinea-born people in Australia were:
  - English – 79.7 per cent
  - Pidgin/Tok Pisin – 7.4 per cent
  - Cantonese – 6 per cent.
- The main religions of Papua New Guinea-born people in Australia were:
  - Catholic – 32.5 per cent
  - No religion – 15.1 per cent
  - Anglican – 13.4 per cent
  - Uniting Church – 10.5 per cent[2].

Communication

- Relations between older and younger people and men and women are generally relaxed for Papua New Guinean people[7]. However, in Melanesian culture, women may be restricted from speaking with the opposite gender[8]. Therefore, many women prefer health providers of the same gender[8].
- On meeting, men and women clasp hands or clasp one another around the waist[7]. However many Papua New Guinean Australians prefer to shake hands[10].
- Direct eye contact is acceptable and people often stand close to each other[7].
- Many Papua New Guinean people place less emphasis on keeping time and being punctual[8]. Reminder calls may be required prior to appointments[8]. 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 in clients getting to appointments on time.

Health in Australia

- Average life expectancy in Papua New Guinea is 66.2 years (male 64, female 68.6) compared to 81.7 years for all people in Australia (male 79.3, female 84.3)[9].
- Although the rates of diabetes in Papua New Guinea are relatively low[11], based on Queensland hospital separation data, Papua New Guinea-born people in Queensland had significantly higher rates of hospital admissions for diabetes than the total Queensland population[12].

- In Papua New Guinea, major cancers in men are oral and liver and major cancers in women are cervical, oral and breast[13]. Standardised separation ratios for Papua New Guinea-born Queenslanders were not significantly higher than the total Queensland population[12].
- In Queensland, mental health service snap-shot data (July 2008) shows Papua New Guinea-born people as the fourth largest group of overseas-born consumers[12]. This ranking is disproportionate to population size, with the Papua New Guinea-born population ranking 12th among overseas-born populations in Queensland. This is indicative of a higher use of mental health services by Papua New Guinea-born people in Queensland[12].
- Papua New Guinea-born Queenslanders have lower rates for musculoskeletal disease and external causes compared to the total Queensland population[12].

Health beliefs and practices

- In considering health beliefs of Papua New Guinean Australians, it is important to acknowledge the great cultural diversity of the country. However, there are some health beliefs that may be common to many people from Papua New Guinea.
- Since the introduction of Christianity, traditional healing through ancestors and spirits has often been replaced by church healing prayers and group gatherings to pray for health[8].
- Some people believe in the power of spirits, sorcery and black magic as causes of illness and death[8].
- There is a belief that the physical and non-physical worlds of the spirits are intertwined and that the health of people is directly related to the maintenance of proper social ties, adherence to the rules around taboos, and making peace with the spirits. If these traditions are disrespected, serious illness and death may result[14].
- Many Papua New Guinea-born people practice traditional health remedies based on plant or tree medicines. For specialised treatment, a traditional practitioner or sorcerer may be consulted[15].
- Papua New Guineans make use of both Australian medicines and traditional remedies and treatments when dealing with illness. Traditional remedies may be used to cure the underlying social and cultural causes of illness[7].

Social determinants of health

- The overall literacy rate[ii] in Papua New Guinea is low, especially in females. In 2000, the literacy rate was 57.3 per cent for the total population, 63.4 per cent for males and 50.9 per cent for females[9].
- Australian census data on Papua New Guinea-born people is impacted by the high percentage of people who are the children of Australians working in Papua New Guinea. As a result, proficiency in English, education and employment rates are not accurately represented for ethnic Papua New Guineans.
- Proficiency in English in Australia (2006 Census)[iii,1]:
  - 96 per cent of Papua New Guinea-born men and 94 per cent of Papua New Guinea-born women reported that they spoke English well or very well.
  - Four per cent of men and five per cent of women reported that they did not speak English well.
  - Less than one per cent of men and one per cent of women reported that they did not speak English at all.
- At the time of the 2006 census[iv], 58.8 per cent of Papua New Guinea-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 population[2].
- The participation rate in the workforce (2006 Census) was 73.3 per cent and the unemployment rate was 5.1 per cent compared to the corresponding rates of 64.6 per cent and 5.2 per cent

in the total Australian population[2]. The median weekly income for Papua-New Guinea-born people in Australia aged 15 years and older was $593 compared to $466 for the total Australian population[2].

- Violence against Papua New Guinean women has been shown to be widespread and domestic violence a normal part of marital relationships[16-20].
- The lack of cohesiveness in the Papua New Guinea community living in Queensland has been highlighted in a qualitative study[12].

Utilisation of health services in Australia

- Barriers to health service access and utilisation (including mental health services) include language, cultural differences, lack of appropriate information, communication and stigma[12,21].
- Qualitative research in Queensland has shown that shyness, fear of asking questions, and a lack of confidence when dealing with authority figures are additional barriers to Papua New Guinea-born people accessing and utilising health services[12].

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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 Papua New Guinean Australians and this profile should be considered in the context of the acculturation process.

[i] At the 2006 Census, up to two responses per person were allowed for the Ancestry question. Therefore, the count is total responses, not person count.
[ii] Definition of literacy – Age over 15 years, can read and write.
[iii] Missing and not-stated responses to this question on the census were excluded from the analysis.
[iv] It needs to be noted that a substantial proportion of Papua New Guinea-born people responding to the census are children of Australians working in Papua New Guinea.
[v] Non-school qualifications are awarded for educational attainments other than those of pre-primary, primary or secondary education.

