Promising Practice Profiles

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| **Project title** | **Fairfield Refugee Nutrition Project** |
| **Project practice** | **Addresses nutrition and food security issues among refugee children and their families who have settled recently in Fairfield (NSW)** |
| **Project undertaken by** | The Smith Family & NSW Refugee Health Service |
| **Start date** | March 2007 |
| **Focal areas** | • Family and children's services working effectively as a team<br>• Supporting families and parents<br>• Child friendly communities |
| **SFCS stream** | Communities for Children (CfC) |
| **Issue** | "Food insecurity exists whenever the availability of nutritionally adequate and safe foods or the ability to acquire acceptable foods in socially acceptable ways is limited or uncertain" (Waxman, 1998, p. 761). Food insecurity and its more severe form, hunger, are associated with poor health and insidiously exacerbate other health inequalities (Palinkas et al., 2003).<br><br>Refugees are considered to be one of the most vulnerable groups. Upon resettlement, refugees must carry the burdens of the past whilst facing current challenges such as being resettled in the poorest neighbourhoods, obtaining suitable housing, limited English proficiency, having limited financial resources and facing limited economic opportunities (Waxman, 1998; Hadley & Sellen, 2006). As a consequence of these challenges, a high prevalence of food insecurity among refugees resettled in developed countries has been observed (Hadley & Sellen, 2006; Palinkas et al., 2003; Potocky-Tripodi, 2002).<br><br>Despite growing international evidence, the prevalence of food insecurity among refugees resettled in Australia to date is largely based on anecdotal evidence, and requires more thorough investigation. One small study reports a prevalence of 70.6% among refugee households in Perth, Western Australia (Gallegos et al., 2008). Although limited, existing data suggests refugees arrive with a range of nutrition and health-related conditions. Approximately 25% of clients seen by the NSW Refugee Health Service suffer from nutrition-related illnesses such as anaemia, Ricketts, gastro-intestinal parasitic infections, poor appetite and dental problems.<br><br>The Fairfield Refugee Nutrition Project was developed in response to extensive consultation. The focus of community consultation was to quantify the existence of food insecurity in the selected refugee communities, and to investigate how aspects of food insecurity affect different refugee communities. This promising practice documents the process employed in the development of the Fairfield Refugee Nutrition Project to overcome barriers relating to:<br>• anecdotally observed discrepancies in the nutritional needs between refugee community groups;<br>• extreme cultural diversity within the target group;<br>• large differences in previous exposure to basic nutrition education; and<br>• linguistic diversity. |

## Program context

**The organisation**

The Smith Family (TSF) is an independent, non-profit social enterprise embedded in over 85 communities, promoting educational opportunities for financially disadvantaged Australian children and their families. The TSF vision is of creating a more caring and cohesive society and is premised upon the family being the central supporting entity for sustainable change at a community level. Drawing on evidence illustrating the importance of family relationships in a child's healthy development, TSF adopts a dual-generational approach. TSF endeavours to grow a family's capacity to provide support for their children, encouraging them to participate and take advantage of opportunities provided by TSF programs. This focus on future generations is reinforced by building sustainable, broad and responsive support structures at the community level into a holistic, accessible system. TSF facilitates seven CfC sites.

**Client group**

The project focuses on refugee families, and families from refugee-like backgrounds, with children aged 0 to 5 years who have recently resettled in Fairfield. The population of the CfC site is 33,202 people, of which 2,860 are aged 0–5. Approximately 60 different languages are spoken by these families, and 72% speak English as a second language.

**The project**

The Fairfield Refugee Nutrition Project focuses on experiences of nutrition and food insecurity among refugee children and their families who have settled recently in the Fairfield local government area (LGA). The project endeavours to achieve this through:

- developing an understanding of how food security is experienced by each of the targeted refugee communities;
- increasing knowledge and capacity of refugee families to access healthy foods; and
- enhancing the capacity of community, health workers and settlement services to identify and address nutrition and food security issues.

The project has included a development phase involving data collection and community consultation; the implementation of a pilot 4-week nutrition education program; and the refinement of learnings from this development phase into an ongoing 6-week nutrition education program customised to meet the needs of identified communities.

