CONTENT

CULTURAL DIMENSIONS OF PREGNANCY, BIRTH AND POST-NATAL CARE

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- This chapter on the cultural dimensions of pregnancy, birth and post-natal care has been produced for Queensland Health by Victoria Team, Katie Vasey and Lenore Manderson, Social Science and Health Research Unit, School of Psychology, Psychiatry and Psychological Medicine, Faculty of Medicine, Nursing and Health Sciences, Monash University.

- It derives from research conducted to identify factors among people from culturally and linguistically diverse (CALD) backgrounds which may affect their use of antenatal services, their care during pregnancy, labour and birth, and postnatal care.

- Culture plays a major role in the way a woman perceives and prepares for her birthing experience. Each culture has its own values, beliefs and practices related to pregnancy and birth. Many women who come to Australia have a pragmatic attitude to traditional practices, and may not be interested in following them here. However, other women may consider it important to adhere to traditional pregnancy and birth practices. If health care providers are familiar with different ideas, rituals and behavioural restrictions and proscriptions, and communicate with the women for whom they care, then women from CALD backgrounds will have a choice.

- Health care providers are not expected to know about the cultural practices of all the communities living in Queensland. They are however, expected to use open communication, knowledge and respect when interacting with all clients.

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■ SUMMARY CHECKLIST FOR CULTURAL ASSESSMENT

Preface

- There may be important questions to consider when caring for women from cultural backgrounds different to your own.
- This checklist is only a guide and can be modified according to women's health and culturally-specific needs, women's health status, and the policies and practices of the health centre or hospital.
- Some of these questions may be optional depending on the clinicians' cultural competency, the circumstances of the woman, and her pregnancy and postnatal outcomes.
- Additional questions are provided at the end of this chapter.

General questions

The following general questions should be considered when providing antenatal care for women from different cultural backgrounds. Some women, in particular those from a refugee background, may be reluctant to disclose personal information. This can often be caused by pre-migration experiences, or a general mistrust or fear of authority. Health workers should explain, using plain English or an interpreter, the need for collecting this information and the requirements for confidentiality. Make sure that the responses to these questions are recorded in the antenatal care documentation, if not already on the chart.

General questions

- Where were you born?
- What is your ethnic background?
- How long have you been in Australia?
- Did you come to Australia as a refugee?
- What is your preferred language?
- Do you need an interpreter?
- Do you prefer the interpreter to be male or female?

Cultural assessment questions

- Are you comfortable with both male and female health care providers?
  - Explain that wherever possible a female health care provider will be provided if preferred, but in an emergency situation this might not be possible.
- Are there any cultural practices that we need to be aware of in caring for you during your pregnancy, giving birth and postnatal period?
  - For example, requirements with the placenta, female circumcision or infant feeding method.
- In your culture, do fathers usually attend births? Does your partner want to attend the birth of his child? If not, is there another close family member you would like to be present? Would you like us to speak to them about your care?
  - Ensure that the woman is aware that the policy of the hospital is to speak directly to the person. However, somebody else can be included if it is culturally important.
- Are there any foods that are appropriate or inappropriate for you according to your religion or customs during pregnancy, birth and the postpartum period?
- Are there any beliefs or customs prohibiting physical activity during pregnancy, birth and the postpartum period? Do you plan to observe these?
  - For example, a confinement period.
- What is the culturally acceptable way for you to express pain during childbirth?
  - For example, screaming or trying to keep silent.
- Are there any precautions with infant care?
  - For example, Vietnamese and Thai women may believe that the head of the infant is the site of the soul and it should not be touched.
- How many visitors do you expect while you are in the hospital?
  - Ensure that the woman is aware of visiting hours and any restrictions on the number of people that may be able to visit her.
- Do you have anyone in your family or community who can help you in practical ways when you get home?
- What is a culturally appropriate way for disclosing bad news?
  - For example, the risk of miscarriage
  - Discuss this as early as possible in the woman's antenatal care (although this might cause anxiety).

■ MATERNITY SERVICES OVERSEAS

Women from CALD backgrounds using maternity services in Queensland have come from diverse health systems. In some countries health systems are well developed and quite similar to that in Australia, but in many countries, health systems and the approach to antenatal care are quite different.

Staff should be mindful that the potential for miscommunication and misunderstanding may be greater when seeing a woman from a CALD background. Women may subscribe to health beliefs which differ from the Australian health system and they may have different expectations about antenatal and maternity services.

This section outlines some of the differences in maternity services found overseas. It is intended to assist staff to understand why women from a CALD background may have certain expectations, fears or past experiences with health services.

Differences in maternity care overseas

- ***Approach to antenatal care*** In Australia, a paternalistic approach, where the doctor or nurse decides what is best for a patient's health, is usually applied only in emergency situations. In other countries (eg. Japan), a paternalistic approach is the main approach applied to maternity care. Women may lack autonomy to make decisions regarding antenatal tests and modes of delivery.
- ***Number of antenatal health checks*** The World Health Organisation recommends at least four antenatal visits for women in developing countries. In Australia, the traditional antenatal care schedule requires 14 visits.
- ***Gestational age at the time of initial antenatal visit*** In Australia, pregnant women are referred to antenatal care by general practitioners immediately after pregnancy confirmation. In other countries, women may attend antenatal care at the end of the first trimester or later.
- ***Range of maternity services*** In many developing countries there is an absence of postpartum support groups, lactation consultancy, and other support services.
- ***Range of antenatal investigations*** In some developing countries there is an absence of genetic testing, amniocentesis and ultrasound.
- ***Frequency of antenatal investigations*** In some provinces of China, there is an overuse of ultrasound during pregnancy. In India, it is illegal to determine the sex of the foetus.
- ***Indication for hospitalization*** In Ethiopia, a cervical opening of 3-4cm is required for hospitalisation of a woman in labour. If a woman's cervix is not sufficiently dilated, she is sent home until the labour progresses
- ***Paternal involvement*** In many African, Asian and Arabic countries, men are required, and often prefer, to stay out of the labour ward.
- ***Birthing positions and mobility during labour*** In Australia, active labour is widely practiced and women are encouraged to stay out of bed. In many other countries, mobility during labour is not common.

Differences in maternity care overseas

- ***Labour pain management*** In Japan, and in other countries, childbirth is considered a natural event and is usually drug-free.
- ***Hygiene requirements*** In Japan, showering and washing hair after birth is prohibited until after seven days.
- ***Duration of hospital stay after normal birth*** This may range from 24 hours as in Australian birth centres, to seven days as in hospitals in Japan.
- ***Postpartum checkups*** These do exist, but are often attended by a small proportion of women, predominantly due to complications after birth (eg. in Sudan).
- ***Postpartum support*** In Taiwan, there are commercial confinement centres.
- ***Elective/emergency caesarean section*** In most developing countries, caesarean section is performed only as an emergency procedure.
- ***Dealing with female genital mutilation*** In Australia, re-infibulation after delivery is prohibited; in Sudan, de-infibulated women are normally re-infibulated after delivery.
- ***Contraception*** In Australia, postpartum women are referred to their general practitioners for contraceptive advice. In some developing countries (eg. Ethiopia, Eritrea, Sudan), on discharge the maternity department may provide women with contraceptive advice and at least a one month supply of contraceptives as part of maternity care.
- ***Placing of the newborn child*** In some maternity hospitals (eg. Ethiopia), all infants are placed in the neonatal wards separate from their mother, and brought to the mother at feeding times.
- ***Infant care, genital cleaning and ear cleaning*** Disposable nappies are not available in many developing countries.
- ***Pelvic floor exercises, healthy eating and early physical activity in a postpartum period*** This may vary according to cultural traditions. Early physical activity is not recommended in countries where a confinement period is usually observed (eg. The Philippines).
- ***What to take to the hospital*** This varies across countries and hospitals. In many countries, nothing is required for admission to maternity departments (eg. Ethiopia and other Horn of Africa countries).

Practical advice

- Provide an interpreter to discuss maternity care if needed
- Inform the woman about maternity care models, the nature of maternity care and the range of services provided
- Provide printed information about maternity care, preferably in the woman's own language
- Encourage the woman to ask questions
- Reassure the woman that she has a choice regarding a model of care or a specific intervention (eg. elective caesarean section rather than vaginal birth).

■ CONCOMITANT CONDITIONS AND CULTURAL GROUPS

Common serious disorders and complications of pregnancy and birth

Any woman with pregnancy and birth complications may feel vulnerable and anxious about her own health and the health of her unborn child. Women from a CALD background may have a limited understanding of these conditions, which can increase stress and anxiety. They may also experience stress related to poor communication skills, the gender of health practitioners and an inability to comply with their cultural or religious practices (eg. fasting, specific dietary requirements). Women from CALD backgrounds may also be unaware of some of the services that assist pregnant women. Proper explanation of the management plan and meeting cultural requirements can reduce stress related to these complications and improve health and pregnancy outcomes.

General practical advice

- Provide an interpreter if needed
- Inform the woman about:
  - suspected complications
  - the suitable model for antenatal care
  - same gender policy during routine visits and in case of emergency (eg. examination provided by physicians according to emergency care roster)
  - the purpose of hospital admission and possible interventions, if required.
- Discuss the use of animal-derived preparations (eg. heparin) and the availability of plant-derived supplements (refer to the Queensland Health guideline Medicines/Pharmaceutical Products of Animal Origin http://qheps.health.qld.gov.au/medicines/documents/general_policies/prods_anim_origin.pdf)
- Ensure that cultural and religious dietary requirements are met (eg. Halal, Kosher)
- Refer the woman to additional pregnancy services (eg. endocrine clinic).

Attitudes to modes of delivery

Vaginal delivery

Women from a CALD background may raise some concerns regarding vaginal delivery after previous caesarean section. In some overseas health systems, previous caesarean section could be considered an indication for a repeat caesarean section. In Australia, in most cases, successful vaginal birth can be achieved safely for both mother and infant. Therefore, vaginal birth should be considered as an option for all women with a history of previous caesarean birth, who present for antenatal care. To make an informed choice, the woman may require additional explanation.

Women with female genital mutilation considering vaginal delivery may require de-infibulation and afterbirth vulvae restructuring procedures (refer to *Female Genital Mutilation* chapter for details).

Caesarean section

Australia has a high rate of caesarean section (31% of births in 2006). This is even higher in Queensland (33.2% of births in 2006) (AIHW, 2008). When a caesarean section needs to be considered, the associated risks and benefits should be clearly explained to the woman. Health professionals should understand that some women may not want to consider a caesarean section despite explanation of the likely outcomes. This may be because of their cultural or religious beliefs.

Some women considering caesarean section may be afraid that they will lose a soul (eg. Hmong women) or be afraid of this intervention for other reasons. Japanese women tend to view a caesarean section as posing a great burden to a postpartum woman and may prefer to avoid this intervention. Some women may fear a caesarean section because of the possibility of blood loss and blood transfusions. Some women may object to blood transfusion for religious reasons, or in the case of women from countries with a high incidence of HIV, because of the fear of infection from transfusion.

In most developing countries, caesarean section is performed only as an emergency surgical procedure. If not informed, women may not be aware of their option to have an elective caesarean section in Australia.

Some issues regarding caesarean section may arise for women with female genital mutilation. It should be explained that a caesarean section is not routinely performed on women with female genital mutilation. However, elective caesarean section could be considered if it is the preferred mode of delivery by the woman, and her informed choice (refer to *Female Genital Mutilation* chapter for details).

Modes of delivery: Practical advice

- Provide an interpreter if needed
- Inform the woman about the modes of delivery. Provide sufficient information about elective caesarean section, and contrast this with emergency caesarean section
- Discuss the woman's eligibility for these modes (eg. women with previous caesarean section and twins are not eligible for a midwifery-led delivery in the birth centre)
- Elicit the woman's preference regarding the mode of delivery and reasons for rejecting the proposed best mode of delivery (if applicable)
- Refer to specialists for advice regarding other issues (eg. female genital mutilation and caesarean section)
- If emergency interventions are required (eg. forceps delivery), discuss the nature of the potential intervention, benefits and possible complications
- Discuss issues linked to complications of surgical procedures, including no-resuscitation order.

Support seeking

Women from a CALD background are less likely to use maternity and other health care services. The potential reasons for this include:

- a lack of knowledge of certain health and other needs and lack of awareness about the services to meet these needs
- doubt about their eligibility to access these services
- fear about the cost of services and their inability to pay
- poor English language skills and a lack of interpreting services (eg. no interpreters for childbirth education classes)
- the participation of men in group sessions
- lack of trust of some services (eg. mental health services).

Support seeking: practical advice

- Inform women about the available services and their eligibility for these services
- Discuss purpose of referral and potential benefits of attending
- Inform about costs for the use of these services, if any. If these services are subsidised or free, emphasise this
- Inform women when, where and how they can seek emergency care, specialist examination, education classes (childbirth, diabetes) and other information
- Ask if the woman requires assistance with booking appointments
- Try to elicit any potential reasons for refusal to use certain services.

Antenatal testing

Pregnancy and childbirth are natural events. Antenatal investigations are aimed at improving maternal and infant outcomes. In Australia and other developed countries, antenatal investigations, including blood tests, amniocentesis and obstetric ultrasound, as well as various psychosocial assessments, are routine. Health practitioners should provide women with an explanation about why they are recommended.

The majority of pregnant women are aware of foetal conditions to be diagnosed and willingly undertake ultrasound and amniocentesis to ensure foetal normality. Some women choose not to have ultrasounds because they know they would not terminate their pregnancies. Some women from a CALD background may not want a recommended test based on their cultural beliefs. For example, some women may object to glucose tolerance tests while fasting.

Genetic counselling

Health professionals should be aware that some ethnic groups have an increased risk of genetic conditions. These increase the chance of poor pregnancy outcomes. For example, at least one in 20 adults is a genetic carrier for a haemoglobin condition. The chance is higher for:

- alpha thalassaemia if their ancestry is from China and South East Asia, southern Europe, the Middle East, Indian subcontinent, Africa, the Pacific Islands and New Zealand (Maori)
- beta thalassaemia if their ancestry is from the Middle East, southern Europe, the Indian subcontinent, Central and South East Asia, and Africa
- sickle cell disease if their ancestry is from Africa, the Middle East, southern Europe, the Indian subcontinent, South America and the Caribbean.