Samoan Australians

- The majority of Samoans in Australia come from the Independent State of Samoa, previously known as Western Samoa[4].
- During the early part of the 20th century, a small number of Samoa-born people migrated to Australia for commerce, education and missionary purposes[2]. The 1921 Census recorded 110 Samoa-born people in Australia[2].
- During the 1970s, educational programs sponsored by the Australian Government resulted in increased numbers of Samoa-born people migrating to Australia[2]. A number of Samoa-born people have also migrated from New Zealand to Australia for work and study[5].
- At the time of the 2006 Census, there were 15,239 Samoa-born people in Australia and 39,992 Australians who identified as having Samoan ancestry (13,536 in Queensland)[1,6].
- **Ethnicity:** The main ethnicity is Samoan (92.6 per cent)[7,8]. Other ethnicities include Euronesians (persons of European and Polynesian ancestry) (seven per cent), Europeans (0.4 per cent).
- **Language:** Samoan and English are both official languages of Samoa[7,8]. Samoan (Polynesian) is the main language spoken. Many people from Samoa also speak English[9].
- **Religion:** Most Samoans are Christian. Religions in Samoa based on a 2001 census include:
  - Congregationalist – 34.8 per cent
  - Catholic – 19.6 per cent
  - Methodist – 15 per cent
  - Latter-Day Saints – 12.7 per cent
  - Assembly of God – 6.6 per cent
  - Seventh-Day Adventist – 3.5 per cent
  - Worship Centre – 1.3 per cent
  - Other Christian – 4.5 per cent
  - Other – 1.9 per cent

Population of Samoa-born people in Australia (2006 Census): 15,239[1,i]

Population of Samoa-born people in Queensland: 4868[1]

Population of Samoa-born people in Brisbane[ii]: 4341[1]

Gender ratio (Queensland): 92.2 males per 100 females[1]

Median age (Australia): The median age of Samoa-born people in 2006 was 41.6 years compared with 46.8 years for all overseas born and 37.1 for the total Australian population[2].

Age distribution (Queensland)[1]:

Age	Per cent
0-19	10.1%
20-39	33.3%
40-59	45.3%
60+	11.3%

Arrivals – past five years (Source – Settlement Reporting Database[3])

Year	Australia	Queensland
2006	60	20
2007	50	12
2008	67	19
2009	89	22
2010	55	14

Ancestry, language and religion in Australia (2006 Census for Samoa-born)[2]

- The top four ancestry[iii] responses of Samoa-born people in Australia were:
  - Samoan – 66.9 per cent
  - Not stated – 7.4 per cent
  - English – 6.8 per cent
  - German – 4.1 per cent[2].
- The main languages spoken at home by Samoa-born people in Australia were:
  - Samoan – 82.7 per cent
  - English – 13.7 per cent[2].
- The main religions of Samoa-born people in Australia were:
  - Catholic – 22.7 per cent
  - Latter-Day Saints – 13.7 per cent
  - Uniting church – 10.9 per cent
  - Pentecost – 9.8 per cent
  - 42.9 per cent of Samoa-born people reported their religion as *other*[2].

Communication

- The handshake is a common greeting for Samoan Australians and appropriate for both men and women[10].
- Prolonged direct eye contact is not common during conversation[10]. Brief and frequent eye contact is recommended[10].
- Samoan Australians may say *yes* when they do not necessarily understand or agree with what is being said[5,9].
- Some Samoan Australians, particularly women, may be reluctant to discuss health issues openly with a health practitioner[11].
- The gender of the health provider may be an issue for Samoan Australians, particularly for younger people, and women may appreciate being asked if they have a prefer a female health care provider[9].
- Samoan Australians are very family oriented[5]. When explaining a serious illness, a patient may prefer to have at least one family member present, or their whole family[9]. It may be preferable for a health care provider to explain the diagnosis first to a close family member and then both tell the patient together[9].
- Although English is spoken widely in Samoa, some Samoan Australians, particularly the elderly, may require an interpreter or assistance when filling in forms[9].

Health in Australia

- There is limited research on the health of Samoan Australians.
- Average life expectancy in Samoa is 72.4 years (male 69.6 and female 75.4) compared to 81.7 years for all people living in Australia (male 79.3 and female 84.3)[7].
- Samoa-born people have high rates of overweight, obesity, Type 2 diabetes and hypertension[6].
- The Samoa-born population in Queensland has a mortality rate 1.5 times higher for total deaths and two times higher for avoidable deaths than the total Queensland population[12]. The rates of hospitalisation of Samoa-born Queenslanders are between two and seven times higher[12].
- Samoa-born people living in New Zealand have been shown to have a higher risk of cardiovascular disease compared to other ethnic groups[13].
- In Hawaii, Samoa-born people have been shown to have higher rates of cancers including nasopharynx, liver, prostate and thyroid in men, and liver, thyroid and blood in women, than native Hawaiians[14].
- In New Zealand, tuberculosis levels are relatively higher in Samoan and other Pacific Islander people[15].
- There is little mental health research on Samoan communities in Australia, New Zealand and the United States[6].