## Practice description

The project is based on the principles of the Ottawa Charter for Health Promotion (WHO, 1986): community engagement and consultation; building personal skills; strengthening community action; creating supportive environments; and advocating for healthy public policy.

All aspects of the program were developed in close consultation with each of the community groups. This approach is similar to other projects targeting nutrition in refugee communities, with a few important differences. Program engagement through the use of a community member who is well linked and respected is an effective strategy often used in Indigenous communities, but has been a key strategy for this program. Taking the time to understand the internal workings of each individual refugee community enabled this project to engage key people within these communities. Once engaged these people provide cultural guidance and ensure the communities are accessed through the most effective and culturally appropriate means.

Finally this program maintains a holistic approach, recognising that nutrition and health cannot be separated from other goals and needs. A holistic focus leads to the creation of supportive environments that enable each community to better achieve health in its entirety.

These principles are enacted in the key program activities discussed below:

- data collection (household);
- community feedback and consultation (community);
- pilot of Nutrition Education Program; and
- on-going Nutrition Education Program.

**Data collection**

The purpose of data collection was to explore the challenges of feeding the family for refugees recently settled in the Fairfield local government area, and to directly inform project activities targeting refugee food security and nutrition.

The primary objectives were to quantify the existence of food insecurity in the selected refugee communities, and to investigate how aspects of food insecurity affect different refugee communities. Secondary objectives were to identify points of intervention.

Data were collected using a semi-structured interview process, conducted in the participant's nominated first language. The survey tool contained 53 questions investigating background demographics, measures of infant feeding practices, and four aspects of household food security, namely: availability; access; utilisation; and vulnerability or stability.

To determine food availability respondents were asked whether foods traditionally eaten in participant's home country were not available, irregularly available, or available but too expensive. Food access addressed the following: people's preferred places to purchase fruit and vegetables, meat, chicken, fish, and dry goods, and their reasons for store preference; difficulties experienced with food access excluding and including transport for food purchase, any difficulties associated with transport and the frequency; and persons responsible for the purchase of household food including changes since settling in Australia and the reasons for any change. Food utilisation considered the persons responsible for cooking at home in Australia, any changes which had occurred since settling in Australia and the reason for changes; and the effect of this on the household's eating patterns. Interviewees were also asked to quantify their level of skill in cooking healthy meals (very good, good, ok, poor). Eight questions assessed adequacy of household food storage and cooking facilities, specifically: acquisition, use and reasons for non-use of essential equipment and facilities. Equipment and facilities defined as essential were drawn from a previous survey of the general population residing in South Western Sydney (Nolan et al., 2006).

Vulnerability to food insecurity consisted of six questions. The first was adapted from the Australian single-item measure posed as: "Since arriving in Australia have there been any times when you felt you did not have enough food to feed your family?" Households which responded "yes" were then asked whether they had used each of the nine coping strategies, adapted from similar research (Centre of Epidemiology and Research, 2002; Nolan et al., 2006). Those who answered "yes" were further asked who in the family ate less if food was not available or limited; the impact food insecurity had on family life; if help, and from whom help, is sought when food is insufficient or anxiety exists about food becoming insufficient; and lastly reasons for not seeking help when food is insufficient or anxiety exists about food becoming insufficient.

The final question asked interviewees to quantify their interest in learning more about 16 listed topics pertaining to child nutrition. Topics were selected to include nutritional milestones, issues commonly encountered with early childhood nutrition, and anecdotal areas of concern expressed by the target audience.

The interviews were carried out by three project staff. Each interviewer was accompanied by the appropriate trained Bilingual Community Educators (BCEs). Training of BCEs consisted of an initial half-day seminar conducted by the research team around food security, interacting and engaging community members, and roles and responsibilities of translating for semi-structured interviews. This was followed by trial interviews in English and feedback of performance. Support and feedback for the BCEs was available throughout the project. The BCEs were paid an hourly rate which included travel expenses. BCEs accompanied project staff and translated both the questions of the interviewer and the responses of the interviewee, allowing all information to be scrutinised and recorded in English.