Antenatal FBE screening can assist in identifying women who may be carriers, and partner testing may also be indicated. Genetic counselling, including a discussion of what genetic testing is available, can be offered to women and their partners who are concerned about their risk of being a carrier or who are found to be carriers of thalassaemia, other haemoglobinopathies or any genetic or inherited conditions. Services can be accessed through Genetic Health Queensland (07 3636 1686).

In some countries in Asia, the Middle East and northern Africa, consanguinity (marriage between blood relatives) is more common than in others. It is associated with a slightly higher than average risk of birth anomalies. For example, first cousins have a 5-6% chance of having a child with a genetic condition or birth anomaly. This risk is much higher if their parents or grandparents are also consanguineous. If consanguinity is identified, referral to genetic counselling may be appropriate.

Genetic counselling: practical advice

- People from certain backgrounds may be at higher risk of some diseases and genetic disorders (eg. diabetes among women from an Indian background, malaria among women from a Papua New Guinean background, thalassaemia among women from a Mediterranean background)
- Be aware that certain traditions may be associated with a higher risk of birth anomalies (eg. consanguinity)
- Provide a professional interpreter to discuss antenatal testing
- Establish whether each test, including its benefits and risks, is understood by, and acceptable to, the individual woman
- Provide information about antenatal testing in the woman's own language
- Before conducting the test, ensure that the woman understands the implications and possible interventions indicated by the result (eg. elective abortion). If she does not intend to consider interventions regardless of the outcome, the procedure may be unnecessary
- Be flexible when making appointments for investigations – remember that some dates may be unacceptable due to religious or cultural considerations
- Respect a woman's decision not to undergo a test
- Suggest genetic counselling.

References

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■ FEMALE GENITAL MUTILATION

Background information

Definition

Female genital mutilation (FGM) comprises all procedures involving partial or total removal of the female external genitalia, or other injury to the female genital organs, whether for cultural and other non-therapeutic reasons.

Terminology

Many terms exist for describing FGM, including female genital procedures, genital cutting, circumcision, traditional cutting and ritual female surgery. The term 'female genital mutilation' may offend those affected, so clinicians should use more culturally sensitive terms during consultation, such as traditional cutting or female circumcision.

Types of FGM

FGM and its effects can vary depending on the type of procedure and the age at which it is conducted. There are four types of FGM:

- Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy or suna)
- Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision)
- Type III: Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation)
- Type IV: All other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping and cauterization.

Reasons FGM is performed

FGM is usually performed during infancy or childhood. The reasons communities give for performing FGM include maintaining cultural heritage, initiating girls into womanhood, promoting the girl's chance of marrying, promoting hygiene, providing aesthetic appeal, and enhancing fertility.

FGM is not mandated or condoned by Islam or Christianity, and does not have any religious grounds or health benefits. Some Muslim communities mistakenly believe that FGM is an Islamic practice, when in fact FGM pre-dates Islam.

Female Genital Mutilation is increasingly an issue for health service providers in Queensland, as the number of women affected by FGM who are accessing health services continues to grow.

FGM is performed in a wide range of countries. Women settling in Queensland who may be affected are usually from Africa (including Egypt, Eritrea, Ethiopia, Liberia, Somalia, Sudan, Tanzania) and the Middle East and Asia (including Iraq, Oman, Pakistan, Syria, United Arab Emirates, Yemen).

FGM is often performed with unsterilised instruments by people with no medical training. The same instruments are often used on more than one girl at the same time, increasing the risks of contracting HIV and STIs.

FGM is a complex issue and women affected by FGM need to be dealt with sensitively and in a culturally appropriate way.

FGM is a procedure which involves partial or total removal of the external genitalia or other surgery to genitals (including infibulation) for cultural and other non-therapeutic reasons.

FGM is illegal in Queensland. FGM should not be performed irrespective of the apparent persuasiveness of any individual case.

Health issues

The impact of FGM varies depending on age and the severity of cutting. The effects continue throughout a woman's life.

Immediate impact of FGM

- blood loss
- shock, death
- joint dislocations as a result of physical restraining
- infection
- an increased risk of HIV transmission.

Long term impact of FGM

- ***Psychological issues*** The traumatic memories are associated with the pain at the time of the excision of the clitoris and/or infibulations and physical restraining. Other long term psychological issues include post-traumatic stress disorder, anxiety and depression.
- ***Bodily functions*** Urinary infections, renal problems and vaginal infections because of fistulas, resulting in pain, unpleasant discharge and obvious odour. The odour, including urinary and faecal leaking, can cause profound embarrassment, marginalisation and isolation. Women who have been infibulated take a long time to urinate (up to 20 minutes), and the amount of time they spend on the toilet, in contrast to other women, may cause comments and embarrassment.
- ***Vaginal introitus*** Women are usually left with a very small vaginal opening when they are infibulated, which inhibits menstrual flow, urination, sexual intercourse and child birth.
- ***Menstrual flow*** The vaginal opening may be too small for menstrual flow. As a result, some women develop haematomas, where menstrual blood is retained and forms a mass inside their vagina. They are likely to experience infection and strong odour, and require medical intervention to remove the compacted dried blood.
- ***Sexual function*** Sexual function can be inhibited and painful. Although some women report that only part of their clitoris is excised, and that they are able to experience sexual pleasure, this is not true in all cases and many women experience reduced sexual desire. In addition, first sex can be very painful as the partner may need to break through the infibulated tissue, which is often thick because of scar tissue.

Risks during pregnancy and labour

- Pelvic examination may be difficult, painful or impossible
- Without opening the birth canal, there is an increased risk to both a woman and her unborn infant because the infant's head has to force through the sutured labia and thickened perineal tissue, and childbirth might take a longer period of time
- Foetal distress may not be monitored as quickly (eg. through meconium staining), and any complication at time of delivery will necessarily require caesarean section.

De-infibulation

- De-infibulation is a practice of removing stitches and scar tissues to re-open the vaginal opening. This procedure is performed before marriage (premarital de-infibulation, prior to first intercourse), during pregnancy (antenatal de-infibulation) or at the time of labour (intrapartum de-infibulation).
- When pregnancy is established and the need for de-infibulation for childbirth is identified, it is best done antenatally in the late mid-trimester. Antenatal de-infibulation allows easier pelvic examination, facilitates vaginal delivery, and minimises tearing and/or the need for an episiotomy at the time of delivery.
- Discussions regarding de-infibulation should begin early in the antenatal care and a plan should be formulated with the woman about how and when this will occur. Using pictures can facilitate effective communication about de-infibulation. The woman's partner should be involved when discussing the de-infibulation plan as in most cases, the man is the decision-maker in cultures which practice FGM.

Re-infibulation

- Re-infibulation, or re-suturing, is a term used for a procedure to restore genitalia of de-infibulated woman to the state that they were before de-infibulation.
- Some women may request to be re-infibulated after childbirth and discussions regarding the illegality and health impact of re-infibulation should occur early in the antenatal care period.
- **Re-infibulation is illegal in Australia.**

Social risks

- With migration to Australia, health problems caused by female genital mutilation can result in disruptions to school attendance and consequently poor results, and can compromise the future employment of women.
- Women may face pressure from their communities to have FGM performed on their daughters and may be ostracised if they do not. There is anecdotal evidence that mothers may take their daughters back to their country of origin for FGM to be performed.

Perspectives to consider

- Women affected by FGM:
  - may feel stigmatised
  - may feel embarrassed to discuss FGM
  - may be afraid of vaginal examination (usually prefer a female doctor)
  - will want to be asked about the involvement of extra staff or students in their health care
  - may not differentiate between episiotomy and de-infibulation
  - will want to know what to expect after de-infibulation
  - may be concerned with insufficient episiotomy, and believe that restrictive cutting may increase the hardship of birth and demand too much pushing
  - may request significant cuts (episiotomy) to be done to avoid extensive tearing and prolonged labour
  - may fear that a caesarean section as a surgical procedure is associated with many risks
  - may believe that Australian doctors perform caesarean sections for all women with FGM
  - may not believe that the Australian health system knows how to provide care for women who have had FGM
  - may not feel comfortable with a team of doctors undertaking examinations.

- Health professionals dealing with women affected by FGM:
  - may be concerned that pelvic examination is sometimes difficult, painful or impossible
  - may worry about the lack of experience in providing health care to women who have undergone FGM (you can contact Family Planning Queensland for free cultural consultancy or support on 07 3250 0240)
  - may express the need to increase their competence in dealing with women with FGM
  - will want to know how to take a meaningful history (asking the right questions)
  - may regard FGM as a form of female oppression
  - may express feelings of sympathy and pity for the woman, often combined with anger
  - may describe dealing with infibulated women as being emotionally and ethically difficult
  - may want to be silent and avoid discussions regarding FGM matters with a woman as their expression of respect for what they perceived to be a taboo subject in practicing cultures
  - may pretend that nothing is wrong, or experience disengagement from the woman
  - may find deliveries challenging – technically, emotionally, and ethically.

Current Australian and Queensland Health policies and legislation

FGM is prohibited by specific legislation in most states and territories, and in New Zealand. Queensland Health also has provisions for the mandatory reporting of children at risk. All Queensland Health employees are obligated to report FGM or the risk of FGM to the Department of Communities (Child Safety).

Legislation

- FGM contravenes both international law and the laws of most countries, including Australia. Under section 323A of the Criminal Code Act 1899 (QLD), it is illegal to perform and/or remove a child from Queensland for the purpose of FGM. Legislation has been introduced because of the harmful effects of FGM, which should not be performed by doctors, regardless of the apparent persuasiveness of any individual case.

- Under section 323A of the Criminal Code Act 1899 (Qld) any person who performs FGM on another person is guilty of a crime. The crime carries a maximum penalty of 14 years imprisonment. It is not a defence that the other person, or, if the other person is a child, a parent or guardian of the other person, consented to mutilation.

- It is also illegal to remove a child from the State for FGM (section 323B). Any person who takes a child from the State, or arranges for a child to be taken from the State, with the intention of having FGM performed on the child is guilty of a crime. The maximum penalty is also 14 years imprisonment. In the absence of proof to the contrary, it is to be presumed that a person took a child, or arranged for a child to be taken, from the State with the intention of having FGM performed on the child if it is proved (a) the person took the child, or arranged for the child to be taken, from the State, and (b) FGM was performed on the child while outside the State.

- The legal implications of performing FGM or taking children out of Australia for the purpose of FGM should be explained to the woman and her partner.

Policies

- Queensland Government Multicultural Policy
- Queensland Health Multicultural Policy Statement
- Queensland Health Strategic Plan for Multicultural Health

Culturally responsive health care should be provided to women already affected by FGM. The Queensland Government is committed to fostering an inclusive, cohesive and open society and Queensland Health is committed to providing culturally appropriate and sensitive health care.

Queensland Health's current response to FGM

- In Queensland, current measures are directed towards the prevention of FGM through community education, information (in different languages) and support undertaken by Family Planning Queensland.
- Queensland Health has a number of local responses to working with women affected by FGM and is currently identifying appropriate support for clinicians to facilitate a culturally-competent and consistent approach to working with women who have experienced FGM.
- To facilitate the provision of appropriate care, Queensland Health staff are encouraged to inform themselves about the health issues related to FGM. Health practitioners are recommended to seek culturally informed assistance through a major teaching centre, such as the Royal Brisbane and Women's Hospital, or the Queensland Health Multicultural Program if encountering difficult issues when caring for women affected by FGM.

Queensland Health's child protection response

- **Identification and monitoring of girls at risk of FGM**
  This involves having an awareness of possible risk indicators that identify girls who, due to their cultural background, may be potentially subject to FGM. Educative and supportive responses need to be considered in these instances.
- **Response for girls who are at imminent risk of any form of FGM**
  Health professionals may become aware of girls who are about to be subjected to FGM. This may be as a result of a direct disclosure or information from other sources. An immediate report of suspected child abuse and neglect to the Department of Communities (Child Safety) would need to be initiated by the health professional in this instance. Supportive and educative responses should also be offered to the child and family.
- **Response for girls who have recently experienced FGM**
  Suspected child abuse and neglect should be immediately report of to the Department of Communities (Child Safety) should be initiated by Queensland Health on receipt of information about a girl having undergone FGM. The provision of support, education and a medical assessment should be considered in these circumstances.
- **Resources**
  Queensland Health Protecting Queensland Children: Policy Statement and Guidelines on the Management of Abuse and Neglect in Children and Young People (0–18 years) available at: http://qheps.health.qld.gov.au/csu/home.htm
  Child Safety Unit fact sheets 4.15 and *5.6* available at: http://qheps.health.qld.gov.au/csu/Factsheets.htm

Further information and skills
If you have any questions, or wish to develop skills in dealing with women affected by FGM, contact Family Planning Queensland on 07 3250 0240, 07 3250 0250 or http://www.fpq.com.au.

■ CULTURAL ISSUES IN GROUP PARTICIPATION

Women unfamiliar with the Australian health system may not be familiar with education or support groups. In Australia, reproductive health education and skills development are part of the antenatal and postnatal care system. Many hospital and community groups provide group based programs aimed at pregnant and postpartum women.

Benefits of group participation

- Improved knowledge of pregnancy, birth and postpartum issues, increased knowledge of family and reproductive rights in Australia, improved knowledge of health services in Australia.
- Improved skills in pain management during childbirth, relaxation, infant care, breast care, pelvic floor exercising. Women may also benefit from improved healthy cooking and weight management.
- Increased social interaction and peer support, including the prevention of puerperal depression.