Health beliefs and practices

- Some Samoan Australians believe that illness (including cancer, musculoskeletal and neurological problems) is caused by spirits, or retribution for not adequately helping family members in Samoa[6,11].
- If Australian medicine is perceived as ineffective, Samoan Australians may use traditional healers[6,11].
- Queensland's climate allows for the growth of many plants used for traditional medicines[11]. Some of these plants are readily available[11].
- Prayer is an important element of the healing process for many Samoans[11].

Social determinants of health

- The overall literacy rate[iv] in Samoa is high. In 2001, the literacy rate was 99.7 per cent (men 99.6 per cent, women 99.7 per cent)[7].
- Proficiency in English (2006 Census)[v,1]:
  - 85 per cent of Samoa-born men and 88 per cent of Samoa-born women reported that they spoke English well or very well
  - 14 per cent of men and 10 per cent of women reported that they did not speak English well
  - One per cent of men and two per cent of women reported that they did not speak English at all.
- At the time of the 2006 Census, 35.2 per cent of Samoa-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 population[2].
- The participation rate in the workforce (2006 Census) was 63.6 per cent and unemployment rate was 9.4 per cent compared to the corresponding rates of 64.6 per cent and 5.2 per cent in the total Australian population[2]. The median weekly income for Samoa-born people in Australia aged 15 years or older was $450 compared to $466 for the total Australian population[2].
- Research suggests that domestic violence may be more prevalent in Pacific Islander communities in Australia, New Zealand and the United States[6]. There is some evidence to suggest that living conditions away from Samoa may increase the occurrence of domestic violence as a result of changes in gender roles with increased opportunities for education and employment for women and decreased opportunities for men, and an absence of extended family buffering and social support[16].
- The loss of close family and social ties and increased family financial obligations, including remittances, may be sources of additional stress for Samoan Australians[6].

Utilisation of health services in Australia

- There are no published studies of health service utilisation of Samoa-born people in Australia.
- Samoan Australians are likely to underutilise health services because of the lower emphasis placed on health prevention and health promotion behaviours[6]. Other major barriers to health service usage among Samoa-born people include education level and type of occupation[6].
- Church-based mobile health prevention programs including breast and cervical cancer screening programs, have proved effective in increasing cancer screening in Samoa-born women in the United States[17].
- Because of shame and stigma, mental health problems are not easily talked about with people from outside of the person's family, with consequent delays in seeking professional help[9].

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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 Samoan Australians and this profile should be considered in the context of the acculturation process.

[i] Samoan Australian community representatives say that the Census data underestimates the true size of the population of Samoan Australians and that the actual number of Samoan Australians living in Brisbane is considerably higher than the number reported based on Census data.
[ii] Brisbane is defined as Local Government Area of Brisbane in ABS Census data
[iii] At the 2006 Census up to two responses per person were allowed for the Ancestry question, count is therefore total responses not person count.
[iv] Literacy is defined as those aged 15 and over 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.

Sri Lankan Australians

- Sri Lankan immigrants were recruited to work on the cane plantations of Northern Queensland in the late 19th Century[2]. Some worked in gold-mining fields in NSW and as pearlers in Broome in Western Australia[2]. By 1901, there were 609 Sri Lanka-born people living in Australia[2].
- Sri Lanka (formerly known as Ceylon when under British rule) gained independence in 1948. As a result of the political ascendancy of the Sinhalese, the dominant ethnic group, many members of minority groups, including Tamils and Burghers (people of Sri Lankan and European descent), felt threatened, resulting in increasing numbers migrating to other countries[2,4].
- As a result of migration restrictions to Australia during the 1960s, the majority of Sri-Lankan migrants to Australia were Burghers[2]. In 1973 when Asian migrants were again admitted to Australia, Sri Lankan migrants were mostly Sinhalese professionals[5].
- In 1983, civil war broke out between the majority Sinhalese and minority Tamils. The war continued for 26 years until 2009. Sri Lankan Tamils increasingly settled in Australia as refugees or skilled migrants. Sinhalese Sri Lankans continued to migrate to Australia, along with Sri Lankan Moors (also known as Muslim Sri Lankans)[2,4,6].
- **Ethnicity:** There are three main ethnic groups in Sri Lanka: Sinhalese (73.8 per cent), Indian and Sri Lankan Tamils (8.5 per cent) and Sri Lankan Moors (7.2 per cent)[2,4]. Burghers make up around 0.2 per cent of the Sri Lankan population[7].
- **Language:**
  - Sinhala is the official language of Sri Lanka and is spoken by 74 per cent of the population (mostly Sinhalese)
  - Tamil is spoken by 18 per cent of the population
  - English is commonly used by government and spoken by 10 per cent of the population[4].

Population of Sri Lanka-born people in Australia (2006 Census): 62,257[1]

Population of Sri Lanka-born people in Queensland: 4808

Population of Sri Lanka-born people in Brisbane[i]: 3603

Gender ratio (Queensland): 99.7 males per 100 females[1]

Median age (Australia): The median age of Sri Lanka-born people in Australia in 2006 was 43.1 years compared with 46.8 years for all overseas-born and 37.1 for the total Australian population[2].