Seventy-six interviews were completed over a period of seven weeks between March and May 2007. Analysis of data found that refugees settled in the Fairfield local government area are eight times more likely to be food insecure than the greater Australian population, and two and a half times more likely to experience food insecurity than residents of a similar Sydney suburb. This represents an overall prevalence of 42% for food insecurity and 11% for hunger among refugees settled in Fairfield local government area.

The results also demonstrate considerable variations in the prevalence of food insecurity among refugees residing in the same geographic area by region of origin and language group. When considered by region of origin, 68% of refugees originating from African countries experienced food insecurity and just 6% of Middle Eastern refugees reported food insecurity. More alarmingly, when considered by language group, refugees speaking Dinka were 8.5 times more likely to be food insecure than both the Chaldean and Arabic (Middle Eastern) speaking communities who reported no incidence of food insecurity. Such large discrepancies between communities warrant more rigorous investigation and may have implications for both national and local settlement policies and service provisions.

**Community feedback and consultation**

Food insecurity, an experience felt by many Australians, is a complex and multifaceted issue. Investigation of the impact of food insecurity amongst newly arrived refugee communities subsequently uncovered a large and diverse range of issues. In light of this, providing feedback about these findings to the communities and creating discussion and prioritisation of these findings at a community level was an important next step.

Community feedback and consultation sessions were arranged with each of the target communities in order to:

- feedback to the communities the findings of the nutrition interviews;
- show thanks and appreciation for people who shared their stories; and
- seek confirmation that the issues uncovered accurately represent what the community is experiencing.

Attendance of the community consultation sessions exceeded expectations attracting a total of 85 families.

Bilingual Community Educators (BCEs) conducted the community consultation in pairs, one person facilitated and the other scribed. This allowed for informative free flowing conversations, which were later translated to English. All community sessions followed the same structure; feedback from the data analysis followed by three topic questions. Each topic question had four prompts, aimed to further discussion and explore how the issue being discussed affected the nutrition and health of young children.

For the Middle Eastern community consultation groups the three topics explored were:

- difficulties in food shopping for newly arrived refugees;
- challenges of maintaining traditional food practices; and
- food related health issues affecting their community.

For the African community consultation groups the three topics explored were:

- difficulties in food shopping for newly arrived refugees;
- challenges of maintaining traditional food practices; and
- why people run out of food and how this affects the family and the community.

Each of the community groups talked openly about their experiences and those of their community. This process enabled data collected to be viewed and discussed at the community level, prioritising issues and identifying clear points of intervention for each of the community groups.

**Pilot of Nutrition Education Program**

Following the extensive data collection and community consultation, a 4-week nutrition education program was developed drawing directly on investigative findings to inform program content and method of delivery. In line with the large variation in needs and experiences of food insecurity the program content varied by region of origin and the method of delivery was tailored to each group's unique needs.

The 4-week nutrition education program was piloted with three community groups defined by language to include Arabic (Middle Eastern), Assyrian, and Kirundi/Swahili who attended together. Bilingual community educators (BCEs) were

recruited to the program by the BCE coordinator at NSW Refugee Health Service. For many of the targeted language groups BCEs could be recruited from an existing pool, while new BCEs were recruited and trained as needed. The BCEs played a pivotal role in community access, disseminating information and evaluating all aspects of the pilot program for their community. BCEs completed self and program-content evaluation forms, as well as an interview to discuss the pilot from a more global perspective.

This evaluation process combined with participant evaluation and program worker evaluation resulted in a refinement and further development of the nutrition education program for 2008.

**Nutrition Education Program**

This has evolved into a 6-week course for which topics and delivery are tailored to meet the unique needs and interests of each cultural group as expressed during data collection and community consultation. A key feature is the ongoing flexibility of program content. This recognises the changing needs of each community throughout the settlement process. In being flexible, this program has been able to address needs as they arise, validating and empowering individuals and the community throughout their settlement.