Women from a CALD background may be unable or unwilling to use education or support groups. Their participation can be affected by:

- resettlement issues
  - New immigrant and refugee women may give less priority to reproductive health and health education programs, including group sessions, because they are often preoccupied with other issues, including obtaining visas, gaining employment, housing, learning English and applying for citizenship.
- transport problems
  - Some women may find it difficult to travel by themselves due to lack of relevant skills and experience with travelling alone in a new environment. They may need a family member to accompany them, but they may not always be available.
  - Limited access to transport may also influence a woman's decision to participate in group activities.
- financial problems
  - In addition to transport costs, course fees may be a barrier to attending group activities.
- existing parenting and caregiving responsibilities
  - Some women may be unable to participate because of existing parenting and caregiving responsibilities. The situation could be exacerbated if a woman is unaware of services provided to caregivers in Australia, or their eligibility.
- an absence of interpreting services
  - A lack of interpreting services for many group activities may prevent women with poor English skills from participating.
- poor English language skills
  - Some women may experience difficulties with understanding the spoken language, and be embarrassed to participate due to poor English language skills.

- low literacy levels
  - Low literacy and perceived inability to understand medical information may impact on a woman's decision to attend group education classes. Some women may perceive group activities as unimportant if they are unaware of the benefits.
- a lack of similar services in the woman's country of origin
  - An absence of relevant group activities in the woman's country of origin may influence their acceptance of such services in Australia.
- religious and social taboos
  - Some women may find group activities culturally unacceptable because discussing pregnancy and birth in public is a taboo. They may feel embarrassed to talk about reproductive health in the presence of other people.
- feelings of otherness
  - Women who have undergone female genital mutilation (FGM) may perceive themselves as different from other women. They may not participate because of embarrassment and fear of being misunderstood.
- a preference for one-to-one education and counselling
  - In some cultures, women may prefer one-to-one education and counselling to group activities.
- the composition of the group.
  - Women may be reluctant to participate in group activities due to the ethnic composition of the group (eg. Serbian and Bosnian Muslim women in one group).
  - Women may also feel that they have nothing in common with other group members (including Anglo-Australians), and so feel reluctant to attend.

Strategies to increase group participation by CALD women

- Clearly explain what is expected during group activities, which topics will be discussed, which skills will be practised, and what benefits could be attained.
- Encourage women to participate by engaging the woman on an informal basis and listening to the reasons for not participating. It is important to build trust to reduce the barriers to communication.
- Verify if there are any taboos regarding speaking about pregnancy and reproductive health in public.
- Link the potential group participants to carer support organisations and services (eg. respite care) to allow them to meet their care giving responsibilities at the time of group activities.
- Be sensitive to the woman's preference to not attend group education. Replace this activity with one-to-one education and counselling sessions, if possible.

■ PSYCHOLOGICAL AND SOCIAL ISSUES RELATING TO PREGNANCY AND EARLY PARENTHOOD

This section examines the cultural manifestations and management of puerperal depression, reproductive loss and grief.

Puerperal depression

- Puerperal depression refers to all depressive illnesses that occur during pregnancy (prenatal depression) and immediately after birth (postpartum depression).
  - Approximately 14% of women experience puerperal depression
  - Postpartum 'blues' is a common phenomenon that occurs three to five days after labour and is experienced by 80% of women
  - Postpartum depression is experienced by approximately 16% of women
  - Postpartum psychosis is experienced by approximately 0.1% of women
  - There is limited data available about postnatal depression in developing countries, or among immigrant women.

Risk factors for puerperal depression

- Personal history of depression
- Lack of partner, family and social support
- Abusive relationship or experience of childhood abuse
- Unplanned pregnancy
- Teenage pregnancy
- Reproductive loss
- Stressful life events, chronic stressors and financial difficulties
- Pre-immigration experiences
- Social isolation
- Lack of access to mental health services or support
- Reluctance to talk about stressors of mental health.

MENTAL HEALTH STRESSORS	POSSIBLE PSYCHOLOGICAL REACTIONS
Pre-immigration experiences	▪ Psychological issues related to past experiences of war, displacement, rape, torture, survival in refugee camps, death of close relatives ▪ Post-traumatic stress disorder (fear, nightmares, lack of control over a situation, depression, hopelessness) ▪ Powerlessness over decision to migrate
Adjustment	▪ Stress related to the loss of job, housing, financial problems, lack of English language skills, lack of knowledge and skills for everyday activities, stress related to lack of knowledge of services
Wellbeing of overseas family	▪ Feelings of guilt for not contributing enough to family overseas ▪ Family members may be missing or living in difficult or dangerous circumstances
Lack of knowledge of antenatal care system and birthing practices	▪ Fear of difference in health care and birthing practices in host country ▪ Inability to navigate the health system due to cultural or language barriers
Traditional beliefs	▪ Fear of illnesses due to not practicing traditional practices ▪ Fear of being cursed by overseas relatives ▪ Fear to displease relatives and/or ancestral spirits ▪ Adjustment stress due to practicing traditional practices
Female genital mutilation	▪ Stigma, feeling different from others, fear of potential procedures, lack of voice ▪ Confusion. Some women feel proud of being circumcised. When entering western culture, the woman may feel different or incomplete and this may impact on mental health.
Antenatal testing, genetic counselling	▪ Fear of tests, lack of choice about continuing or terminating a pregnancy due to religious beliefs
Sex preference	▪ Negative emotions linked to having a female foetus, lack of choice about continuing or terminating a pregnancy due to family pressure
Arranged/early marriage, unwanted/unplanned pregnancy	▪ Hopelessness, lack of personal voice, lack of choice about continuing or terminating a pregnancy, lack of choice about remaining married, or separation or divorce due to family pressure and religious beliefs
Inflicted violence	▪ Post-traumatic stress disorder (fear, emotional distress, lack of control, frequent use of psychotropic medication)
Lack of support	▪ Loneliness, isolation, nostalgic feelings, burden of care for the newborn infant, lack of extended family support in Australia
Lack of knowledge and skills to care for new born child	▪ Fear that the infant might die due to inadequate care, anxiety and fear that something is not right with the infant, self-blame for inadequate care, fear of reactions to immunisation
Breast feeding problems	▪ Stress related to insufficient lactation, fear that the infant is hungry, stress related to introducing formula and solid foods

Diagnosis of puerperal depression
Antenatal screening questionnaires that have not been validated cross-culturally should be used with caution.

- The following signs may alert the health practitioner that a woman has postnatal depression:
  - lability of moods
  - weepiness
  - tension and irritability
  - panic attacks, with symptoms of tachycardia, hyperventilation and faintness
  - exhaustion with increasing sleep problems above and beyond the demands of the baby
  - self-blame and low self-esteem
  - frequent complaints of headaches, abdominal pains and breast tenderness with no adequate physical cause.

  (Adopted from Dunkley, 2000: 175)

In some cultures, the shame and the stigma associated with mental illness, the absence of appropriate words to describe psychological conditions during pregnancy, the inability to associate depression to mental illness due to a lack of mental health awareness, and early parenthood may lead to somatising of puerperal depression.

Management of puerperal depression
Current management of puerperal depression is focused at developing coping skills in women through antenatal and postnatal education.

- The main approaches aim to:
  - prevent or reduce the symptoms of postnatal depression and self awareness
  - improve maternal functioning in terms of self-esteem, assertiveness and coping
  - address marital and partner difficulties
  - deal with parent-infant difficulties
  - establish social networks.

Postnatal depression support in Queensland

Lifeline	13 11 44
Parentline	1300 301 300
Belmont Private Hospital	07 3398 0238
The North Queensland Postnatal Distress Support Group	07 4728 1911
Women's Information Link	1800 177 577
Women's Health Queensland Wide	1800 017 676
Royal Brisbane and Women's Hospital	07 3636 8111

Breastfeeding and parenting support in Queensland

- The Australian Breastfeeding Association offers antenatal and postnatal breastfeeding education, parenting support and social support.
- Community child health services provide free breastfeeding clinics and support. Some lend mothers breast pumps.
- Queensland Health maternity services offer pregnant women universal antenatal screening for key risk factors such as tobacco, alcohol and other drug use, psychosocial issues and depression under the Universal Postnatal Contact Services (UPNCS) initiative. This initiative includes the establishment of a number of newborn and family drop-in services around the state to provide advice and support for new parents on a range of parenting, infant feeding, developmental and other issues in the first eight weeks after birth.
- The Child Health Line has been integrated with 13 HEALTH, to provide 24 hour, seven day a week telephone access to health professionals on parenting, infant and child health matters.

Practical advice in dealing with puerperal depression

- Be sensitive to cultural differences in understanding or relating to mental health issues. While providing your explanation of puerperal depression, replace terms such as 'mental illness' or 'postnatal depression' with 'pregnancy-related psychological condition' or 'birth-related emotional condition'.
- Acknowledge and explain to the woman the role of various factors that may contribute to puerperal depression.
- Reassure the woman that prenatal and postnatal depression is common.
- Discuss the potential consequences of puerperal depression with the woman.
- Discuss the current approaches to the management of puerperal depression.
- Provide printed information about puerperal depression, preferably in the woman's first language. A booklet *Emotional Health during Pregnancy and Early Childbirth*, which has been translated into several languages, is available for download from the *beyondblue* website at: www.beyondblue.org.au/index.aspx?link_id=102.944.
- Attempt to arrange home visits by maternal and child health nurses.
- Help the woman to establish a connection with existing health and social support services (eg. postnatal depression support group, breastfeeding group, marital counselling).
- Ask the woman if she would like to receive support from a mental health professional (eg. face-to-face professional counselling, telephone helpline).
- Provide the woman with the contact details of the *beyondblue* info line (1300 224 636). Inform the woman that for the cost of a local telephone call, she can access information and referral to relevant services for emotional health related matters.
- Try to elicit potential reasons for refusing psychological support.
- If necessary, refer the woman for a psychiatric consultation.

If you have any questions or require additional information, resources or clinical consultation services, contact the Queensland Transcultural Mental Health Centre on 1800 188 189 (in Australia, outside the Brisbane metropolitan area) or 3167 8333 (in the Brisbane metropolitan area).

Reproductive loss and grief

Reproductive loss includes:

- miscarriages, foetal deaths in utero and stillbirths
- abortions.

In most cases abortions are planned and wanted by women. However, women still may experience grief related to the termination of pregnancy.

Cultural variations in grief expression

Expressions of grief in western culture can include:

- personal feelings - sadness, anger, guilt, anxiety, and helplessness
- physical sensations - shock, hollowness in the stomach, tightness of the chest, weakness of the muscles
- cognitions - confusion, disbelief
- behaviours - sleep disturbances, crying, social withdrawal.

Women from a CALD background may express their grief differently. This will be influenced by many factors including cultural and religious backgrounds, stage of the pregnancy and their personal reproductive situation.

In addition to crying, grieving people may shout, bite their hands and fingers, tear out or cut their hair, jump, rock backward and forwards, or sit in a corner with their eyes closed. In some cultures, grieving people may attempt to vomit. Self harm is an extreme psychological reaction (eg. people may cut their veins or attempt suicide), and is a pathological reaction to grief.

In some cultures, people mourn for their deceased children less than they mourn for deceased adult relatives. In most societies, women are expected to mourn longer and deeper than men. Men are expected to be strong and not to show their emotions linked to grief.

Gender variations in grief expression

Women usually experience greater grief to reproductive loss than men, particularly at the time of the loss. Women may cope with the reproductive loss better if they have opportunities to express their reactions to grief.

Men usually react to reproductive loss differently to women; men often internalise their feelings. They may pretend that nothing has happened, blame themselves for the lack of care they provided to the pregnant woman, feel the loss of their expected fatherhood status, or try to work extensively to occupy their time and to provide support to the grieving woman.

Reproductive loss is a severe trauma to both partners, and both partners require psychological support. Some couples may develop post traumatic stress disorder related to reproductive loss, particularly if the grief was unresolved. The next pregnancy may be a time of high stress and anxiety to the couple.

Accessing psychological support

Unresolved parental mourning may result in psychosocial problems and vulnerability to future losses and crises. Timely psychological support may reduce the duration of mourning.

Generally, immigrants are less likely to seek psychological support than Australia-born people, even if they have multiple psychological stressors related to immigration and adjustment.

Reasons why immigrants may not seek psychological support include:

- the stigma associated with mental health issues
- a lack of knowledge of mental health services
- a lack of familiarity with psychological services
- mistrust of psychologists and psychiatrists based on experiences in their country of origin
- believing that all required support will be provided by a medical practitioner
- viewing mental health issues as family issues and not a condition that can be treated by a health professional
- dealing with psychological issues in a culturally or religiously specific way (prayers, healing services, special ceremonies).

Disclosure of bad news	**Example of cultural variations in disclosing bad news**
Health professionals should elicit culturally sensitive ways of disclosing bad news at the beginning of antenatal care.	In some cultures, bad news should not be disclosed directly to the person. Some cultures may also have some preferences regarding the time of disclosure of bad news. For example, in Ethiopian and Eritrean culture, the death of close relatives is not disclosed directly to the person, or over the phone. Distant relatives or friends are usually contacted first. Then, in the evening, these friends and relatives gather together in the house of the person whom they plan to communicate bad news. They prepare food, eat together with the person whom they plan to inform, and then, they disclose the bad news. All relatives provide emotional support to the grieving person, and they give them a night to grieve and to sleep.

Communicating reproductive loss: practical advice

- Explain in simple language
- Allow time for grief
- Encourage expression of emotion
- Be aware of, and respect, cultural variations of mourning
- Be aware of individual variations of mourning (eg. do not assume that a quiet person experiences less grief)
- Remember that some mourning people may be dissatisfied with health services and blame health professionals without reason (be patient and consider their grief and shock)
- Access cultural consultancy services through Family Planning Queensland or your district multicultural health coordinator
- Reassure the woman that mourning is normal
- Pay attention to the father's grief as well
- Promote open communication between the couple
- If desired, communicate or allow communication with other family members
- Propose to discuss the cause of the infant's death or miscarriage and encourage questions
- Ask the couple if they want to see or hold the stillborn infant
- Ask the couple if they would like to name the stillborn infant
- Discuss with the couple if there are any traditional or religious rituals or ceremonies that should be observed
- Ask the couple if they would like support from a mental health professional (face-to-face professional counselling, telephone helpline). You may need to explain the benefits of using these services
- Try to elicit potential reasons for refusing psychological support
- Refer the woman for a psychiatric consultation with a psychiatrist, preferably of the same cultural background (contact the Queensland Transcultural Mental Health Centre on 1800 188 189 for assistance)
- Encourage early contact with the general practitioner
- Suggest booking an appointment in case the couple might have additional issues to discuss
- If the couple is in a state of denial, reassure them that mental health support is available to them whenever they wish
- Respect a woman's or a couple's decision not to seek mental health support, as many people prefer coping with grief in a personal manner
- If available, provide printed information (eg. booklet, pamphlet) about grief, preferably in the woman's or couple's own language
- Pay attention to your own mental health and stress levels. Always maintain a separation between your own values and those of the client.

