**Multicultural Health Diversity Café 4:**

**Migrant Men’s Health**

Executive Summary and Key Points

21 May 2015



Cultural Diversity Unit, Chronic Disease Prevention Directorate,

Public Health Division,

WA Department of Health

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# Executive Summary

The Cultural Diversity Unit (CDU) hosted the fourth Multicultural Health Diversity Café on Thursday 21 May 2015 with a focus on migrant men’s health.

The Café was hosted in collaboration with the Humanitarian Entrant Health Service (HEHS), Association for Services to Torture and Trauma Survivors (ASeTTS), Office of Multicultural Interests (OMI), Swan Adult Mental Health Service (SAMHS) and North Metropolitan Public Health and Ambulatory Care (NMPHAC).

This Café continued with the CDU’s vision of replicating a friendly café ambiance to facilitate conversations where ideas and insights are shared, and participants gain a deeper understanding of the subject and the issues being discussed.

Ruth Lopez, CDU Senior Policy Officer, facilitated the morning and was joined by three keynote speakers that discussed migrant men’s health matters focusing on:

* The impact of migration on immigrant males’ mental health – Dr John Adegboye, Consultant Psychiatrist, SAMHS
* Gender and inequalities in health: men’s health for a change– Dr Hussein Farah, Public Health Physician, HEHS
* The changing role of migrant men – Jabrulla Shukoor, Clinical Services Manager ASeTTS.

The presentations were intermixed with ‘buzz sessions’ where the 45 participants, a third of which were men, sat in small groups around café tables.

The ‘buzz sessions’ enabled participants to reflect on the migration processes, the resulting impact on men’s health as they settled in Western Australia, and the challenges faced by service providers when interacting with them.

Common ‘buzz’ ideas for the day included:

* understanding perceptions of mental health among males from culturally and linguistically diverse backgrounds (CaLD) as being key to addressing the stigma of mental health
* linking service providers with community organisations to support a well-being approach, not a health problem approach
* realising that some migrants have been professionals in their country of origin but either find themselves unemployed or underemployed in WA
* raising awareness and educating the non-migrant community about migration processes and male health issues.

Additionally, a series of posters highlighting the main findings of a recent study done by NMPHAC on ’Perceptions of physical activity and diet among recently arrived humanitarian entrants from selected ethnicity groups,’ were displayed on the walls of the venue. While the research was not solely based on men’s health, study participants were mostly men. The research focused on healthy eating, physical activity, alcohol and smoking perceptions soon after arrival in Western Australia. The key findings from this group of people about these health topics are listed below:

* Alcohol
	+ Increased access and availability of alcohol in Australia
	+ Perception that alcohol relieves stress
* Health food
	+ Food preferences and dietary habits strongly linked to culture
	+ Important part of religious observance and spiritual ritual for many faiths including Christianity, Judaism, Islam, Hinduism and Buddhism
	+ Food preferences and dietary habits are complex and differ among individuals and communities within similar cultures and religious beliefs
* Physical activity
	+ Incidental activity included walking, gardening and housework the main source of physical activity
	+ Stress and poor mental health impacting on motivation to participate in physical activity
* Smoking
	+ Perception that smoking relieves stress
	+ The high cost of cigarettes, and Government restrictions with smoking in Australia having some impact

For further information on the study please see pg.12 or contact Vilma Palacios atvilma.palacios@health.wa.gov.au

A summary of the presentations, key points from the three buzzing sessions, list of attendees and pictures from the café are included in this report. For more information, contact CDU through Ruth Lopez, Senior Policy Officer or Kelli Monaghan, Policy Officer on culturaldiversity@health.wa.gov.au.

**Ruth Lopez** opened the Café with an acknowledgement to country, a warm welcome to all participants and a brief background to the Café series. Ruth also introduced the Café concept and mechanics and invited everyone to actively participate, share their own experiences and enjoy the morning’s forum.

**Dr John Adegboye** presented on **The Impact of migration on immigrant males’ mental health**. He discussed the phenomenon that whilst many migrant males arrive in Australia with good mental health, their mental health tend to deteriorate after the first 12 months spent in Australia. This is often linked to the stressful process of acculturation, language and social difficulties and finding employment.

Referring to the migration process, Dr Adegboye explained why humans migrate, the push/pull factors, various migration streams (including voluntary, displaced and economic) and the health consequences that may arise from each. He also touched on specific settlement issues that male migrants face and the psychiatric disorders that may result from these.

A discussion on managing the consequences of migration and how services can become ‘culturally responsive’ followed. Barriers to treatment and how to overcome these barriers through education and engagement with migrant men, use of interpreters, liaising with cultural leaders and migrant resource centres and the provision of culturally appropriate facilities for mental health care were also cited.