The program aims to build personal skills through practical and targeted training which reflects individual and community needs. The program empowers individuals to make healthy choices, to share information and to advocate for themselves and their community. A more empowered group helps strengthen their community and their ability to stimulate action around need. The program also works hard to create a more supportive environment through breaking down barriers to food security, such as increasing food literacy and cooking skills, and demystifying utilities that impact significantly on money available for food purchase.

A variety of lesson plans and resources covering 10 nutrition topics have been developed. Six topics have been selected for each community group addressing their specific needs as identified during the processes outlined above. Lesson plan manuals are available for Arabic (Middle Eastern), Arabic (Sudanese), Assyrian, Chaldean, Dinka and Kirundi/Swahili. The lesson plans and resources developed through this project have been requested and utilised by several other health services in Australia. The transferability of this program stems from the consultative process, however should not neglect the need to consider each community's specific needs, interests and learning requirements. The national use of these resources will be evaluated at the completion of the program.

The first course has been completed for three groups; Arabic (Middle Eastern), Arabic (Sudanese) and Kirundi/Swahili Men. Participant, BCE and project staff evaluation has been meticulously collected and is currently being compiled.

Community members were recruited into the program through four main avenues: advertising; service mapping; recall; and BCE community links. Advertising of the program included the development of several resources that were designed and translated into the targeted languages to increase community awareness of the project and referrals into the project. Advertising resources included posters, pamphlets, and recall forms. Consent to contact participant forms were designed, translated and used to record the details of all people interested in participating in the program. This has grown into a large database of community contacts who receive regular information about program activities and progress. Throughout the project, every opportunity to contact new groups has been sort. This has included writing articles, attending functions, and providing "one-off" nutrition education sessions on request.

The program continues to rely on BCEs both as educators and as key community links. The BCEs have been integral in establishing community networks, advertising the program, maintaining group attendance and shaping the project activities to reflect the needs, interests and learning style of each of the groups. As BCEs grow their skills and contacts they often secure full time employment elsewhere. For this reason the position of a BCE coordinator is required, who maintains the BCE pool.

**Research base**

Households experiencing food insecurity are associated with depressive and behavioural disorders, poor dietary practices, obesity and morbidity (Victorian Foundation of Survivors of Torture Inc., 2000). Research has shown that groups at high risk of food insecurity include those on low incomes (absolute or disposable), and those with other disadvantages that result from disabilities, homelessness, mental illness, drug and alcohol dependencies, geographic location, or people living in residential areas not serviced by a supermarket or adequate public transport (Anderson, 2000; Chinook Kids Food Security Coalition, 2004; Nolan et al., 2006; Potocky-Tripodi, 2002; Smith, 2002).

In 1995, the prevalence of overall food insecurity among households in Australia was reported to be 5.2% (Dauchner & Tarasuk, 2002). Within this study the rate of food insecurity was much higher for the unemployed (11.3%) and those paying rent or board (15.8%). The 2001 Child Health Survey estimated 6.2% of Australian households were food insecure. This same study showed considerable variations by geographic location, with respondents from low-income areas three times more likely to be food insecure than respondents from other areas (Booth & Smith, 2001). Smaller community-based studies also highlight inter-population variations in food security. For instance, using a similar study tool Nolan et al. found 15.8% of households to be food insecure in three socially disadvantaged suburbs in south-western Sydney (Nolan et al., 2006). In a very different sample, Babbington and Donato-Hunt (2007) reported an overall prevalence of food insecurity of 95% and prevalence of child hunger of 22% among Anglicare emergency relief clients residing in Wollongong, New South Wales.

Australia accepts approximately 13,000 people annually through the Humanitarian Program administered by the Department of Immigration and Citizenship (DIAC, 2005). In recent years the majority of refugees have arrived from African countries (71%), Middle Eastern countries and the South West Asian region (24%) (DIAC, 2005). Many more people with “refugee-like” experiences settle in Australia through the Family Migration Program. In 2000, one in eight of the 32,000 entrants through this program originated from countries from which Australia currently accepts refugees (Victorian Foundation of Survivors of Torture, 2000).