If you have any questions or require additional information, resources or clinical consultation services, contact the Queensland Transcultural Mental Health Centre on 1800 188 189 (in Australia, outside the Brisbane metropolitan area) or 3167 8333 (in the Brisbane metropolitan area).

CULTURAL PROFILES

- The following cultural profiles have been developed to support clinicians to enhance their service delivery to women from a culturally and linguistically diverse (CALD) background.

- There are risks in summarising particular cultural issues that could be important in the provision of health care. There is enormous diversity in populations of all cultures. In all societies, there are sub-cultures, and important differences between rural and urban groups, and among different classes and genders. Even within these groupings, individuals can vary to the extent that they believe in or adhere to particular cultural practices.

- The inclusion of cultural profiles does not aim to provide clinicians with a list of ready-made rules for working with different cultural groups – this would be antithetical to individualised and good quality care. Rather, the aim is to highlight some possible areas of difference and provide a demographic overview of the cultural community in Queensland.

- The main point to remember is to maintain respect for other cultures and their practices.

- Revealing some awareness of cultural issues shows interest, concern and respect. This is likely to enhance rapport with your patients, as long as you do not assume that you know what they think and believe. Ask your patient: she is her own cultural expert.

- Clinicians should also be aware of their own cultural assumptions and of the culture of hospitals and bio-medicine, as well as its impact on people for whom this is unfamiliar.

- The following profiles are included in this chapter:
  - Burmese
  - Chinese
  - Fijian
  - Filipino
  - Japanese
  - Indian
  - Malaysian
  - Papua New Guinean
  - Samoan
  - Sudanese
  - Vietnamese

For more health profiles, go to
www.health.qld.gov.au/multicultural/health_workers/cultdiver_guide.asp.

BURMA: KAREN, CHIN AND ROHINGYA ETHNICITIES

Communication

- Karen and Chin people are usually more traditional than other Burmese people, as many are from rural tribes and view themselves as different from other Burmese. Karen and Chin people may not be comfortable with a Burmese interpreter and may need a Karen, Chin or Falam Chin interpreter.
- Karen people regard not imposing on others, or being quiet or less talkative as positive traits. Rohingyans, who are the most recently arrived group in Queensland, tend to be shy and not very outspoken.

Patients from Karen background may not be comfortable questioning doctors or expressing dissatisfaction with their treatment. Health care providers should ask open-ended questions and allow the opportunity for Karen patients to follow up with additional questions about their healthcare.

- An impersonal approach at health visits may lead to mistrust and less than optimal outcomes. A warm, personal yet business-like approach is far more effective. All health encounters should address the issue of understanding, capacity and related compliance with treatment issues. Generally, patients consult with members of their own community about health-related matters.
- Karen people are addressed by their given names. Traditionally, they do not have family names. This can cause confusion when people are identified by last names. Married couples do not share the same name.

Health related beliefs and practices

- Like many others from South East Asia, Karen people may attribute illness to imbalance in natural forces, including wind, fire and water. Traditional health beliefs are related to an almost complete lack of medical resources for Karen living in Burma, isolated life in the mountains and rural areas, and animistic beliefs (belief that a soul or spirit exists in all objects, particularly in the natural environment). In Burma, Karen people are largely dependent on traditional medicines (eg. herbs) available in the mountains, and this may affect their familiarity with biomedical procedures.
- A concurrent strong belief in western medicine and traditional beliefs about health and illness is common among many Karen people.

Pregnancy

- Karen people are family oriented. There is a lot of respect for pregnant women, although pregnancy outside of marriage is frowned on. Pregnant women observe dietary restrictions and other taboos, including the avoidance of traditional spicy foods. Karen women in Thailand believe that every sight, sound, touch, taste or smell, every thought and action of the mother, has some effect on the foetus.

Health professionals should be aware of possible past sexual trauma.

- Karen, Chin and Rohingya people in Burma have often been subject to systematic human rights violations, including murder, rape, forced labour and torture, and have had limited access to maternity care.

Population in Australia: 12,376 people

Population in Queensland: 741 people

Population in Brisbane: 463 people

Gender ratio: 93.7 males per 100 females

Median age: 46.4 years

Age	%
0-14	3.3
15-24	8.6
25-44	35.1
45-64	33.8
≥ 65	19.2

The main languages spoken in Australia are Burmese, English and Karen. Minor dialects inlcude Rohingya, Chin and Falam Chin.

Two-thirds speak a language other than English at home. Of these, 78.2% spoke English very well or well.

Most are Christians; the majority practising Catholics. More recent immigrants are mainly Buddhists; some are Hindus or Muslims. In Australia, most of the Karen people are Christians and are from the east of Burma. The Rohingyans are from the west of the country and they are Muslims.

Two-thirds arrived in Australia prior to 1996. Recent refugee migration to Australia has occurred as a result of oppression under a succession of military regimes (internal displacement, forced labour, executions) and Burmese dominance over Karen, Shan, Rakhine, Mon, Chin, Kachin and other minorities.

Places of transition: Thailand, Malaysia, India and Bangladesh. Most Karen and Chin people immigrated from refugee camps in Thailand. Most Rohingyans arrived from refugee camps in Bangladesh.

The Burmese community in Queensland is well established, but there is a new and emerging community of families who arrived as refugees living on Brisbane's northside.

- Displaced Rohingya women, while living in refugee camps, were eligible for elementary maternity care at health centres. During antenatal visits, every pregnant woman was provided with a home delivery kit, including gloves, sheets and soap, to ensure the birth was as hygienic as possible. Women who lived in slums or informal settlements would not have had access to services, and they may doubt their eligibility for maternity services in Australia.

Birth

- There has been little research on traditional Karen and Rohingya childbirth practices.
- Karen women fear complications in childbirth, knowing this to be a common cause of death.
- To ease the birth, traditional midwives cast magical spells and conduct ceremonies to placate spirits, and traditional healers use special medicines prepared from *Euphorbiaceae* root.
- A study conducted with Karen women in a refugee camp revealed that home births with the use of traditional midwives was preferred over delivering in the hospital. Many women reported that shame was the main reason for avoiding hospital deliveries. For example, women reported shame with vaginal examinations, the exposure of their legs when they were not completely covered by a sarong, and the presence of male health staff. The comforts of family and friends were also key factors in preferring traditional delivery.
- Rohingya women in refugee camps in Bangladesh preferred childbirth to take place at home with the assistance of traditional birth attendants.

After birth

- Traditionally, Karen mothers sit by the fire for three days after birth. Hot water bottles, warm clothes and heaters may be used instead.

Infant care

- Infants born in Burma or refugee camps can be of low birth weight because their mothers may be malnourished or anaemic. Midwives should be aware of the possibility of low birth weight infants among recently arrived Karen and Rohingya refugee women.

Infant feeding

- Neonates of the Karen people are usually given a few grains of rice before introducing breast milk. This tradition is practiced to introduce infants to the food which they will receive after breast milk. Infants are generally breastfed. The risks of introducing prelacteal feeds to infants should be discussed.
- Infants may be breast fed for around three years, but the average period of breast feeding is one and a half years.
- In 2006, of the five Burma-born women who gave birth in Queensland Health facilities, at the time of discharge, three exclusively breastfed and two breastfed and formula fed.

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CHINESE ETHNICITY AND BACKGROUND

Languages spoken and primary place of origin

Mandarin	Cantonese	Hokkein	Hakka	Teo-chieu
PRC, Taiwan, Malaysia, Singapore	Hong Kong, PRC (Guandong), Vietnam, Malaysia, Singapore and Christmas Island	Malaysia, Singapore	Malaysia, Indonesia and Brunei	Thailand

Communication

- Social roles may influence interactions, because of the potential for 'loss of face'. Loss of face brings shame to the whole family.
- Chinese people may not talk about their problems, especially psychosocial ones, because they may assume that westerners will not understand their culture or experiences.

Avoiding eye contact, shyness and passivity are cultural norms for many Chinese people.

- Many people will avoid saying no because they consider it impolite.
- Open discussion about sexuality is often considered a taboo.
- A doctor of the same sex is preferred by most Chinese, especially women.

Health related beliefs and practices

- Health beliefs and profiles of the descendants of Chinese migrants who arrived a number of generations ago are often similar to those of Anglo-Celtic Australians.
- Food, illness and medications are usually classified as 'hot' or 'cold' according to the perceived effects on the body. Health is believed to be a balance of positive (yang) and negative (yin) energy in the body. Chi refers to the life force or energy in the body.
- Some Chinese may attribute illness to:
  - disharmony of body elements (eg. an excess of hot or cold foods)
  - moral retribution by ancestors or deities for misdeeds or negligence
  - cosmic disharmony, as 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, (ie. the impact of the natural and built environment on the fortune and wellbeing of inhabitants).
- Many people will use traditional Chinese medical treatments including acupuncture, acupressure and Chinese herbs. Dietary therapy and supernatural healing (eg. through a fortune teller, Feng Shui practitioner or temple medium) may also be used. Modern versions of traditional medicines are available through Chinese grocery stores in all major Australian cities.

Population in Australia: 206,588 people

Population in Queensland: 15,060 people

Population in Brisbane: 11,420 people

Gender ratio: 82.3 males per 100 females

Median age: 46.4 years

Age	%
0-14	3.5
15-24	22.9
25-44	37.2
45-64	24.5
≥ 65	12.3

The term Chinese includes diverse communities and individuals, sometimes having no more in common than ancestral heritage.

The main ethnicities of people born in China are Chinese and Russian.

Up to 65% of people speaking a language other than English at home are proficient in English.

Common religious affiliations include Buddhism, Christianity and Islam. Although, many people have no religious affiliation.

Places of transition: Brunei, Christmas Island (Australia), Hong Kong, Indonesia, Malaysia, New Zealand, Singapore, Taiwan, Thailand, and Vietnam.

Chinese settlement has taken place in Australia from the mid-19th century, with most people coming from southeast China (Guandong). Many Chinese in Australia are descendants of people who migrated here more than one hundred years ago. Over the past 20 years, Chinese people have arrived from Malaysia, Singapore, Hong Kong, Vietnam and elsewhere in Indochina. More recently, immigrants have arrived from Taiwan and the People's Republic of China.

Pregnancy

- Many Chinese people, when they are ill or pregnant, assume a 'sick role' in which they depend heavily on others for assistance. This means that some health care providers may be seen as uncaring because they encourage independence rather than catering directly to the wishes of the patient.
- Pregnancy and especially childbirth are believed to disturb the balance of hot and cold required for good health. Because of this, various dietary and behavioural practices are customary to keep the mother and baby physically healthy including:
  - eating special soups and chicken/chicken broth
  - not eating lamb because of the belief that it may cause the baby to have epilepsy (pronunciation of word lamb is similar to the word for epilepsy in some Chinese languages)
  - not eating pineapple because it is believed to cause miscarriage.

Birth

- Many Chinese people believe that a woman should not cry out or scream during labour.
- Women may experience distress if not given a choice between cultural traditions and western practices.
- Women may prefer sitting or squatting to give birth.
- Ideally, the labouring woman's mother or mother-in-law attends childbirth, rather than the father of the child. This practice varies among communities.

After birth

- Some women may observe a period of confinement after birth, during which they rest, dress warmly, limit showers, and eat only foods classed as hot. These ideas conflict with Australian medical ideas which recommend early ambulation and showering after birth. Staff may need to discuss the option of exercises to avoid deep vein thrombosis while in bed (eg. bending knees, moving legs).
- According to some customs in Guandong and Hong Kong, postpartum women may not eat with other family members for up to one month due to the notion of pollution linked to lochial discharge. For the same reason, postpartum women may abstain from sexual relations.

Infant care

- Women are often expected to follow certain traditional practices advocated by older female relatives. However, practical constraints mean that many Chinese women opt for an approach to child-rearing which combines practices from both Australian and Chinese culture.
- Infants may be over-wrapped and slept in prone position.
- Many Chinese people believe that infants should not be dressed in used clothing as the baby may take on the characteristics of those that wore the clothes previously. Therefore, the family may bring new clothing for the baby instead of dressing the baby in hospital clothing. Disposable shirts may be acceptable.

- Infants may be separated from their mother for at least the first 24 hours. This tradition is practiced to allow the postpartum woman to rest. The Australian practice of leaving infants with their mother should be discussed with women of Chinese background. The woman should be informed that the required infant care could be provided by health professionals if she wishes to rest.
- Some women believe that if a newborn child is praised, bad spirits will take the infant away or the child will fall ill.
- Grandmothers, particularly the father's mother, are often very involved with the new infant and the new mother's recovery. Their authoritative positions should be acknowledged when caring for the mother and during teaching sessions.
- The 'Mongolian blue spot' – a bluish pigmentation in the lumbo-sacral region – is common at birth among Indo-Chinese and other Asian babies, and persists until the age of 18 months or two years.

Infant feeding

- Colostrum may be considered stale or dirty and discarded. Staff may need to explain the benefits of colostrum feeding and encourage women to feed their infant.
- Babies may be fed with boiled rice water or formula instead of colostrum during the first two days.
- In 2006, of the 282 Chinese-born women who gave birth in Queensland Health facilities, at the time of discharge, 68% (193) exclusively breastfed, 24% (67) breastfed and formula fed, and 8% (22) exclusively formula fed.

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FIJIAN ETHNICITY AND BACKGROUND

This profile relates to Melanesian Fijians – not Fiji-Indians who comprise 56% of Fiji-born people in Australia. Melanesian Fijians comprise 19% of Fiji-born people in Australia. For information about the Indian background, refer to the Indian profile.

Communication

- A handshake and saying *bula* (hello) is the traditional Fijian greeting.

It is important not to touch a Fiji-born person on the head as to do so is considered an insult. If you do need to touch a Fijian's head it is vital you explain why and excuse yourself for having to touch.