**Dr Hussein Farah** presented on **Gender and inequalities in health: men’s health for a change**. “It is easy to stereotype refugees but everyone is different – different journeys, health needs, backgrounds and reasons for being here,” he said. “Don’t assume you understand. Take the time to find out.”

He talked about how males generally have poorer health and an overall shorter life expectancy than females. He linked these to their biology and roles in society; different rates of injury, illness and mortality; different attitudes towards health and risks; and the way each group uses, or does not use health services.

He cited statistics relating to all men, generally, and males born overseas, specifically, to highlight these points. Initially, migrant men (excepting vulnerable new arrivals such as refugees) display what is the ‘healthy migrant effect’. Due to Australia’s stringent migration policies where migrant men have to satisfy specific health requirements, they are generally healthy on arrival and enjoy better health for about five years. After which, the healthy migrant effect begins to disappear. Evidence indicates that migrant men have poorer outcomes for diabetes and lung cancer compared to Australian born men.

Dr Farah then looked into the demographic and socioeconomic characteristics of males born overseas. As at 30 June 2010, there were 3 million males born overseas currently living in Australia (26% of the total male population). In 2010 the median age of males born overseas was 44.3, compared with 32.4 for males born in Australia. Lifestyle factors also impact on migrant men’s health.

He emphasised that migrant men are reluctant to visit their General Practitioner for various reasons such as work obligations; lack of health awareness; because “big boys don’t cry” and not making their health a top priority.

He ended his presentation by sharing prevention strategies and key points about diet and nutrition; exercise and fitness; cardiovascular disease; diabetes; cancer; prostate health and a list of approaches to help men lead a healthier and fuller lifestyle.

**Jabrulla Shukoor** presented the third topic titled **‘The changing role of migrant men’.** He talked about how migrants come from ‘all walks of life’ - they could be a skilled worker; a student; a refugee/asylum seeker or humanitarian entrant or sponsored through marriage or other means.

The issues that impact on the ‘role’ of migrant men relate to, among others, acculturation, accommodation, language, social isolation, lack of family support, unemployment, family values, trauma, and identity. A person’s sense of cultural identity and their behaviour are shaped and influenced by such things as ethnicity, country of origin, local norms and conditions and education and impacted by the immigration experience and external factors like discrimination.

The changing roles and community standing resulting from the migration experience is further impacted by family and extended family support, parenting styles, religious customs, ideas about masculinity, social isolation, recovery from trauma and language.

Financial issues also impact on migrant men’s health as do employment skills, finding a job and providing accommodation for themselves or their family.

Jabrulla showed two short videos called “The Lost Boys of Sudan.” The first was about the exodus of 27,000 boys from Sudan to the Kakuma Refugee Camp in Kenya, the hardships of their journey and living in a refugee camp. The second video told of the story of a few of the boys from the refugee camp and adaptation to a new life and lifestyle in an American city.

Jabrulla highlighted that learning about each different culture was not the only way to cultural competence and that it was important to ensure you understand the individual client who has come seeking help and to be aware of stereotyping.

# Key Points from the Diversity Café Summary Wall

## Buzz session 1

### 1. What are the key mental health issues that affect migrant men?

* Access to culturally appropriate services continues to be an issue for migrant men
* Realities of living in Australia do not meet expectations
* Health effects of culture shock on physical health
* Key issues:
	+ Unemployment
	+ Isolation
	+ Stress and culture shock
* Disempowerment of men in relation to loss of position in family, unfamiliar systems and job status
* Grief and loss for family left behind
* Mental health symptoms hidden, men don’t show emotions

### 2. What do you currently do to help migrant men with mental health issues?

* Understanding perceptions of mental health among CaLD men is critical to address stigma
* Develop men’s **health literacy** skills as a key priority
* Need to focus research on **engagement and prevention**
* More multicultural support groups and organisations for men
* Providing assistance through community engagement and **referral** to available services
* 6-12 month follow up for migrants post settlement
* Working with existing groups including sports; GPs; faith based groups; schools and educational institutions; community groups and employment services
* Need to focus on being ‘mentally healthy’
* Raise awareness of mental health issues which arise “post honeymoon” period
* Provide culturally appropriate services
* Ensure accessibility
* Build trust

**Additional points from the table tops**

1. What are the key mental health issues that affect migrant men?

**Mental health issues -** depression and anxiety

**Mental health issues caused by:**

* Torture and trauma of past experiences
* Interrelated health issues – co-existing conditions
* Financial stress
* Unemployment / underemployment / exploitation
* Family pressures (sending money home, shame, guilt)
* Lack of acceptance from the community – Racism
* Cultural conflicts:
	+ Between different CaLD populations
	+ Within own community and new community
* Lack of confidence
* Migrant men taught not to show emotions
* Disempowerment of men:
	+ Position in family
	+ Family breakdown
	+ Unfamiliar systems
	+ Language
* Grief:
* Previous life:
	+ Status – provider (Centrelink payments going to the wife/mother )
	+ Family dynamics changes
	+ Job
	+ Perceived loss of children (children become parents interpreters and ‘shape’ information to parents)
	+ Employment
	+ Culture – customs (get stuck in the past and how they were; and can’t move on)
	+ Monetary responsibility to financially support family in new country and country of origin, but can’t get a job
	+ Loss and guilt about family left behind

**Barriers to recovery**

* The stigma of ‘mental health’
* Attitudes towards access and participation
* Expectations vs reality
* Employment and education
* English level / language barriers
* Navigating the health system
* Limited time, flexibility, transport.