Prior to departure, refugees endure conditions of social disconnection, displacement, isolation, famine, war and overcrowding. Such complex humanitarian emergencies are associated with high rates of social, physical, emotional and mental health problems (Shiekh-Mohammed et al., 2006). Migration policy which mandates health checks on humanitarian entrants requires refugees over the age of 15 years to be screened for HIV, and those over 11 years to have a chest x-ray (DIAC, n.d). For those others who are granted refugee status, recent initiatives have been established to identify those requiring medical attention on arrival. Some pre-existing conditions are diagnosed through this process; however for those who are asymptomatic relatively little is known about their health on arrival. This is of concern, particularly for refugee children arriving in Australia.

Emerging literature suggests that refugees are nutritionally compromised on arrival. A study of common health issues diagnosed by general practitioners in newly arrived African refugees settled in Melbourne, Victoria found a high incidence of nutrition related conditions. Alarmingly over 40% of children under 15 years were Vitamin D deficient and approximately 30% suffered iron deficiency. Twenty five per cent of the sample was also diagnosed with gastrointestinal infections (Tiong et al., 2006).

A high prevalence of food insecurity has been observed among refugees resettled in developed countries (Hadley & Sellen, 2006; Palinkas et al., 2003; Potocky-Tripodi, 2002). Hadley and Sellen (2006) reported food insecurity prevalence of 73%, and child hunger at 22% among recently resettled Sudanese refugees in Atlanta, Georgia, USA. In a similar study conducted among a sample of 30 refugee families resettled in London, 100% of households were food insecure, and the prevalence of child hunger was reported at 60% (Sellen et al., 2002).

Limited data exists quantifying the existence of food insecurity among refugee communities settled in Australia. One small study in Perth, Western Australia reports a prevalence of 71% among refugee households (Gallegos et al., 2008). The high prevalence observed however was consistent across all nominated places of birth (Gallegos et al., 2008). This contrasts with overseas studies that

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| | found differing degrees of food insecurity among refugees based on place of origin. A study of a multicultural sample of refugees settled in the UK found that food insecurity was reported by all (100%) however the prevalence of child hunger varies from 40%–90% by region of origin (Sellen et al., 2002). This study highlights the existence of differences in the experience of food insecurity between the refugee communities. Discrepancies between refugee communities observed in this and other studies warrant more rigorous investigation and have implications for both national and local settlement policies and service provision.<br><br>For many refugees poor on-arrival health and nutritional status is therefore further compromised by the high prevalence of household food insecurity. Being food insecure has serious consequences for both short-term and long-term health. Nutritionally, food insecurity is linked with lower intakes of micronutrients (vitamins and minerals), dietary fibre, fruit and vegetables. Paradoxically food insecurity is increasingly associated with high rates of overweight and obesity. This is attributed to a reliance on high fat, high calorie foods, which are cheap, filling and for the most part nutritionally deplete (NSW Centre for Public Health Nutrition, 2003).<br><br>Food insecurity also has implications for social and cultural integrity (Gallegos et al., 2008). The social implications of chronic food insecurity include an intensification of a sense of powerlessness and exclusion as well as an inability to maintain a sense of optimism. Food insecurity also decreases the transfer of knowledge around cultural food practices. It is a major concern that nutritional vulnerability and poor health among refugees has been linked to poverty and social exclusion in the country of asylum rather than experiences before arrival (Sellen et al., 2002). Food insecurity increases the magnitude of difficulty involved in the settlement process (Gallegos et al., 2008), the alleviation of which requires immediate and global action. |
| **Outcomes** | Strategies to address food insecurity among refugee communities in the Fairfield LGA draw largely on the Ottawa Charter for Health Promotion and have shown the following outcomes:<br>• improved food security;<br>• increased personal skill;<br>• strengthened community action; and<br>• creation of supportive environments. |
| **Evidence of outcomes** | The 6-week nutrition education program has recently completed the first round. This program has been evaluated in the following ways:<br>• attendance, including preferred language and number of children under the age of five years, is recorded for each nutrition session;<br>• participants complete pre- and post-evaluation forms for each of the six nutrition topics;<br>• Bilingual Community Educators (BCEs) complete evaluation forms for each of the six nutrition sessions, which reflect their opinion of the session and their skills required during the session;<br>• the project worker/presenter completes an evaluation form pertaining to the session and the BCEs for each of the six nutrition sessions;<br>• BCEs are interviewed at the completion of the 6-week course to critically assess the course's relevance, impact, cultural appropriateness, interest, and impressions amongst the community. Interviews are conducted by a staff member not linked to the 6-week course;<br>• the project worker completes the same interview process as outlined above; and<br>• at the completion of the course each participant is asked to identify one lesson they have learnt and implemented that they will continue to share with their community (this works towards building community knowledge of food and sustainability).<br><br>The evaluation report of the effectiveness of this program will be available in the second half of 2008.<br><br>The incredible interest this project has generated and continues to generate is evidence of a well-executed consultative process. In 2007, the program offered seven training sessions to BCEs, six training sessions to health professionals and advocacy organisations, and 37 nutrition education sessions, which captured 2,016 |