- It is inappropriate to walk in front of someone (especially if you are standing and they are sitting down), but if you accidentally do so, it is important you lower yourself to their height and say *tu lou* (excuse me).

Health related beliefs and practices

- It is common for Fiji-born people to tell good friends or family if they are in pain, but not if a stranger is present.
- Fiji-born people will accept medication and pain relief, if the health professional clearly tells the person the benefits.
- Instructions of health professionals will be followed if the health professional has developed a trusting relationship with the person.
- Fijian people are often less likely to participate in traditional healings due to Christian beliefs.

Pregnancy

- Motherhood elevates the status of a married woman; infertile women may be seen as wasting family resources.
- Use of antenatal care by Fijian women is relatively high.
- Unwanted pregnancy is considered a personal responsibility and is linked to moral failure of control and bad luck. It is not linked to failure in the use or effectiveness of contraception.

Birth

Almost all women (98%) in Fiji deliver in hospitals. However, NSW data indicates that Fiji-born women are less likely than Australia-born women to have their first antenatal appointment before 20 weeks.

After birth

- Postpartum women have relief from household duties and from work on plantations.
- In Fijian culture, it is important to support postpartum women and infants emotionally and materially. Women lacking social support could be at risk of postnatal depression. Postnatal depression is relatively rare among Fijian women, and may take a culturally sanctioned form of dissatisfaction with social support.

Information in this column relates to all Fiji-born Australians

Population in Australia: 48,150 people

Population in Queensland: 8,950 people

Population in Brisbane: 6,789 people

Gender ratio: 86.3 males per 100 females

Median age: 35.9 years

Age	%
0-14	5.5
15-24	12.8
25-44	45
45-64	29.7
≥ 65	7

The main spoken languages are Hindi, English, Fijian

Almost all Fijians are proficient in English

The Fiji-born comprise people of Fijian, Chinese, Indian, European, Rotuman and other ancestries

Religious affiliations: Hinduism, Islam, Christianity

The Fijian community is well established, with immigration from the mid-1950s.

Reasons for immigration to Australia included better employment, higher wages, and improved welfare services. Migration accelerated in post-independence (in the 1970s) and by 1986, there were 14, 749 Fiji-born people in Australia.

Following military coups and political unrest in Fiji in 1987, Australia received an influx of Fijian-Indians seeking asylum.

Infant care

- Traditionally, no special treatment is given to the stump of the umbilical cord, except applying some oil.
- It is believed that infants benefit from extensive material and emotional support provided by family and maternal relatives.
- Close relatives, extended family members and friends frequently share the provision of the infant's care.

Infant feeding

- Breastfeeding is usually prolonged.
- Fijians believe that breastfeeding is essential for a child's development. According to Fijian cultural norms, becoming pregnant during lactation is considered unacceptable and shameful. Pregnancy while still breastfeeding is believed to weaken the child, due to an insufficient period of breastfeeding.
- Bottle and mixed feeding are also popular. In Fiji, cans of infant formulas are often given to women as samples at the time of their visits to health centres.
- Solid foods are usually introduced from the age of four months.
- In 2006, of the 196 Fiji-born women who gave birth in Queensland Health facilities, at the time of discharge, 77% (150) exclusively breastfed, 15% (30) breastfed and formula fed and 8% (16) exclusively formula fed.

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FILIPINO ETHNICITY AND BACKGROUND

Communication

- The word 'Filipina' refers to women from the Philippines; 'Filipino' refers to people from the Philippines in general, or men in particular.
- Many Filipinos may be familiar with American English. They may not be as familiar with the Australian accent or Australian idioms.
- Tagalog (Filipino) is the national language. Filipinos also speak a number of other languages; the most common are Ilocano and Visayan. A Visayan dialect, Cebuano, is widely spoken among the Filipino communities in Australia.
- Doctors and nurses are generally highly respected for their knowledge, education and expertise and few Filipinos will question them.
- Filipino people, especially from rural areas, may not like to voice their concerns to health professionals.

Filipinos generally consider it impolite to stare or look directly at people with whom they are talking. This should not be mistaken for mistrust or lack of confidence.

- An important cultural value of Filipinos is hiya, which can be translated roughly 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 they may be very careful of the feelings of others.

Health related beliefs and practices

- In the Philippines, biomedical services may be supplemented by herbalists and other healers who specialise in herbal remedies, massage or healing by spiritual means, through power derived from devotion to Christian saints.
- People may use the concepts of 'hot' and 'cold' to classify and explain illnesses. Foods, medicines and temperature/weather conditions are classified according to their hot or cold qualities 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 can differ substantially. Bathing can be associated with a draining of strength from the body, particularly if a person is already ill.

Pregnancy

- Women often have children within a year of getting married in Australia.
- According to some Filipino beliefs, cravings for food during pregnancy should be satisfied.
- Some pregnant women may avoid eating black foods to avoid the birth of an infant with a dark skin tone.
- Some pregnant women may place great emphasis on being tidy and beautiful, believing that these practices will influence the beauty of their child.
- Unpleasant emotions experienced by pregnant women may be blamed for causing birthmarks.

Population in Australia: 120,539 people

Population in Queensland: 18,705 people

Population in Brisbane: 9,870 people

Gender ratio: 54.8 males per 100 females

Median age: 40.3 years

Age	%
0-14	7.1
15-24	13.4
25-44	40.9
45-64	33.6
≥ 65	4.9

The main languages are Tagalog, Filipino and English

Most Philippines-born people who speak a language other than English at home are proficient in English

Most Philippines-born people in Australia are Christian, primarily Catholic and Pentecostal

A high proportion of migrants have come to Australia to marry Australians or to join Australian husbands. Others migrated to join family members, or to escape political oppression under the Marcos regime. Many of those in this latter group have been sponsored to come to Australia by relatives.

The Filipino community is well established. There are many ethno-cultural and religious community organisations operating in the state. The Filipino Community Council of Queensland is the peak body for Filipino community organisations.

Birth

- The most common birthing position is to lie down. Some women may prefer a squatting position.
- In some regions of the Philippines, it is believed that putting squash leaves on the abdomen of a labouring woman can facilitate labour.
- Some women believe that drinking coconut water can facilitate a fast labour.
- Some fathers may prefer to be close to their labouring wife, so they can bury the placenta.

After birth

- In some regions a father is responsible for the burial of the placenta. He usually buries the placenta very quickly, because the burial of the placenta indicates the end of the labour, and therefore the end of pain and blood loss experienced by the labouring woman. The placenta should be offered to the postpartum woman or the father.
- Traditional custom in the Philippines dictates that women should not bathe for about ten days after giving birth and during menstruation. Bathing during these times is seen as a cause of ill health and rheumatism in old age. Sponge baths and steam baths could be used as alternatives. Women may object to having a shower immediately after giving birth.
- Traditionally, after labour, women wear heavy clothes or wrap themselves in blankets to prevent exposure to 'cold' and 'wind'.
- Some Filipinas bind their abdomen tightly, believing that this practice helps to prevent bleeding and helps the uterus to retract.
- New and lactating mothers are often given rice porridge (rice boiled soft to a consistency halfway between soup and puree). This may be served with sweet, salty or spicy accompaniments. Soup made of meat and vegetables is also believed to help promote lactation.
- Women fear what is referred to as a 'relapse' if they become active too soon. This involves extreme tiredness, weakness and chronic headache.
- In the Philippines when a woman has a baby, she usually rests while her relatives do all the housework and cooking. Many women can have difficulty coping with the daily routine of looking after a baby in a country where they may not have the support of an extended family.
- Postpartum women may be massaged with coconut oil, with the aim of restoring their lost health, expelling blood clots from the uterus, returning the uterus into a normal position, and promoting lactation.
- Some women perform various practices for the purpose of 'drying out' the womb. For example, 'mother roasting' can involve lying beside a stove for up to 30 days, squatting over a burning clay stove, sitting on a chair over a heated stone or a pot with steaming water, or bathing in smoke from smouldering leaves. In Australia, these practices may be replaced by hot water bottles and placing a postpartum woman close to a heater.

Infant care

- Infants and small children are thought to be susceptible to fright, which causes crying and trembling. A traditional belief is that an infant may be hexed by an admiring glance, but many Filipinos in Australia are likely to be ambivalent or doubtful about such beliefs.
- Colds and rashes may be accepted as natural in young children, although some may be regarded as serious. In rural Philippines, women will often take a child with a cough to a traditional healer. Filipino women should be educated to contact health services if they notice any unusual symptoms.
- Traditionally, parents sleep with their children or have their children sleep with another relative, and do not separate them when they are ill.

Infant feeding

- Colostrum is usually considered 'dirty milk' and discarded. Some women may be reluctant to feed colostrum to their newborn, despite encouragement by health professionals.
- Breast feeding on demand is normal practice for rural Filipinas. Women may adopt mixed feeding because of the demands of work outside the home.
- Some mothers believe that a mother's mood can be transmitted through breast milk and therefore do not feed if they feel sorrow or anger. Breast feeding may also cease if the child contracts diarrhoea, in case the illness becomes worse.
- Of the 459 Philippines-born women who delivered in Queensland Health facilities in 2006, at the time of discharge, 78% (358) exclusively breastfed, 12% (55) breastfed and formula fed and 10% (45) exclusively formula fed.

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INDIAN ETHNICITY AND BACKGROUND

Communication

- Patients from an Indian background may say yes in order to please the health professional, even if they do not understand the medical concept or treatment plan. Health professionals should ensure the patient understands.
- People of Indian background often expect that a physician will gather a complete history and perform a thorough examination.

Health related beliefs and practices

- Health related behaviours mainly derive from traditional Ayurvedic (ayur – longevity, veda – science) principles. According to Ayurvedic theory, good health requires that there is a balance of three humours: bile (fire), phlegm (water) and wind. Disturbance of this homeostatic condition causes illness.
- Certain foods can aggravate a particular humour, causing a loss of balance.
- Blood may be perceived as the life force and treated as precious.
- In India, western medicine is increasingly popular among the educated and wealthy. Immigrants of Indian background usually have both a western and Ayurvedic understanding of health and illness. Indians from Fiji, Malaysia or South Africa may have less understanding of Ayurvedic principles.

Pregnancy

- In India, pregnancy is usually viewed as a normal physiologic phenomenon that does not require any intervention by health care professionals. Only in the event of a problem will pregnant women seek medical advice.
- A fatalistic view about life can extend to pregnancy. Many Indian women believe they have little or no control over their pregnancies or outcomes.

Sons are often preferred to daughters. This has implications where parents know the sex of the foetus. Women could decide to terminate pregnancy if they believe the foetus is female.

- Nutrition-related practices during pregnancy are based on a belief that 'hot' foods are harmful and 'cold' foods are beneficial. Because pregnancy generates a hot state, pregnant women are advised to attain balance by eating cold food and avoiding hot food. Cold foods are recommended in early pregnancy to avoid miscarriage. Hot foods are encouraged during the last stages of pregnancy to facilitate labour.
- Some women believe that excessive eating during pregnancy may result in a large foetus and difficult labour.
- Fiji-Indians may believe that it is the responsibility of others to satisfy a pregnant woman's cravings. A baby which dribbles excessively indicates that the mother was not taken care of properly during her pregnancy.
- There are no restrictions applied to physical activity during pregnancy. Women from lower socioeconomic classes may continue their daily activities until labour starts, including carrying heavy loads. Women from higher socioeconomic classes are usually nurtured by their families.
- Twins and other multiple pregnancies may be viewed as unlucky.
- Some women may take herbal medicines to promote the development of a male foetus.

Population of India-born people in Australia: 147,110 people

Population in Queensland: 10,976 people

Population in Brisbane: 7,546 people

Gender ratio: 123.2 males per 100 females

Median age: 35.8 years

Age	%
0-14	7.3
15-24	14.8
25-44	45
45-64	22.8
≥ 65	10.2

Languages spoken: English, Hindi, Punjabi, Tamil

The majority (94%) of people who were born in India, who spoke a language other than English at home (96 010), spoke English very well or well.

Main ancestries: Indian, English and Anglo-Indian

The top three religions: Hinduism, Catholic, Sikhism. While the majority of Indians in Australia are Hindus, some are followers of other religious faiths such as Christianity, Islam, Sikhism, Buddhism and Jainism.

The number of Anglo-Indians and India-born British citizens immigrating to Australia increased following India's independence from Britain in 1947. Since 1966, many skilled professionals have migrated to Australia.

The three major countries of immigration are Pakistan, Bangladesh, and Sri Lanka. Immigrants of Indian background also come from Fiji, UK, USA, Canada, New Zealand, Singapore, Malaysia, Indonesia, Philippines, Middle East, Mauritius, South Africa, East Africa, Madagascar and the Caribbean.

The Indian community is well established. Many recent arrivals to Queensland have been skilled migrants and overseas students.

Birth

- Labouring women are isolated due to birth-related pollution beliefs.
- Women usually cry in pain and scream as the birth approaches.
- Some women may prefer lying on a bed during delivery, while others may prefer to squat, either on the floor or on a stool.
- Profuse bleeding after delivery may be viewed as a good sign linked to the purification of the uterus

After birth

- The mother and the child are usually isolated immediately after delivery, due to beliefs about pollution and impurity linked to the delivery process.
- The period of seclusion and confinement of postpartum women varies across regions. In many regions, the confinement period of postpartum women can be up to 40 days.
- Confinement is is practiced to protect mother and infant from exposure to disease and from evil spirits. Both mother and child are considered to be in a vulnerable state after birth.
- Postpartum practices are usually upheld and enforced by mothers-in-law, aunts and other elderly female relatives. These women may decide the kinds of food a postpartum woman can consume.
- Some women may be required to follow a diet of puffed rice, tea and hot water for the first three days after delivery.
- The consumption of milk, butter, ghee and some types of fish is encouraged due to the belief that these foods will increase the quantity and quality of breast milk.
- Postpartum women may consume a large quantity of garlic, to aid in the contraction of the uterus or to ‘dry the womb’.
- Common foods that are traditionally avoided by postpartum women include certain varieties of green leafy vegetables, fibrous vegetables, melons, pumpkin, papaya, eggplant, shell fish, eggs (in certain castes and communities), certain varieties of fish, lemons, limes, oranges, grapes, chillies, bell peppers, spices, bananas, yoghurt, and oily food.
- The placenta may be disposed of by burying it under the floor of the room where the birth occurred, or in the courtyard of the house. The placenta is buried to keep an enemy or evil spirit from seizing it and influencing the well-being and longevity of the child. Health professionals should offer the placenta to a postpartum woman.
- Cold baths or showers are avoided. In the hospital, a postpartum woman may accept a warm bath, but may be reluctant to have a warm shower.