Age distribution (Queensland)[1]:

Age	Per cent
0-19	9.6%
20-39	24%
40-59	40.6%
60+	25.8%

Arrivals – past five years (Source – Settlement Reporting Database[3])

Year	Australia	Queensland
2006	3703	337
2007	3842	275
2008	5187	372
2009	5039	368
2010	3997	300

- **Religion:**
  - Sinhalese: The majority of Sinhalese are Theraveda Buddhists
  - Tamil: Most Tamils are Hindus, but some are Muslims or Christians. The majority of Christians are Catholics
  - Sri Lankan Moors: The majority are Muslim
  - Burghers: The majority are Christian[2,4,8].

Ancestry, language and religion in Australia (2006 Census for Sri Lanka-born)[2]:

- The top four ancestry responses[ii] of Sri Lanka-born people in Australia were:
  - Sinhalese – 69.5 per cent
  - Tamil – 8 per cent
  - English – 5.3 per cent
  - Dutch – 5 per cent.
- The main languages spoken at home by Sri-Lanka born people in Australia were:
  - Sinhalese – 38.8 per cent
  - English – 35 per cent
  - Tamil– 23.3 per cent.
- The main religions of Sri-Lanka born people in Australia were:
  - Buddhism – 31.1 per cent
  - Catholic – 26.9 per cent
  - Hinduism – 18.6 per cent
  - Anglican – 7.7 per cent.

Communication

- Sri Lankans have various naming conventions dependent on their ethnic group. In most cases the family name comes first, and given name second[9].
- When addressing a person from Sri Lanka, particularly the elderly, it is important to use the appropriate title (e.g. Mr, Mrs) followed by their family name[10,11].
- Younger Sri Lankan Australians generally shake hands and are socialised towards soft rather than firm handshakes. A firm handshake may surprise a newly arrived Sri Lankan Australian[12].
- Sri Lankan Australians usually avoid eye contact in interactions where they feel deference or respect[12].
- Although many south Asians nod their heads to indicate *yes* and shake their heads to indicate *no*, this is not always true[12]. A horizontal head swing can mean *yes* for some Sri Lankan Australians[12].
- The following communication issues are particularly important for Sri Lankan Buddhists:
  - It is disrespectful for legs to be stretched out with feet pointed towards a person[13]
  - The head is considered the spiritually highest part of the body and sensitivity is advised if it is necessary to touch the head[13]
  - Using both hands to give and receive an object is a sign of respect, particularly with older people[13].

Health in Australia

- Average life expectancy in Sri Lanka is 75.3 years (male 73.2, female 77.5) compared to 81.7 years for all people living in Australia (male 79.3, female 84.3)[4]. This relatively high life expectancy for a country with a low income level appears to be related to a highly efficient use of curative services by Sri Lankans[14].
- A recent population-based survey in Colombo showed considerably lower rates of depression in Sri Lankans compared to rates in Western countries[15]. However, Tamil refugees living in South India have been shown to have poor mental health, including high rates of depression, anxiety and post traumatic stress disorder (PTSD)[16].
- Tamil asylum seekers in Australia have been shown to have higher levels of anxiety, depression and PTSD compared to Tamil refugees and immigrants[17].
- Vitamin D deficiency is a common health problem and Asian women are at high risk for osteoporosis[18].

Health beliefs and practices

- Many Sri Lankan Australians value and use Australian medicine in conjunction with traditional remedies including traditional medicines and spiritual practices such as *Ayurveda* and *Sinhala*[10,14,19]. *Ayurveda* places emphasis on herbal medicines, aromatherapy, nutrition, massage and meditation to create a balance between the mind and body[10].
- The involvement of family in major and minor medical decisions is crucial for many Sri Lankans[12]. Disclosing a serious or terminal diagnosis is best undertaken with the consultation and help of family members. It may be appropriate to ask a patient his or her wishes about confidentiality and privacy before discussing any sensitive issues[12].
- A Sri Lankan cultural practice that may influence health care is the designation of left and right hands for specific tasks. The right hand is typically used for sanitary tasks such as eating while the left hand is reserved for unsanitary tasks[12]. This may affect a patients comfort with the use of one arm or the other for drawing blood or for the insertion of an IV[12].
- Mental illness has strong negative connotations and stigma[12]. Shame and denial may be the normal response to any suggestion of mental illness[12].

Social determinants of health

- Literacy[iii] rates in Sri Lanka are high at 90.7 per cent (male 92.3 per cent, female 89.1 per cent) based on a 2001 census[4].
- Many Sri Lankan Tamils have experienced numerous traumatic events including unnatural death of family or friends, forced separation from family members, witnessing the murder of strangers, being close to death and witnessing the murder of family or friends[22]. More than one in four Tamil asylum seekers reported exposure to torture[22].
- Asylum seeker status, difficulties in adapting to life in Australia and loss of social and cultural support have been shown to contribute to PTSD symptoms of Tamil refugees[22].
- Proficiency in English (2006 Census)[iv,1]:
  - 97 per cent of Sri Lanka-born men and 92 per cent of Sri Lanka-born women reported that they spoke English well or very well
  - three per cent of men and seven per cent of women reported that they did not speak English well
  - Less than one per cent of men and one per cent of women reported that they did not speak English at all.
- At the time of the 2006 Census, 64.8 per cent of Sri Lanka-born people in Australia aged 15 years and older had some form of higher non-school qualifications[v] compared to 52.5 per cent of the total Australian population[2].
- The participation rate in the workforce (2006 Census) was 70.9 per cent and unemployment rate was 6.5 per cent compared to the corresponding values of 64.6 per cent and 5.2 per cent in the total Australian population[2]. The median weekly income for Sri-Lanka born people in Australia aged 15 and older was $555 compared to $466 for the total Australian population[2].