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| | adult community members from the targeted groups. During the first half of 2008, 88 sessions have taken place and have included 520 families.<br><br>**Improved food security**<br><br>Household food security is influenced by many factors several of which this project has addressed. Project evaluation shows improved knowledge and skills, social support and increased awareness of food availability in outlets.<br><br>**Increased personal skill**<br><br>This outcome is two-fold. Firstly the nutrition education sessions are structured practical education based on community need. This has created an education package which recognises that community needs differ and builds on personal skills, creating increased knowledge, skill and empowerment. Through the program, people have indicated their ability to exercise more control over their health and to make decisions that are conducive with health.<br><br>Secondly, through training and delivery of the nutrition education sessions the team of BCEs has enhanced their skills in community development, health promotion and nutrition. Through this program BCEs have also increased their personal networks resulting, for many, in increased work opportunities.<br><br>**Strengthened community action**<br><br>The success of this program is in its accurate reflection of community need. Program decisions, priorities and strategies were all decided by the targeted communities creating a strong sense of community ownership and control of the program and groups. The program utilised human resources within the community enhancing social support and self-help. Finally the program was flexible in its approach to strengthening public participation.<br><br>**Creation of supportive environments**<br><br>This project recognised that nutrition cannot be separated from other goals and settlement needs. For many refugees their new environment is unfamiliar and provides many obstacles to health. From learning about Australian energy and food systems to supermarket tours many aspects of this project focus on assisting people in becoming familiar with their new environment. Increasing familiarity with services for health has also assisted people in finding more enjoyment in their new environments. |
| **Policy analysis** | The Communities for Children Fairfield Refugee Nutrition Project is a positive example of place-based early intervention and prevention approach to child protection and development. The project provides a significant contribution to evidence about the nature of food insecurity among refugees settled in Australia, and contributes resources to practice approaches designed to equip migrants with practical and culturally appropriate knowledge and skills. |
| **Evaluation** | The Communities for Children Fairfield Refugee Nutrition Project was submitted for consideration for the Promising Practice Profiles (PPP). The project was assessed across a range of criteria relating to how the service results in positive outcomes for children, families and communities. The submission was peer reviewed and validated as evidencing promising practice. More information on the PPP selection process may be found at http://www.aifs.gov.au/cafca/ppp/pppprocess.html<br><br>The Communities for Children Fairfield Refugee Nutrition Project has undergone internal evaluation at each stage by the facilitating partner for the CfC site. An evaluation of the project will be available by the end of 2008. |
| **Project related Publications** | *Nutrition Education Training Manual* in the following languages: Arabic (Middle Eastern); Arabic (Sudanese); Kirundi/Swahili; Assyrian; Chaldean; and Dinka<br><br>Emergency food relief mapping<br><br>Feeding the family in an unfamiliar environment<br><br>All documents are available on the NSW Refugee Health Website: (http://www.swsahs.nsw.gov.au/areaser/refugeehs/main.asp) |

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| **More information** | More information on the Communities for Children Fairfield Refugee Nutrition Project and Promising Practice Profiles can be found on the Communities and Families Clearinghouse Australia website. |

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