Infant care

- It is believed newborns are highly susceptible to *nujur* (evil eye). Admiring a newborn is discouraged because it may cause envy and cast the evil eye.
- Physical examination of the newborn may also be considered casting the evil eye, and some Indian families may be reluctant even to have their newborns weighed for this reason.
- There are some precautions practiced to prevent the consequences of evil eye (eg. applying kohl on the infant's forehead – (Hindus only).
- Infants are usually placed in the maternal bed, and mother and child stay together for up to 40 days.
- Infants are usually massaged with oils on a daily basis.
- Some ethnicities practice giving honey mixed with ghee to evacuate the meconium. In Australian hospitals, this practice is prohibited because of the risk of bacterial infection and increasing the level of blood sugar. Health professionals should inform women of this policy, explain the potential risks and discourage this practice after discharge.

Infant feeding

- Breastfeeding in India is universal and prolonged.
- In India, cultural practices related to lactation and breastfeeding are based upon the concept of ritual purity and hot and cold foods, restricted diet after childbirth, and postpartum isolation due to the polluting effects of childbirth.
- Initiation of breastfeeding by Indian women is usually prolonged, and starts when colostrum is fully expressed. Health professionals should inform women of the benefits of colostrum feeding and encourage them to feed their infant.
- Before the initiation of breastfeeding, infants may be given prelacteal feeds, including boiled water, sugar-water, tea, honey, cow or goat milk and mustard seed oil. These foods are given to cleanse the infant's digestive system from impurities of the womb that have been swallowed during childbirth, and to substitute breastfeeding before colostrum is completely expressed. These practices should be discouraged.
- Infants are usually fed when they cry at any time during the day or night.
- Foods supplementary to breast milk are given to the majority of infants within the first six months.
- Of the 165 India-born women who delivered in Queensland Health facilities in 2006, at the time of discharge, 86% (142) exclusively breastfed, 11% (18) breastfed and formula fed and 3% (5) exclusively formula fed.

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JAPANESE ETHNICITY AND BACKGROUND

Communication

The main languages spoken at home in Australia are Japanese and English. But 75% of those who speak a language other than English at home, are proficient in English.

In Japanese culture, harmony and consensus are vital parts of any communication, including interpersonal, professional and governmental interactions. Japanese make considerable effort to ensure that they maintain harmony, and may do so by expressing agreement, regardless of the level of comprehension or genuine agreement, or simply by following instructions and recommendations. Japanese health professionals, especially doctors, are highly respected and represent positions of authority and power. Most doctors in Japan are men.

Health related beliefs and practices

The state of health is associated with purity. The notion of purity equally applies to physical aspects such as hygiene and to moral values and behaviour. Individuals' hands are not considered pure, and are washed frequently. Wet towels may be used instead of washing.

Pregnancy

- Alongside prayer, it is believed that stepping over a placenta, adopting a child, warming the body, sharing a bed with a postpartum woman, or eating a postpartum woman's leftover food may help a woman to conceive.
- During pregnancy, 'dark' foods which are considered 'cold' energy are usually avoided (eg. eggplant). Aki no nasu wa hanayome o kuwasweru na (don't let brides eat autumn eggplant) is an old saying.
- Morning sickness is not usually discussed, even within the woman's family.
- Pregnant women are usually advised to abstain from any activities which require concentration. They may believe that epinephrine released at the time of maternal mental stress may harm the foetus.
- Women may not restrict the types of foods they eat. They may not avoid raw fish or stop drinking green tea (despite the risks of bacteria and caffeine), and may not take prenatal vitamins.The importance of following the dietary recommendations for pregnant women should be highlighted.
- According to Japanese tradition, women in their eighth month of pregnancy should reduce their level of physical activity and move to their maternal home for delivery.

Birth

- Childbirth is considered a natural event and is usually drug-free and midwife assisted.
- Women in labour are encouraged to eat, as it is believed that food will provide the strength and energy needed for effective pushing.
- Women are also encouraged not to cry during labour.
- In Japanese culture, Caesarean section is viewed as a great hardship to a woman, but it is considered very important to do what the doctor says.
- Fathers are not usually present during labour.

Population in Australia: 30,778 people

Population in Queensland: 8,589 people

Population in Brisbane: 3,297 people

Gender ratio: 50.8 males per 100 females

Median age: 33.9 years

AGE	%
0-14	10.2
15-24	15.5
25-44	50.8
45-64	18.5
≥ 65	5.1

Early Japanese settlers worked in the pearling industry in Broome and Thursday Island. A small number also worked in the sugar industry in Queensland.

At the end of World War II, only 74 Japanese nationals and their children were permitted to remain in Australia. Within two years, about 200 Japanese 'war brides' are believed to have entered the country.

Currently, a large number of Japanese students and tourists come to Australia.

The main ancestries are Japanese or have Japanese and Caucasian ancestry.

Most people are followers of Buddhism or Shintoism.

After birth

- In Japan, women stay at their maternal home for up to eight weeks after the baby is born. There a postpartum woman can rest, recuperate, and learn how to take care of the infant.
- Infants are usually cared for by the mother of a postpartum woman. This should be kept in mind as Japanese women in Australia may not have access to this support system.
- In Japan, showering or washing hair is prohibited until seven days after birth (including in hospitals).Postpartum women should be informed that in Australia showering after birth is recommended, but it is the woman's choice.

Infant care

- Bathing the infant is acceptable.
- Nappies are changed whenever they are wet or soiled.

Infant feeding

- Breastfeeding in contemporary Japan is no longer as widespread or as prolonged as it was in the past. Japanese women who breastfeed their infants are in the minority. In Queensland, the majority of Japanese-born women breastfeed their infants.
- Breast massage is practiced by some women to increase lactation.
- Breastfeeding outside the home, even in mothers' care rooms, is still considered embarrassing and shameful, so very few women feed their infants outside the home.
- Japanese women may be concerned with gaining weight during their pregnancy and postpartum period. They may restrict their diets and subsequently, may be unable to produce enough milk to feed their infant.
- Formulas are usually introduced at two or three months.
- Of the 254 Japanese-born women who delivered in Queensland Health facilities in 2006, at the time of discharge, 85% (215) exclusively breastfed, 10% (25) breastfed and formula fed and 5% (14) exclusively formula fed.

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MALAYSIAN ETHNICITY AND BACKGROUND

People who have migrated to Australia from Malaysia may have Chinese, Indian or Malay backgrounds. The information here refers mainly to the Malay population. For information about those with Indian or Chinese backgrounds, see those profiles.

Malays first came to Australia – mostly from islands in Indonesia – to work in the pearling industry in the 19th Century. Many Aboriginal families in northwest Australia have some Malay ancestry. Overseas students, mostly Malay from Peninsular Malaysia, came to Australia under the Colombo Plan in the 1950s. Some married in Australia, and later sponsored parents or siblings. From the late 1960s, following political tension, many Chinese and Indian people from Malaysia have settled in Australia.

Communication

- In Malay culture, social interaction is concerned with the maintenance of harmonious relations between individuals. Unobtrusive communication is the ideal sort of social interaction. Subscription to this style of communication is desired to avoid the discomfort associated with shame.
- Some Malay women may not wish to shake hands with men.
- In general, women prefer to be examined by female doctors, and women who adhere strictly to Islamic precepts may find antenatal or midwifery care by men especially difficult.

Health related beliefs and practices

Malays, Chinese and Indians in Malaysia share beliefs based on humoural medical theory. Illnesses, body states, foods and medicines are regarded as 'hot' or 'cold' depending on the effect on the body. Chinese and Indian women from other countries observe similar customs.

- Pregnancy is a hot state, and women should avoid overheating. Cold foods are usually preferred. After giving birth, women are said to be cold, and drink warm drinks and eat hot foods.
- Women may observe a period of confinement of 30-40 days. During this time they do not leave the house and may stay by a heater and dress warmly.

Pregnancy

- Traditionally, women were cared for by village midwives, but antenatal care and hospital birth have been common practices for many decades.
- Malays regard pregnancy and birth as a normal process in a woman's life.
- During pregnancy, women may see a midwife for massage.
- A ceremony may be held in the seventh month of pregnancy to ensure the mother's safety and the safe arrival of the infant.

Population in Australia: 92,320 people

Population in Queensland: 9,610 people

Population in Brisbane: 6,688 people

Gender ratio: 83.6 males per 100 females

Median age: 39.5 years

AGE	%
0-14	4.3
15-24	20.8
25-44	34.0
45-64	33.4
≥ 65	7.4

People may be from Chinese, Malay or Indian background

Depending on their background, people will speak English, Malay, Cantonese , another Chinese dialect or language, Hindi, or Tamil.

Almost all people born in Malaysia (92%) are proficient in English, regardless of the language spoken at home.

The main religions are Islam, Christianity, Hinduism and Buddhism.

The Indian, Malay and Chinese communities are well established.

Birth

- Malay women are usually familiar with biomedical health services.
- They may prefer female practitioners and usually place a high importance on maintaining their modesty. During childbirth they may like to be protected by curtains or screens.
- Malay women are encouraged to pray during labour and avoid crying and screaming.

After birth

- Postpartum restrictions and rites for Malay women usually reflect humoural medical theory. Many practices are designed to restore heat thought to be depleted by the birth process. In Australia, hot water bottles, staying close to heaters and dressing warmly are used to restore heat. During the postpartum period (30-40 days), the woman's abdomen may be bound. The diet is restricted to hot foods, omitting such items as fruits, vegetables and cold drinks.
- To warm the body, postpartum women may be given a special drink *jamu* (herbs), made with turmeric. This practice is based on a belief that *jamu* may relieve cramps and prevent rheumatism.
- Postpartum women are given up to 10 sessions of gentle massage.
- It is important for the health provider to discuss what will happen with the placenta with the woman prior to delivery. Malay women may wish the placenta to be treated like a body that once had a life. They may wish it to be wrapped in a white cloth and buried.

Infant care

- If parents are Muslim, the father of the newborn may whisper the *azan* into the infant's right ear and the *iqamat* into the left ear (prayers).
- Also according to Islam, a chewed date, honey or something sweet may be rubbed into an infant's palate. In Australia, this practice is prohibited due to potential risk of bacterial infection and increasing level of blood sugar.
- According to Islamic tradition, boys may be circumcised at any time from seven days. In Malaysia, boys are usually circumcised when they are around seven or eight years old.
- According to Islamic tradition, between seven and 40 days after birth, the head of the newborn should be shaved.

Infant feeding

- Colostrum is usually expressed before the initiation of breastfeeding. Malay women need to be informed of the importance of colostrum feeding and encouraged to feed their infants.
- During the first one or two days, until the colostrum has been expressed, some liquid, such as a paste of cornflour and water, may be given to the infant.
- Supplementary foods, including thinned cow milk or formula, or thin rice water, are usually given during the first month. Health workers should consider discussing the benefits of prolonged breastfeeding.
- Bottle feeding was introduced in colonial Malaya in the 19th Century and many women, especially from Chinese backgrounds, will have been formula fed.
- Of the 141 Malaysia-born women who delivered in Queensland Health facilities in 2006, at the time of discharge, 74% (104) exclusively breastfed, 18% (26) breastfed and formula fed and 8% (16) exclusively formula fed.

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PAPUA NEW GUINEA ETHNICITY AND BACKGROUND

Papua New Guinea is one of the most ethnically and linguistically diverse countries on earth. There are more than 850 indigenous languages and traditional societies. The information in this section should be read with this in mind.

Communication

- In Melanesian culture, women may not be allowed to communicate with people of the opposite gender. Therefore, most women will prefer health practitioners of the same gender.
- Many Pacific Islander cultures place less emphasis on keeping time and punctuality and may require a reminder call prior to appointments.

Health related beliefs and practices

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. Some people may believe in the power of spirits, sorcery and black magic as causes of illness and death.

Pregnancy

Domestic violence in Papua New Guinea is very common. Health professionals should discuss this issue with pregnant women and refer them to the relevant services if appropriate.

- People from some regions of Papua New Guinea may link malformations to maternal attempts to abort the pregnancy.
- Among some groups, pregnancy and birth are compared to women's other productive roles, such as planting crops and raising pigs.
- Twins are often regarded with concern, the result, according to some beliefs, of sexual intercourse during pregnancy.

After birth

According to commonly found cultural norms in Papua New Guinea, postpartum women must remain abstinent until weaning. In some communities, this may be for up to five years.

- Women from some tribes may become disoriented after birth. This disorientation is a culturally influenced state by which labouring women are able to express the severity of pain.
- There is a strong belief that a woman may die if the umbilical cord is cut before the delivery of the placenta. Some women may wish to take the placenta with them, or to take a section of the umbilical cord.

Population in Australia: 24,020

Population in Queensland: 12,590 people

Population in Brisbane: 6,702 people

Gender ratio: 80.1 males per 100 females

The median age is 37.8 years and more than half are between 25 and 44 years.

Age	%
0-14	6.5
15-24	9.5
25-44	53.9
45-64	24.4
≥ 65	5.9

People may identify as Australian, Papua New Guinean, or English, or by any of the many tribal groups of the country.

The main languages are PNG English, Pidjin, or among those of Chinese background, Cantonese. Regardless of language spoken at home, the majority speak English.

Most people are Christian (primarily Catholic or Anglican), or have no specific religion.

Most people in Australia who were born in PNG are the children of Australians who were working there when Australia was responsible for administering either the Australian territory of Papua or the Territory of Papua and New Guinea.