Utilisation of health services in Australia

- Due to the strong negative attitudes towards mental illness among Sri-Lankan Australians, seeking help for psychiatric problems usually only occurs in chronic cases and may start with the pursuit of traditional treatment options[12]. Sometimes a patient will agree to treatment by a family physician or a psychologist in a primary health care setting but will refuse to go to an external psychiatrist or mental health clinic because of the strong stigma involved[12].
- Young Asian migrants tend not to seek professional help for mental health problems and instead use personal support networks including close friends and the religious community[23].

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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 Sri Lankan 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] 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.

Sudanese Australians

- Sudan's first civil war began shortly after independence from joint British-Egyptian administration in 1956 and continued until 1972. A second civil war broke out in 1983 and continued until 2005[4,5].
- Sudan experienced major famines largely as a result of extended periods of drought in the 1980s and 1990s[6].
- The toll from war and famine combined is estimated at almost two million deaths and four million displaced people[7].
- Drought, famine and war have caused large numbers of Sudanese refugees to seek refuge in neighbouring countries[2].
- At the time of the 2001 census, there were 4910 Sudan-born people in Australia, including a large number of skilled migrants[2].
- Between 2001 and 2006, the population of Sudan-born people in Australia more than quadrupled to 19,049[7].
- **Places of transition:** Most Sudanese refugees arrive from Egypt, Kenya, Ethiopia and Uganda[5,8]. Other places of transition include: Eritrea, Lebanon, Malta, Sweden and Syria[9].
- **Ethnicity:** Although Sudan is a country of considerable ethnic diversity, the Sudanese are often characterised into two major groups: Arabs (in the north) comprising 39 per cent of the population and black Africans (in the south) comprising 52 per cent of the population[7,10]. However, there are hundreds of ethnic and tribal divisions within the two major groups[7]. Arab groups include the Kababish, Ja'alin and Baggara[7] and African groups include the Dinka, Nuer, Shilluk, Azande (Zande), Madi, Acholi and Bari[7,11]. The Beja (a semi-nomadic group distinct from both Arabs and Africans) make up 6 per cent of the population[7,10]. The concept of ethnicity in Sudan is complex and it is often based on cultural affiliations[7]. Sudanese also identify by region such as Nuba and Equatorian and these groups are comprised of many different ethnicities and languages.

Population of Sudan-born people in Australia (2006 Census): 19,049[1]

Population of Sudan-born people in Queensland: 2402

Population of Sudan-born people in Brisbane[i]: 1805

Gender ratio (Queensland): 80.5 females per 100 males

Median age (Australia): The median age of Sudan-born people in Australia in 2006 was 24.6 years compared with 46.8 years for all overseas born and 37.1 for the total Australian population[2].

Age distribution (Queensland)[1]:

Age	Per cent
0-19	41.7%
20-39	43.3%
40-59	13.6%
60+	1.4%

Arrivals – past five years (Source – Settlement Reporting Database[3])

Year	Australia	Queensland
2006	3375	534
2007	1587	258
2008	939	160
2009	866	117
2010	617	66

- **Language**: Arabic is Sudan's official language and is the most widely spoken[7]. English is the language of instruction for schools of South Sudan. A Sudanese Government policy in 1990 forced South Sudanese schools to use Arabic rather than English[7,11]. Many other languages are spoken in the south including varieties of Dinka, Fur, Nuer, Ma'di, Acholi, Bari and Zanda[5,11]. Many Sudanese are bilingual or multilingual[7]. Sudanese refugees may have a preference for using their own language rather than Arabic, which was forced on them.
- **Religion**:
  - Sunni Muslim: About 70 per cent of the population, mainly in the northern two thirds of the country[10]
  - Traditional beliefs: 25 per cent have traditional beliefs including animist and tribal religions[10]
  - Christian: About five per cent of the population including Catholic, Anglicans, Coptic Christians and Greek Orthodox[10].

Ancestry, language and religion in Australia (2006 census for Sudan-born)[2]

- The top four ancestry responses[ii] of Sudan-born people in Australia were:
  - Sudanese – 61.6 per cent
  - Not stated – 6.9 per cent
  - Dinka – 4.3 per cent
  - African – 4.3 per cent.
- The main languages spoken at home by Sudan-born people in Australia were:
  - Arabic – 51.2 per cent
  - Dinka – 23.6 per cent
  - Other African Languages – 5.5 per cent
  - English – 4.4 per cent.
- The main religions of Sudan-born people in Australia were:
  - Catholic – 35.8 per cent
  - Anglican – 18.9 per cent
  - Islam – 13 per cent
  - Oriental Orthodox – 11.1 per cent.