**Barriers to accessing services**

* Cost
* Lack of culturally appropriate services
* Lack of cultural awareness of services
* Interpreter services thinly spread or not available
* GPs not referring
* Attitudes and perceptions of mental health services

2. What do you currently do to help migrant men with mental health issues?

* Work reactively once people are ‘in the system’
* Access resources to address and support:
	+ Driving issues
	+ Child abuse
	+ Domestic violence
	+ Traffic infringement issues Racial discrimination
	+ Religious discrimination
* Identifying and educating community
* Encourage social connections, e.g. volunteer work etc., giving hope, building networks for employment, language
* Supporting individuals
* Provide information about services at entry
* Raising awareness in mainstream services regarding migrant males
* English classes
* Support and transport
* Providing information in own language
* Support to engage and understand systems
* Family centred approach
* Timely responses from service providers
* Inform and support with settlement
* Language services

## Buzz session 2

### 1. What are the key physical issues that affect migrant men?

**Physical health issues**

* Diabetes
* Diet related problems caused by risk factors including physical activity, poor diet and alcohol
* Back pain
* Sleep problems
* Chronic illness

**Other issues**

* Cultural and traditional nutritional practices
* High calorie food not matching new activity levels
* Not having the ‘know how’ to change
* Men’s attitude – men don’t accept that sickness can be treated
* Inability to vocalise fears – internalise
* Limited time for self-care e.g. taxi drivers do not have time to stop and eat or go for a toilet break
* No prior need to address physical health issues in country of origin resulting in lack of awareness of these issues
* Mental health issues impacting on capacity to make healthy choices

### 2. What do you currently do/could do to help migrant men with their physical health issues?

**Actions for agencies**

* Start from a well-being perspective rather than health problem
* Taking a holistic approach is essential
* CaLD men’s group establishment with existing CaLD organisations
* Take the services into the communities
* Sharing information
* Use of appropriate languages
* Lack of data and stats specific to CaLD groups
* Important to increase the priority and value of health among men
* Need strategies to address lung cancer and diabetes deaths and CVD in migrant men
* Building capacity and providing support for groups to service their own communities on their terms
* Need champions to encourage physical activities and participation

**Actions for migrant men**

* Maintain traditional diets if possible
* Incorporate physical activity every day, not just going to the gym

**Additional points from the table tops**

1. What are the key physical issues that affect migrant men?

**Physical issues**

* Panic attacks and fatigue caused by mental health issues
* Forced medication in other countries but cannot be forced in Australia
* No older family support to get direction
* Sedentary lifestyle in Australia
* Avoidable deaths from lung cancer and diabetes

**Healthy lifestyles**

* Link between physical and mental health and general well being
* Difficulty implementing healthy lifestyles due to time and resource constraints

**Nutrition**

* In the West, ready availability of more processed, cheap and high calorie foods
* Changes in diet and calorie intake not matching activity levels

**Other issues**

* Lack of peer support groups for migrant men (e.g. culturally appropriate men’s shed)
* Same community political issues discussed at home and overseas
* Resistance to change impacting on choices
* Lack of acceptance with regards to treatment of sickness.
* Lack of data/statistics of the breakdown of CaLD population
* Historical / long standing / chronic unresolved issues
* Impact of social determinants on health
* Lack of education and awareness among both service providers and community
* Lack of coordinated and collaborative service provision

2. What do you currently do/could do to help migrant men with their physical health issues?

**Approaches**

* Strategic planning to enable resources, support and access
* Find out what migrant men need, give information and support with referrals
* Development from wellbeing perspective rather than ‘health’ problem
* Raise awareness and health literacy
* Psycho-education importance for health
* Appropriate community education
* Community grants e.g. from Department of Sport
* Capacity building within individual communities

**Networks**

* Engage migrant men in social and sports activities (e.g. soccer tournament – good turnout) to:
	+ Draw families together
	+ Provide education and health talks for men (varying levels of engagement)
	+ Sought evaluation from men – i.e. what worked, what could be done differently?
* Engaging people in workshops
* Referral to community based programs, activities and services
* Identify ways to integrate migrant men’s past activities in home countries to their present situation

**Resources**

* Creating user friendly resources
* Use of interpreters / community nurses

## Buzz session 3

### Some migrant men are difficult to work with considering their background, attitude and general outlook towards service providers. What are some of the successful strategies you have or may use to engage these men?