Infant feeding

- Breastfeeding is widespread across the country and in Australia. Of the 337 Papua New Guinea-born women who delivered in Queensland Health facilities in 2006, at the time of discharge, 91% (306) exclusively breastfed, 2% (9) breastfed and formula fed and 7% (22) exclusively formula fed.
- Some women express colostrum, believing that it is 'dirty' milk, but other women conventionally feed colostrum to their infant. Expressing colostrum is more common among women from the highland regions than among those from coastal regions. Health professionals should discuss the benefits of colostrum feeding.
- Breast massage and traditional medicines may be used to increase milk production.
- The breast is given whenever the infant cries, and an infant's cry is considered as an indicator of hunger.
- Infants may be withdrawn from the breast and given supplementary foods and cleansing enemas during sickness. These practices should be discussed and women should be advised about the importance of breastfeeding when infants are sick.
- Solids are generally introduced from the age of four months. Some mothers may introduce solids earlier.
- Breastfeeding usually continues up to two years of age despite the introduction of solids.
- In Papua New Guinea, bottle feeding is uncommon and used predominantly by working mothers. In Australia, working mothers from Papua New Guinea may replace breastfeeding with bottle feeding. Additional information about the continuation of breastfeeding while working should be provided.

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SAMOAN ETHNICITY AND BACKGROUND

Many Samoans come to Australia from New Zealand and may be familiar with the New Zealand health care system. Unlike Australia, there are many Pacific Islander-specific health services available in New Zealand.

Communication

Women from a Samoan background may be reluctant to discuss health issues openly with a health practitioner. Pacific Islanders in general may be reluctant to discuss personal issues with strangers. This should be kept in mind in health interactions.

Health related beliefs and practices

- Some Samoans believe that illness is caused by spirits, or retribution for not adequately helping their family in Samoa
- If western medicine is perceived as ineffective, then Samoans may use traditional healers.
- Queensland's climate allows the growth of many plants used for traditional medicine in Samoa. Some of these plants are readily available.
- Prayer is an important element of the healing process for many Samoans.
- Traditionally, Samoans have believed that the more they eat, the higher their status. This has had major health implications. However, dietary patterns are changing as awareness of healthy eating habits increases.

Pregnancy

Some Samoans believe that if a pregnant woman wears earrings, her infant's ears may be disfigured or misshapen. Similarly, wearing floral arrangements around the neck may cause the foetus to become entangled with the umbilical cord.

- Samoans often have many children and view pregnancy as a sickness.
- Pregnant women are cautioned against being alone in the house or going outside, especially after dark. Samoans believe that a lone pregnant woman can be hexed by evil spirits, causing abnormalities to the unborn child. A pregnant woman should always be accompanied by an elderly woman, even to the toilet.
- Samoans believe that pregnant women should avoid heavy work which may lead to the displacement of internal organs.

Birth

- For their first delivery, Samoan women usually return to their mother's home and after a confinement period, the new family returns home. This should be kept in mind since in Australia, Samoan women may have no parental support.
- Episiotomy is not considered a part of usual delivery-related procedures.
- Birth attendants usually perform a cut on the umbilical cord after it has stopped beating. After birth, the baby is massaged with blood from the placental part of the umbilical cord. Health professionals should be aware of this practice.

Population in Australia: 15,240 people

The second largest community is in Queensland

Population in Queensland: 4,867 people

Population in Brisbane: 4,343 people

Gender ratio: 92.3 males per 100 females

Median age: 41.6 years

Age	%
0-14	5.4
15-24	10.2
25-44	44.7
45-64	34.3
≥ 65	5.5

Australian-government sponsored education programs in the 1970s led to an increase in the number of Samoan immigrants.

Samoan is the main language spoken at home by Samoa immigrants in Australia.

Most people are Catholic, Latter Day Saints or followers of the Uniting Church.

After birth

- In Samoa, the placenta is usually expelled by pulling, while the abdomen is massaged. Sometimes the father is asked to apply force to facilitate expulsion.
- Care should be taken to ensure that the placenta is offered to the new parents. In Samoa the placenta is disposed of in various ways. It may be wrapped in a cloth and buried in the ground by close family members, burned in a hole dug in the ground, or thrown into the sea. It may be believed that the newborn is at risk if anything happens to the placenta.
- In Samoa, after labour, the woman's abdomen may be firmly bound with cloth to prevent the uterus from 'falling down'. This remains in place for up to one month.
- After delivery, women traditionally receive abdominal and pelvic floor massage to correct any displacement that may have occurred during labour. They will then bathe.
- Sometimes, a bowl of steaming water is placed between a woman's legs, so that the rising steam can cleanse the birth canal. In Australia, Samoan women could be asked if they would like a hot water bottle to replace this procedure.
- Once postnatal procedures are complete, a woman may be given a bowl of sago cooked in coconut cream and flavoured with lemon leaves.
- According to Samoan practice, a woman should rest for a month after her first delivery. After subsequent deliveries, she should rest until the infant's umbilical cord falls off. The benefits of early physical activity after birth should be discussed with Samoan women in Australia.

Infant care

- Samoan infants are usually bathed immediately after birth.
- A newborn is usually placed in cold water to make them breathe.
- Many attendants massage newborns with oil.
- Once bathed, infants are wrapped in a clean cloth or blanket and laid down to sleep. In Australia, Samoan women should be informed that they are not restricted from giving their infant gentle massage.

Infant feeding

- Samoan midwives may recommend that a woman breastfeed immediately after birth; others give boiled water only for up to five days.
- Samoan infants are fed on demand.
- Breastfeeding is often considered to be a contraceptive and the insufficiency of this as a sole method needs to be emphasized.
- Of the 193 Samoa-born women who delivered in Queensland Health facilities in 2006, at the time of discharge, 78% (150) exclusively breastfed, 8% (15) breastfed and formula fed and 14% (28) exclusively formula fed.

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SUDANESE ETHNICITY AND BACKGROUND

Most of the information presented here relates to the beliefs and behaviours of people from the south of Sudan who live in rural areas. It may not represent those who live in larger population centres.

Immigration history

- The Sudanese community is one of the fastest growing groups in Australia.
- Before 2001, Sudan-born people included a number of skilled migrants.
- Drought, famine and war have caused large numbers of refugees to flee to neighbouring countries. Australia has assisted in resettling some of those people who have been worst affected.
- Since 2001, more than 98% of Sudan-born people arriving in Australia have arrived under humanitarian programs.

Community establishment

- Since 2001, more than 98% of Sudanese people arriving in Australia have come from southern Sudan, most fleeing the war in the south of the country.
- There is a minority within the community who came as asylum seekers fleeing political persecution. These groups tend to be from the north of Sudan and of Islamic denomination.
- During its early days, the community established the Sudanese Community Association of Queensland as a social network which continues to operate.
- The organisation's members are mainly southern Sudanese. The northern Sudanese community tends to be more fragmented.
- People from the northern Sudanese community generally have higher levels of education than their southern counterparts.
- Sudanese people value education and put a lot of emphasis on their children's schooling.
- In Brisbane, large groups of Sudanese people have been settled in Moorooka, Annerley and Woodridge. There is also a large community in Toowoomba. The community generally prefers to reside close together as there is a strong communal culture and people tend to do things together.

Communication

- There are some distinctions in communication style between the Islamic people from the north and those from the south. For Muslims, when greeting, men shake hands with men, but it is not culturally appropriate for men to shake hands with women, except within their own family. Prior to interacting with a woman, respect should always be afforded to the man as the head of the household. In southern Sudan, the rules of interaction are less strict, and women can be addressed directly.
- Separation of the sexes is common in the Muslim north, and homes may be divided into male and female areas.

Great diplomacy must be used in negotiation on gynaecological matters. When referring to genitalia, Sudanese women frequently use euphemisms. They may avoid this topic completely, especially if their English is poor. Female health care providers are usually preferred by both Muslim and Christian Sudanese women

Population in Australia: 19,050 people

Population in Queensland: 2,401 people

Population in Brisbane: 1,805 people

Gender ratio: 118.2 males per 100 females

Median age: 24.6 years

Age	%
0-14	26.6
15-24	24.4
25-44	36.4
45-64	10.2
≥ 65	2.5

In the southern regions of Sudan, each tribe has its own language and sometimes several dialects. Rudimentary Arabic is spoken by almost all Sudanese; however the level of proficiency differs according to the level of education. In southern Sudan, English is only spoken by the educated minority. Sudanese Arabic is slightly different to Arabic spoken by other groups like Lebanese and Egyptians. Dinka and Nuer are written languages which have been Romanised by missionaries.

Literacy in Sudan is very low.

The main languages spoken at home by Sudan-born people in Australia are Arabic, Dinka and various African languages. Generally, educated Sudanese have a good understanding of the English language. Men tend to have a better command of the language than women because of better access to education.

Of the 18 040 Sudan-born who spoke a language other than English at home, almost one third (30.3%) spoke English not well or not at all.

No accredited interpreters are available for Madi, Ewe and Nuer languages.

Main ethnicities: Sudanese (Nuer, Dinka), African, and Arabic

Religious affiliations: Catholic, Anglican and Islam

Places of transition: Egypt, Ethiopia, Kenya, Lebanon, Malta, Sweden, Syria

- Among southern groups, relative age is important in interpersonal relationships. Men of the same age call each other brother (even if not related) and act informally with one another. Older people are usually shown a higher level of respect.
- Muslim women from northern Sudan may be quite reluctant to be examined by a male physician. Most southern Sudanese women will view this examination as a medical necessity.

Health related beliefs and practices

- In northern Sudan, circumcision for men and circumcision and infibulations for women is widely practiced. Female genital surgery rates are currently declining.
- Polygamy is practiced and is a sign of wealth and prestige, but is uncommon in southern Sudan.
- A widow is the responsibility of the deceased's younger brother.

In southern Sudan, early marriage (as young as 12 years old for a girl) is still widely practised.

Pregnancy

- Great emphasis is placed on a woman's ability to bear and raise children. Birth control is typically viewed as an oppositional practice to this cultural value, and there may be resistance to contraception by women or their partners.
- There are no food restrictions specific to pregnancy, other than general taboos (eg. Muslims are prohibited from eating pork).
- During pregnancy, women often eat a special type of salty clay. When chewed, this clay is believed to increase the appetite and decrease nausea. Nutritional advice during pregnancy is highly desirable.
- In Australia, a lack of awareness of antenatal care classes and other health and support services may prevent pregnant women from attending these services. Women may be unable to attend if other men are in attendance. Other parenting responsibilities, a lack of access to transport or poor English skills may also prevent attendance.

Birth

- Village midwives usually assist women to deliver at home. Few women, other than civil servants and the wealthy, have access to hospitals.
- Women from a Sudanese background may benefit from a detailed explanation of the Australian maternity care system. Eligibility for maternity care services and Medicare coverage should be discussed.

After birth

- Many Sudanese women choose to undergo re-infibulations immediately after giving birth. Sudanese women should be informed about the harmful effects associated with re-infibulation, and informed of policies prohibiting this practice in Australia. Family Planning Queensland can provide cultural advice or assistance.
- After birth, women may kneel over a fire to purify the birth canal. This practice could be replaced with hot water bottles or placing a postpartum woman close to a heater.

Infant care

- In Sudan, it is common for a couple to initially reside with the woman's family until after the first child is born and weaned. The couple will then re-locate to the man's village. In Australia, Sudanese couples may lack parental or wider community support. Sudanese women are frequently isolated and there are many single mothers. Health professionals should discuss the benefits of using health and social support services, and connect women with the relevant organisations.
- Sudanese women in Australia can benefit from education about infant care, child development and parenting skills.

Infant feeding

- In Sudan, breastfeeding is widespread and popular.
- Of the 120 Sudan-born women who delivered in Queensland Health facilities in 2006, at the time of discharge, 89% (107) exclusively breastfed and 11% (13) breastfed and formula fed.

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VIETNAMESE ETHNICITY AND BACKGROUND

The Vietnamese community does not comprise a single group. It includes ethnic Vietnamese, people of Chinese (usually Cantonese) ancestry and smaller minority groups, including Khmer and Hmong. Care should be taken to avoid the assumption that all Vietnamese people share common cultural experiences.

Communication

- Vietnamese people generally value flexibility, a readiness to compromise, and the avoidance of conflict.
- People from a Vietnamese background usually list their family name first, then their middle name, with their first (given) name listed last. Many given names are common to both men and women. Vietnamese people usually prefer to be addressed using their title (eg. Mr or Mrs).
- Vietnamese people usually avoid eye contact as a sign of respect, particularly when talking to a person of higher status or different gender.
- Vietnamese people usually bow their head to show respect.
- Smiling is a common social response, which can sometimes be difficult to interpret. In Vietnamese culture, smiling can show respect or express agreement, apology or embarrassment.

The answer 'yes' may be used to indicate that the listener is paying attention. It does not necessarily indicate agreement. It is important to obtain feedback from your client to ensure understanding, especially when they are giving consent to treatment.

- In Vietnamese culture, items are passed with both hands. Passing an item with one hand or passing an item over someone's head is impolite.
- Women usually do not shake hands with each other or with men.
- Most Vietnamese women prefer a physician of the same gender.
- Vietnamese women may wish to be assisted by family members instead of trained interpreters. Health practitioners should explain the Queensland Health policy on the use of professional interpreters early during antenatal visits, and the benefits of engaging a professional interpreter.
- Vietnamese women may place great value on a health professional's awareness of their traditional practices, and place importance on the opportunity to follow or observe these during their maternity care.

Health related beliefs and practices

- A belief in the 'hot' and 'cold' qualities of food and medicine (herbal and pharmaceutical) is widespread. 'Wind' is another quality that may also be considered important. For example, an excess of 'cold' food is believed to cause coughing and diarrhoea.
- The body is seen as operating in a delicate balance between these elements. Before seeking or complying with treatment, Vietnamese people may consider the effect the treatment will have on this balance.

Population in Australia: 159,850 people

Population in Queensland: 13,085 people

Population in Brisbane: 11,859 people

Gender ratio: 89 males per 100 females

Median age: 41 years

Age	%
0-14	1.9
15-24	8.1
25-44	50.3
45-64	32.5
≥ 65	7.3

The main languages spoken in Australia are Vietnamese and Cantonese.

Of the 154,010 Vietnam-born people who spoke a language other than English at home, 43.3 per cent spoke English not well or not at all.