Communication

- There are many different names for languages spoken in South Sudan and speakers of a particular language may not recognise the English name for the language they speak[5].
- It is advisable when contracting the services of an Arabic interpreter for a Sudanese Australian person that a Sudanese-Arabic interpreter is requested. The Sudanese Arabic dialect is distinct and the person may not understand an interpreter using another Arabic dialect[12].
- There are distinctions in communication style between Sudanese Muslims from the north and South Sudanese people:
  - Northern Sudanese greetings tend to be formal with a handshake only extended to members of the same sex. There may be a reluctance of Muslim men and women to shake hands with the opposite sex and prior to interaction with a woman, it is advisable that acknowledgement be afforded to the man as the head of the household[9,12]
  - Typically, South Sudanese greetings are less formal. People greet friends and relatives with handshakes and men and women shake hands. Women can be addressed directly[9,12].
- People are called by their first name, except for elders, teachers and religious leaders who are addressed by their title and surname[13].
- Members of the same family may appear to have different surnames in Australia as a result of confusion in the transfer of names during immigration. In Sudan, family names are silent and considered *other* names, and as a result many Sudanese Australians will have their middle name recorded as their surname on official documents[11].
- The right hand is used for greeting and eating and all other activities. The left hand is generally only used for bodily hygiene[13].

- Eye contact is very important among Sudanese people and indicates a caring attitude[13].
- Muslim women from north Sudan may be reluctant to be examined by a male physician. In contrast, most South Sudanese women will view this examination as a medical necessity[9].

Health in Australia

- Average life expectancy in Sudan is 54.2 years (male 53, female 55.4) compared to 81.7 years for all people living in Australia (male 79.3, female 84.3)[10].
- In a study of common medical conditions diagnosed in newly arrived African refugees in Melbourne, the major health issues included a lack of immunity to common vaccine-preventable diseases, vitamin D deficiency or insufficiency, infectious diseases (gastrointestinal infections, schistosomiasis and latent tuberculosis) and dental disease [14]. Musculoskeletal and psychological problems were common in adults[14].
- A Western Australian infectious disease screening study of 2111 refugees and humanitarian entrants in 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 Mantoux[iii] test result requiring tuberculosis treatment (28.9 per cent)[15].
- Other health concerns for Sudanese refugees include the sequelae of broken bones, injuries as a consequence of torture, flight or accident[16].
- Common health concerns in women include the physical and psychological consequences of rape, menstrual problems and pelvic pain. Most women have not had any preventive screening such as pap smears, breast examination or mammography[16].
- Sudanese refugees settling in Australia have been shown to have high rates of depression, anxiety and post traumatic stress disorder[8]. However, many Sudanese Australians are more concerned with current acculturative stressors such as family problems, employment issues, housing and transport than they are about past trauma[8].

Health beliefs and practices

- Many Sudanese refugees practice herbal and traditional health remedies. These practices are often limited by a lack of availability of herbs and a lack of specialists to prepare them[17].
- Sudanese refugees may be unfamiliar with a formal health system, Australian medical practices or being treated by a doctor of the opposite gender[7].
- Female genital mutilation (FGM)[iv] is practiced in Sudan, particularly in the north. Complications of FGM may include: incontinence, obstructed miscarriage and childbirth, vaginal and perineal damage at childbirth and sexual difficulties including non-consummation and painful intercourse[19]. Some families may want their daughters to undergo FGM, even if this means undertaking the operation outside Australia[16]. 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.
- Polygamy is common across Sudan and is considered a sign of wealth and prestige[9,11]. The practice is decreasing in South Sudan[11].
- For more information on Islamic beliefs affecting health care please refer to the Health Care Providers' Handbook on Muslim Patients[20].

Social determinants of health

- The overall literacy rate[v] in Sudan is low, especially for women. The rate has risen from an overall rate of 45.8 per cent in 1990[7] to an overall rate of 61.1 per cent in 2003 (71.8 per cent for male and 50.5 per cent for female)[10].
- Many Sudanese refugees have experienced traumatic and life threatening experiences before fleeing Sudan and while in countries of transit. This can lead to difficulties when resettling in Australia[21].
- Many Sudanese have directly experienced multiple traumatic events including forced separation from family members, the murder of family or friends, lack of food and water, lack of shelter, combat situation, being close to death, imprisonment or detention, forced isolation and torture, ill health without access to medical care, unnatural death of family or friends, being lost or kidnapped, serious injury, and rape or sexual abuse[22].
- Many Sudanese have spent long periods of time in refugee camps in countries such as Kenya, Uganda and Ethiopia[4] where continued violence and sexual assault has been reported as common[7].
- Common difficulties experienced by Sudanese refugees when settling in Australia include concerns about family members not living in Australia, difficulties gaining employment, and difficulties in adjusting to the cultural life of Australia[22].
- Social support such as the presence of family and support of others within the Sudanese community have been shown to assist mental health functioning in Australia[22].
- Proficiency in English (2006 Census)[vi,1].
  - 76 per cent of Sudan-born males and 60 per cent of Sudan-born females reported that they spoke English well or very well
  - 20 per cent of males and 32 per cent of females reported that they did not speak English well
  - four per cent of males and eight per cent of females reported that they did not speak English at all.
- At the time of the 2006 Census, 38.8 per cent of Sudan-born people aged 15 years and older had some form of higher non-school qualifications[vii] compared to 52.5 per cent of the total Australian population[2].
- The participation rate in the workforce (2006 Census) was 40.3 per cent and unemployment rate was 28.5 per cent compared to 64.6 per cent and 5.2 per cent in the total Australian population[2]. The median weekly income for Sudan-born people in Australia aged 15 and older was $231 compared to $466 for the total Australian population[2].
- 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 qualifications[23].

Utilisation of health services in Australia

- The use of hospital services among people born in refugee-source countries including Sudan is lower or similar to that of the Australia-born population[24,25].
- 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 sick[26]. 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 services[26].