**How to engage**

* Engaging with men through positive means , not having a problems-focused approach
* Engage men at TAFE, University, work and places of worship

**What is needed?**

* Employment opportunities
* Mentors also need support and funding through an organisation
* Ongoing support, monitoring and funding to ensure migrant men become empowered and self sufficient

**Strategies**

* Break down concepts into small steps and repetition to aid understanding
* Use other organisations such as disability sector with examples
* Connecting people with mentors and champions
* Coaching and support to integrate
* Person centred, solution focused care
* Service provider assess service and processes to identify issues and provide culturally appropriate service
* Link migrant men with (volunteer) peer support via mentors who have shared experience
* Link service providers with community organisations i.e. men’s shed or sporting groups
* Build trust and rapport
* Person centred understanding e.g. “please tell us about yourself”
* Warm empathic approach – personal
* Reflection skills (empathy)
* Raising awareness and educating non migrant community
* Men helping men
* Active listening

**Other**

* The service provider has the difficulty not the client
* Safeguard self and empowers client

**Additional points from the table tops**

* You don’t know what you don’t know
* Some migrants have been professionals in their country of origin
* Encourage shared learning
* Leadership programs to build capacity and understand the issues
* Assistance with providing employment

**Support to deal with socio-cultural stressors and integration**

* Orientation to Australian culture, staged:
	+ Immediate
	+ Practical
	+ Men working with men, those who have been through acculturation themselves
	+ Longer term
* Support for wider integration outside their immediate culture e.g.:
	+ through sporting activities
	+ clubs
	+ volunteering
	+ mentoring
	+ Settlement – scattered to facilitate connection to others and opportunities for integration

# The Presenters:

**Dr Adegboye is** a senior psychiatrist at the Swan Mental Health Adult Service. Originally from Nigeria, he completed his psychiatry degrees both in Nigeria and Australia and is a Fellow of the Australian and New Zealand College of Psychiatrists (FRANZCP).

**Dr Farah** is a Public Health Physician at HEHS with a unique insight into the lives of the refugees he screens for health checks because he, too, was once a refugee. Through his work at HEHS and the Tuberculosis Program, he introduces refugees to the public health system and looks for signs of diseases that are prevalent among those entering Australia on a refugee visa. Dr Farah’s foreign degree was not recognised when he arrived in Australia so while earning a living he embarked on post graduate studies and worked his way to his current position as Senior Medical Officer for the TB Control Program at WA Health.

**Jabrulla** is a migrant from Singapore who came to Western Australia to study and has settled into Australia after graduating in Psychology in 2009. He undertook mandatory supervision for two years to attain general registration as a Psychologist while working as an employment consultant and then as a counsellor with ASeTTS. Jabrulla has been with ASeTTS for more than 4 years and is the detention coordinator with the clinical team. The clients he works with are all from CaLD background and present various mental health issues particularly torture and trauma issues.

# The Posters

Between 2013-14 the North Metropolitan Public Health Unit (NMPHU) conducted a study with the purpose of identifying and comparing similarities and differences between newly arrived and established humanitarian entrants, regarding their behaviours, perceptions, attitudes, knowledge, barriers, enablers and beliefs in relation to smoking, nutrition, alcohol and physical activity,  so to provide evidence to develop a CaLD chronic disease prevention framework and  implementation of tailored preventive intervention programs for those community groups.

A total of 21 focus groups were conducted with 177 individuals from 8 ethnicity groups including Burmese: Karen and Chin: Sudanese: Arabic and Dinka; Afghanistan: Hazaragi, Dari; Iraqi: Kurdish and Arabic in this study, which used an ethnographic research approach.

Overall it was evident participants in the study, including newly arrived migrants have already embarked in the acculturation process with changes to their lifestyles including the uptake of fast food and limited participation in physical activity, both of which are identified risks factors to chronic disease.

Significant findings included:  food insecurity; as reported by over 50% of participants, increased consumption of fast food due to its perceived low cost, availability and a perception there are no healthy choices available to them. Most participants claimed Australian food was unhealthy due to exposure to chemicals and being kept in refrigeration.

Diversity Café participants:

The Diversity Café was attended by 45 participants from various government and non-government organisations. Those who gave permission have their names and contact details included below.

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| --- | --- | --- | --- |
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**The Multicultural Health Diversity Café is hosted by the** Cultural Diversity Unit (CDU)**, Chronic Disease Prevention Directorate, Public Health and Clinical Services Division, Department of Health. The CDU provides expert advice and strategic leadership to develop culturally competent and linguistically appropriate health services and programs to enable equitable access, safe and high quality health care for people from culturally and linguistically diverse (CaLD) populations.**

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