Most Vietnam-born people in Australia are Buddhists and Christian, primarily Catholic.

Since the establishment of the communist government and declaration of the Socialist Republic of Vietnam in 1976, many Vietnamese have fled their country. Most initially settled in refugee camps in neighbouring South East Asian countries. In Australia, Vietnamese refugee resettlement occurred from 1975 to 1985, since then most migration has been family reunion.

The Vietnamese community in Queensland is well established. There are many ethno-cultural and religious community organisations throughout the state, including the Australian Vietnamese Women's Welfare Association.

- People from a Vietnamese background may use traditional methods of healing in parallel with biomedical health care. However, there is an increasing tendency for Vietnamese people to attend a doctor before visiting a traditional practitioner. If not asked, Vietnamese people may be reluctant to reveal the use of traditional remedies.

Pregnancy

- During pregnancy, some women may follow dietary restrictions to prevent difficult labour due to a large foetus. These restrictions may vary across trimesters and are in accordance with 'hot and cold' theory. The first trimester of pregnancy is considered a 'cold' state. Women are recommended to eat 'hot' foods, including ginger and black pepper and to avoid 'cold' foods, including lemon, melon, pineapple, spinach and green papaya. In the second trimester, which is considered a 'neutral' state, women may be allowed to eat these foods. In the third trimester, which is considered a 'hot' state, women may decrease the amount of food they consume and avoid taking natural supplements.
- Vietnamese women remain physically active during pregnancy, but usually avoid strenuous work.
- Women from a Khmer background may believe that oedema is a normal condition during pregnancy and may not seek medical attention. Khmer women with a high risk pregnancy should be informed about the potential risk of oedema and advised to access appropriate health care.
- Khmer women may view ante-partum bleeding as normal. They call it 'bleeding to wash the baby's face' and believe that it stops without medical intervention. It should be explained that ante-partum bleeding is a sign that something may be wrong and the woman should be instructed to attend emergency services.
- Khmer women commonly believe that sleeping during the day or waking up late may result in large foetus. Some Vietnamese and Khmer women may believe that sitting in a door frame or on a step may cause obstructive labour. Health professionals should be aware of these beliefs and ensure that, in the case of obstructive labour, women understand the reasons and do not blame themselves.
- It is often believed that sexual intercourse during pregnancy can cause foetal illness and abnormalities.
- Some women may be concerned about invasive tests during pregnancy (eg. drawing blood). Women may benefit from additional explanations regarding the ability of the body to replace lost blood.

Pregnant Vietnamese and Khmer women may regularly use traditional plant medicines and herbal tonics to maintain their own and foetal health and to stimulate labour. Concerns about the harmful effects of certain traditional medicines during pregnancy should be explained as early as possible.

Birth

- Women usually avoid excessive movement while in labour. The preferred position for a labouring woman is to lie on her side with a pillow. She may prefer drinking hot rather than cold fluids.
- In Vietnamese culture, the father is usually not allowed to be present in the labour ward. However, in Hmong culture, the father usually supports the labouring woman and may prefer to stay with her in the labour ward.
- Caesarean section is usually not preferred due to fears of blood loss or exposure to 'winds'. Health professionals should be aware of these beliefs and provide additional explanation about blood loss when discussing the labour management plan.

After birth

- Vietnamese women in Australia may follow traditional post-partum practices including strict bed rest and keeping warm to avoid potential 'colds'.
- Some women may not wish to use a pillow after birth.
- Many women will follow traditional dietary restrictions after birth such as avoiding cold drinks, green vegetables and beef. Some women may drink ginger broth. Hmong women do not usually eat hospital food after birth and may prefer home-cooked rice and chicken soup.
- Women may avoid showering and washing their hair after birth. It may be believed that the postpartum woman may be affected by 'cold' and 'wind' while showering, and this may weaken her body. A sponge bath may be an acceptable alternative. Hot baths and steam baths may be possible after the second postpartum day.
- Some women practice variations of 'mother roasting'. Traditionally, this involves lying beside or over a small stove. In Australia, women may place a portable heater close to the bed or use a hot water bottle.
- If these practices are not followed, some women may become anxious that postpartum conditions such as weakness, headache, palpitations and abdominal cramps may re-occur.

Infant care

- Vietnamese women may expect health professionals to provide advice regarding infant care.
- Infant fatness may be considered as a sign of good health.
- The 'Mongolian blue-spot' – a bluish pigmentation in the lumbo-sacral region – is common at birth among Indo-Chinese and other Asian babies, and persists until the age of 18 months to two years. Health professionals should be aware of this as it may be misinterpreted as a sign of child abuse.

Infant feeding

- Some women may not start breastfeeding until colostrum is fully expressed. They may believe that if they start breastfeeding prematurely, the infant may further deplete the mother of 'heat' and fluids. An explanation of the nutritional values of colostrum may be required.
- Almost one quarter of Vietnamese women feed their infants exclusively with formula. Health professionals should explain the benefits of breast feeding as early as possible, preferably during antenatal visits.
- Women who breastfeed their infants may start adding formula very early, believing they have insufficient breast milk.
- Of the 358 Vietnam-born women who delivered in Queensland Health facilities in 2006, at the time of discharge, 58% (207) exclusively breastfed, 20% (73) breastfed and formula fed and 22% (78) exclusively formula fed.

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■ ADDITIONAL CULTURAL ASSESSMENT QUESTIONS AND PROMPTS

Be clear about the reasons for asking these questions. Some women, especially those from a refugee background, may fear and mistrust authority and government institutions.

Antenatal care

Ask the woman

- Do you want to be pregnant? If not, are there any cultural or religious beliefs impacting upon the termination of the pregnancy?
  - Do you want any psychological or spiritual support, or counselling related to this decision?
- Would you prefer a nurse or a doctor to see you while you are pregnant?
  - Explain that both are appropriate, risk free and acceptable in Australia.
- Are you comfortable with both male and female health care providers?
  - Explain that wherever possible a female health care provider will be provided if preferred but in an emergency situation this might not be possible.
- Have you attended antenatal care in Australian before?
  - Ask the woman if she would prefer to attend a women-only group.
- Have you experienced any problems with your antenatal care before?
- Do you have any concerns or worries about your care?
- Do you have cultural or religious support with your emotional health during your pregnancy?

Nutrition and physical activity during pregnancy, childbirth and postpartum period
Culture, religion and personal beliefs, and the availability of certain foods, can influence people's ideas about an appropriate diet to maintain their health status, or to ensure good health at particular times of the year or during periods of stress. People may hold definite ideas about the kinds of food, and amounts of food, appropriate for women during pregnancy, childbirth and the postpartum period.

Ask the woman

- Are there any foods that are appropriate or inappropriate for you according to your religion or customs during pregnancy, birth and the postpartum period?
- Do you plan to consume traditional homemade beverages or brews during pregnancy?
  - Some homemade traditional drinks may contain alcohol at a concentration that may pose a risk to the unborn child.
- Are you going to fast during your pregnancy or while in the hospital if during festival periods?
- Do you intend to take any traditional herbal remedies during pregnancy, childbirth and breastfeeding? Are you taking any now?
- Are there any beliefs or customs prohibiting physical activity during pregnancy, birth and the postpartum period? Do you plan to observe these?
- In your culture, do women have a confinement period? If so, what does this involve? Do you plan to observe this?

Discuss with the woman

- appropriate nutrition during pregnancy, taking into account any food restrictions she wants to observe
- whether she needs special food (eg. kosher food, halal meat) during her hospital stay
- whether she needs help to understand what is on the menu each day
- whether she needs disposable cutlery (eg. Orthodox Jews use different utensils for preparation/consumption of dairy products, meats and vegetables)
- whether she would like chilled, cold, warm or hot meals and drinks
- whether she would like to arrange her own food if the hospital does not cater for her dietary needs.

Prenatal screening and diagnostic tests

Discuss with the woman

- the option of either having or declining prenatal screening and diagnostic tests
  - Ensure that the woman is clearly aware of these options.
- if the required tests conform to her cultural and religious beliefs and practices (eg. taking blood)
- the nature of ultrasound scanning, and ensure that this procedure is culturally and religiously acceptable
  - In some cultures, it may be unacceptable to see the unborn baby.
- the result outcomes (either positive or negative)
  - In some cultures, the word negative may be interpreted as bad or ill.
- if the results are pathological, the options that she has in relation to her pregnancy outcome (continuation, termination)
  - Have you ensured that the woman clearly understands these options?
  - Have you discussed if either of these options contradicts her cultural or religious beliefs and practices?
- if available, the option of attending pre and post-screening/diagnostic counselling?
  - Does she need help with arranging counselling sessions?
  - Have you involved the woman's partner? (He may be the decision-maker).

Other issues

- In some cultures news about twin pregnancy or female sex of the foetus could be considered bad news and should be disclosed with caution.

Complications during pregnancy and birth

Discuss with the woman

- a culturally appropriate way for disclosing bad news (eg. the risk of miscarriage)
  - Ask what happens if the woman miscarries. Who tells her?
- the type of support she would prefer to receive to overcome emotions related to bad news
  - Ask the woman what she would prefer to happen if something did go wrong.
- the purpose of an emergency caesarean section.
  - Ask the woman if she has any concerns about surgical intervention based on cultural and religious beliefs. (eg. Hmong women may be afraid that they lose a soul or be afraid for other reasons.)

Birth and hospital stay

Ask the woman

- In your culture, do fathers usually attend births? Does your partner wish to attend the birth of his child? If not, is there another close family member you wish to be present?
- When would you like the umbilical cord to be cut?
  - Women in some cultures believe that making a cut before the placenta is expelled may cause an infant death.
- How long should the cord be that is left with the infant?
- How would you like the placenta and umbilical cord to be disposed?
  - In some cultures, the placenta may be kept, buried or thrown in the sea; the umbilical cord may also be dried and kept.

Discuss with the woman

- if there are any customs/traditions that you need to be aware of in caring for the woman during birth (eg. birthing position, bathing before labour, dealing with female genital mutilation)
- whether it is acceptable for her to express pain during childbirth, according to her culture
- female genital mutilation. Establish her expectations of labour and the level and nature of expected medical interventions (see Female Genital Mutilation section for further information)
- if early contact with her infant would be appropriate (some women may not want to have skin to skin contact with the infant immediately after childbirth, or until the infant has been bathed. They may see the infant as polluted)
- if there is anyone who can look after her children while she is in the hospital
- the number of visitors she expects to visit her while she is in the hospital.
  - Have you ensured that she is aware of visiting hours and any restrictions on the number of people that may be able to visit her while she is in the hospital?

Postnatal period

Ask the woman

- Do you plan to do anything to increase your breast milk production?
  - Some women may wish to massage their breasts or take special drinks.
- Would you like to observe any practices to encourage your recovery?
  - Some women may wish to have a heater on close to their bed.
- How are you feeling emotionally?
  - Are you aware that in some cultures women feel guilty or embarrassed to admit having psychological problems?

Discuss with the woman

- any practices that health professionals need to be aware of while caring for her during the postnatal period (eg. bathing after labour, dealing with female genital mutilation, requirements with the placenta, and requirements with resting).

Ask the woman

- Is it acceptable in your culture to compliment a newborn child?
  - Some women may dislike compliments addressed towards their infants, believing that an evil eye can cause the infant to fall ill.
- Are there any precautions with holding the infant?
  - Vietnamese and Thai women may believe that the head of the infant is the site of the soul and it should not be touched.
- When would you like your infant to have their first bath?
- Do you plan to practice any type of skin care for your child?
  - Some women may wish to massage the infant with oil.
- How would you like your child's belly button cared for?
  - Muslim parents may object to the use of a local antiseptic or surgical spirit for the prevention of umbilical infection as Islam prohibits the use of alcohol.
  - In some cultures, women may make an effort to ensure that the child has an attractive belly button by placing a coin on the infant's navel and binding it with a piece of cloth. The woman should be advised to clean the coin with alcohol/antiseptic and use a clean piece of cloth to avoid infection.
- Do you have any precautions towards infant eye, nose or ear care?
- Do you want to provide care to your infant yourself or do you want support staff to do this while you rest?
- How would you like to dress your newborn child?
  - Some women may not wish their child to wear clothes that have been worn by another infant.
  - Chinese people may believe that an infant that wears used clothes will adopt the behaviour of the previous wearer.
- Do you plan for your son to be circumcised and at what age?
  - Have you provided sufficient information about circumcision - preferably in the woman's first language?
- Do you intend to feed colostrum to your infant?
  - Have you discussed preferable substitutes for colostrum (eg. water, formula)? Are these substitutes acceptable or not?
- Will you follow any cultural practices before breastfeeding?
  - Some women may wish to wipe their infant's palate with honey or honey water before breastfeeding.
  - Have you explained that honey will not be offered to newborns due to the risk of botulism and increasing blood sugar levels?

Other issues

- Are you aware that some women may not breastfeed their infants until colostrum is fully expressed? Explain the importance of breastfeeding, including colostrum

Complications in infant health

Discuss with the woman

- health conditions and treatments required
  - Have you discussed if the woman has any concerns related to her cultural or religious background (eg. severe jaundice or exchange transfusion)?
- if an infant needs to be admitted to intensive or special care. Discuss the purpose of admission, and how the infant might benefit.
  - Have you ensured that all questions and concerns regarding the admission have been addressed?
  - Have you explained what happens to the infant while under special care?
  - Have you explained how the woman can access her child?
  - Have you explained how she can help?

Discharge planning and home visits

Ask the woman

- Do you have anyone in your family or community who can help you in practical ways when you get home?
- Is there anyone who can provide you with emotional support during early parenthood?
  - Explain that it is very common for women to feel sad or nervous after birth.

Discuss with the woman

- the role of maternal and child health nurses in their care and the purpose of home visits (eg. support rather than control)
- if there are any practices that need to be observed by health professionals during home visits
- available contraceptive methods.
  - Are there any contraceptive methods that are culturally or religiously unacceptable? Discuss the options.

Other issues

- Provide the woman with information about community support systems and child health systems, preferably in the woman's own language.
- Have you ensured whether the woman needs your help in establishing a link with some support organisations?

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