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[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 ≥15mm.
[iv] Female Genital Mutilation (FGM) has been defined as comprising "all procedures which involve partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons.
[v] Definition of literacy- Age over 15 years can read and write.
[vi] Missing and not-stated responses to this question on the census were excluded from the analysis.
[vii] Non-school qualifications are awarded for educational attainments other than those of pre-primary, primary or secondary education.

Vietnamese Australians

- Large numbers of Vietnamese people fled their country during the Vietnam war after Saigon fell to the Communist Government in the north in 1975 and the Socialist Republic of Vietnam was declared in 1976[2].
- From 1975 to 1985, an estimated two million people fled Vietnam. People initially fled by sea to refugee camps in South East Asia before seeking refuge in countries including the United States, Canada, France and Australia[2].
- Before 1975, there was about 700 Vietnam-born people in Australia. Most were students, orphans and wives of military personnel who had served in Vietnam[2].
- By 1981, there were 49,616 Vietnam-born people in Australia[2]. This increased to 159,849 Vietnam-born people in 2006. Family reunion significantly contributed to the more than 320 per cent increase of Vietnam-born people in Australia in the 25 years between 1981 and 2006[2].
- **Places of transition:** Thailand, Malaysia, Singapore, Indonesia, The Philippines, Hong Kong and Cambodia.
- **Ethnicity:** The main ethnic group is the Kihn (86.4 per cent)[4,5]. Smaller ethnic groups include: Tay (1.9 per cent), Muong (1.5 per cent), Khome (1.4 per cent), Hoa (1.1 per cent), Nun (1.1 per cent) and Hmong (1 per cent)[4,5].
- **Language:** Vietnamese is the official language and is spoken by the majority of the population[4,5]. English is becoming increasingly favoured as a second language[4,5]. Other languages include French, Chinese, Khmer, and the mountain languages of Mon-Khmer and Malayo-Polynesian[4,5].
- **Religion:** According to a 1999 census, more than 80 per cent of the Vietnamese population were not affiliated with any religion[4]. Of the remaining population, 9.3 per cent were Buddhist and 6.7 per cent were Catholic. Other religions include Hoa Hao (1.5 per cent), Cao Dai (1.1 per cent) and Muslim (0.1 per cent)[4,5].

Population of Vietnam-born people in Australia (2006 Census): 159,849[1]

Population of Vietnam-born people in Queensland: 13,084[1]

Population of Vietnam-born people in Brisbane[i]: 11,857[1]

Gender ratio (Queensland): 91.6 males per 100 females[1]

Median age (Australia): The median age of Vietnam-born people in 2006 was 41.0 years compared with 46.8 years for all overseas born and 37.1 for the total Australian population[2].

Age distribution (Queensland)[1]:

Age	Per cent
0-19	4.6%
20-39	44.2%
40-59	40.5%
60+	10.6%

Arrivals – past five years (Source - Settlement Reporting Database[3])

Year	Australia	Queensland
2006	3419	337
2007	3522	306
2008	3515	375
2009	3648	396
2010	2768	279

Ancestry, language and religion in Australia (2006 Census for Vietnam-born)[2]

- The top two ancestry[ii] responses of Vietnam-born people in Australia were:
  - Vietnamese – 65 per cent
  - Chinese – 24.6 per cent.
- The main languages spoken at home by Vietnam-born people in Australia were:
  - Vietnamese – 78 per cent
  - Cantonese – 15.7 per cent[2].
- The main religions of Vietnam-born people in Australia were:
  - Buddhism – 58.6 per cent
  - Catholic – 22.1 per cent[2].

Communication

- Vietnam-born people list their family name first, then their middle name, with their first (given) name listed last. Many given names are common to both males and females[6].
- In addressing others, Vietnam-born people often use a person's title (e.g. Mr, Mrs), followed by their first name.
- Some Vietnamese Australians may appear to answer *yes* (*da*) to all questions. This may be a polite way of saying *Yes, I am listening* or *Yes, I am confused*[7].
- Vietnamese people can use a smile to show many different emotions including happiness, anger, embarrassment or grief[7].
- Vietnamese Australians may prefer to speak about sensitive subjects indirectly[7].
- Traditionally, Vietnamese people greet each other by joining hands and bowing slightly[7]. The handshake has been adopted in Vietnamese cities[7]. In public, men often hold hands as an expression of friendship[7]. In Vietnam, women rarely shake hands with each other or with men.
- Outside of Vietnamese cities, making direct eye contact when talking is considered impolite particularly with people senior in age or status. Many Vietnamese people also speak in a low tone[7].

Health in Australia

- Average life expectancy in Vietnam is 72.2 years (male 69.7, female 74.9) compared to 81.7 years for all people living in Australia (male 79.3, female 84.3)[4].
- Vietnam-born people in Australia have higher rates of dental problems including decay, and require more restorations and extractions compared to Australia-born people[8,9].
- The incidence of tuberculosis in Vietnam-born people in Australia is substantially higher than the incidence among Australia-born people[10,11].
- Compared to the general Australian population, 15-74 year old Vietnamese Australians have significantly lower mortality rates[6]. However, Vietnamese Australian men have higher mortality from cancers of the digestive system, and Vietnamese Australian women have higher rates of cervical cancer compared to the rest of the Australian population[6].
- A survey in New South Wales showed that 13.6 per cent of the 175 Vietnamese Australians surveyed were daily or occasional smokers[13]. This equated to 30 per cent of Vietnam-born men and 2.5 per cent of Vietnam-born women[13]. Smoking rates among Vietnam-born men in the United States have been shown to be high, ranging from 35 to 42 per cent[12].
- In the United States, Vietnam-born men have high rates of liver and naso-pharynx cancer and lymphoma, and both Vietnam-born men and women have relatively high rates of lung and liver cancer[12].
- Research in the United States shows that Vietnam-born people are susceptible to chronic illnesses such as heart disease, stroke, hypertension and diabetes[12].
- Mental health studies of Vietnamese refugees show that they have high levels of depression, anxiety and post-traumatic stress disorder[14].

Health beliefs and practices

- Traditional beliefs regarding shame and guilt are important in understanding how older Vietnamese Australian adults report symptoms[12]. Since Vietnamese culture is oriented towards the family and the group, the individual is thought to represent the family as a whole[12]. If an individual loses respect or status in the community, the whole family loses respect and status as well. The concept of *loss of face* may be why some older Vietnam-born adults and their families are reluctant to report distressing symptoms[15].
- Oriental medicine, which incorporates traditional Chinese and Vietnamese medicine, is important in Vietnamese culture. Emphasis is placed on the balance of *yin* and *yang* and *hot* and *cold,* and a proper balance is required to maintain health[6,12].
- Illness is believed to result from an imbalance of *Yang* (male, positive energy, hot) and *Yin* (female, negative energy, cold) forces in the body. Self control of emotions, thoughts, behaviour, diet and food and medication intake are all important in maintaining balance and health[12]. For example, excess eating or worrying can lead to an imbalance or excess of heat, thus resulting in mental and physical illness[12]. For example, an excess of *cold* food is believed to be related to coughing and diarrhoea[6].
- Illness may also be considered a result of environmental influences such as wind and spirits that can offset the internal balance of a person[12]. For example, a Vietnam-born person may refer to a cold or flu as being exposed to *poisonous wind* or *catching the wind* instead of *catching a cold*[12].
- Vietnamese Australians may use traditional remedies, including medicines, in conjunction with Australian medical treatments[6,16]. It is common to use two types of medicine to treat a disease in Vietnam, and some Vietnamese Australians may consider prescribed and traditional medicines to be compatible[16]. Many Vietnamese Australians may be reluctant to inform their doctors about their use of traditional medicines because of fear of disapproval[17,18].
- Two common treatment methods of *wind* illnesses are coining and cupping[12]:
  - Cupping uses round glass cups which contain a lit taper and are pressed into the skin
  - Coining involves rubbing medicated oils onto the chest and back in parallel lines in order to release poisonous wind.
- To prevent stress for older adults, some Vietnamese families may prefer that the diagnosis of a serious or terminal illness is not disclosed directly to the older family member[12].
- Mental illness is generally considered shameful and is often associated with wrong-doing in a previous life. It is often not discussed in the family or the community. Somatisation is a common response to problems of psychogenic origin. For example, a Vietnamese male is more likely to explain psychological difficulties as physical symptoms such as abdominal pains or headaches[6].
- Many Vietnamese Australian women prefer a female practitioner, particularly for procedures such as breast and cervical cancer screening[12].
- There is considerable variation in beliefs among Vietnamese Australians, including between earlier migrants and those who migrated more recently[12]. Health practitioners should acknowledge these variations and seek the preferences of patients and their families[12].

Social determinants of health

- In 2002, the overall literacy[iii] rate in Vietnam was 90.3 per cent (male 93.9 per cent, female 86.9 per cent)[4].
- Proficiency in English[iv] in Australia (2006 Census)[1]:
  - 64 per cent of Vietnam-born men and 50 per cent of Vietnam-born women reported that they spoke English well or very well

- 31 per cent of Vietnam-born men and 39 per cent of Vietnam-born women reported that they did not speak English well
- 5 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, 35.1 per cent of Vietnam-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 population[2].
- The participation rate in the workforce (2006 Census) was 61.9 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 population[2]. The median weekly income for Vietnam-born people in Australia aged 15 years or older was $349 compared to $466 for the total Australian population[2].
- Vietnamese Australians who were exposed to a high degree to trauma before seeking refuge in Australia may still experience mental health issues and disability more than ten years after the events[19].
- 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 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 education[20].

Utilisation of health services in Australia

- There is little research in Australia on the utilisation of health services by Vietnam-born people. There is some evidence in Australia and the United States that the use of preventive health services by Vietnam-born people is low[21-23].
- Identified barriers to health service usage include not having a regular doctor, economic disadvantage and low English language proficiency[21,23]. People who are married and have lived in Australia longer have been shown to have more adequate access to health care[21,23]. Traditional beliefs and practices do not appear to act as barriers to health service access[21].
- Vietnamese Australians have been shown to have lower rates of access to mental health services than the Australia-born population[24,25].
- Identified barriers to mental health service use for Vietnamese Australians include a lack of knowledge about mental health services, differences in understanding of mental illness, belief that mental disorders cannot be treated, language barriers, lack of availability of interpreters, and lack of bilingual and ethnically matched staff[26]. Somatic presentations and fear of stigma may also contribute to avoidance of mental health services[26].

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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 Vietnamese 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] 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.