Left out, left off, left over: Why migrants from non-English speaking backgrounds are not adequately recognised in health promotion policy and programs

Andre Renzaho, Catherine Renzaho and Michael Polonsky

Australia has a long history of migration. Up to 1945 there was a 'white Australia' policy, which changed to accepting a more diverse migrant pool, including forced migrants (e.g. refugees).There is increasingly a need to understand and cater for the specific health needs of migrants, especially those from non-English speaking (NES) backgrounds, many of whom are not adequately recognised in population health planning. The vast increase in investment in prevention and health promotion may not cater for their needs without their participation in research and planning. Below we discuss the main five challenges.

Challenge 1: Under-estimation of health issues and the salmon bias

Methodological flaws and negative cultural and religious taboos associated with certain behaviours (e.g. drug and alcohol use)[1] have resulted in a gross under-estimate of health issues facing NES migrants, resulting in false assumptions and paradigms. For example, the 'healthy migrant theory' proposes that migrants have better health than the host community, because of pre-migration health screening that excludes unhealthy migrants, and the occurrence of self-selection, where only healthy migrants can afford to relocate.[2] However, the healthy migrant effect is, indeed, unlikely to be true for those who are forced migrants and were often exposed to trauma prior to their forced departure from their home country. Another methodological flaw is the 'salmon bias hypothesis', which postulates that critically ill migrants tend to return home to convalesce and possibly to die.[3] These migrants are not included in mortality data, thus distorting reported mortality rates.

Challenge 2: Under-representation in research

Migrants remain under-represented in most community-based research, distorting health planning and policy and resulting in their needs being unmet. A systematic review of the literature[4] found that socioeconomically disadvantaged communities (including NES migrants) are no less likely to be willing to participate in research than mainstream communities. Rather, they are in fact less likely to be invited to participate in research.[4] For example, randomised trial protocols often explicitly exclude participants who have poor English[5], even when these sub-populations are among the most affected by the health conditions being researched.

Challenge 3: Recruitment and sampling challenges

Much of the published research insists on probabilistic sampling as the gold standard for maximising external validity**.** However, probabilistic sampling potentially excludes NES migrant communities and may not be warranted. Probabilistic selection assumes that the population is known and can be accessed. This is not reasonable when researching hard-to-reach populations who are often highly mobile, especially soon after migration. Additionally, migrant cultures may be wary of sharing information with 'strangers' (i.e. researchers), often because of negative pre-migration experiences with home country authorities. Therefore, traditional data collection methods frequently miss out vital NES migrant segments, skewing research findings, even though other approaches might provide representative results.

Challenge 4: Poor data mapping, integration and co-ordination

Extensive migrant health data are collected by multiple agencies (e.g. the Australian Department of Families, Housing, Community Services and Indigenous Affairs, Department of Immigration and Citizenship).The differing purposes and lack of co-ordination between organisations means that there is no data linkage or integration, missing an opportunity to leverage results across studies or obtain a holistic view of NES migrants' health. This impedes integrated policies geared toward addressing migration-related health inequalities.

Challenge 5: Differing cultural values

Many NES migrants and refugees come from collectivist societies, which are misunderstood by researchers and policy makers from western individualistic societies (i.e. Australia). Collectivist communities are characterised by group memberships in which hierarchy, respect for opinion formers, and family relations are extremely important. There is an emphasis upon interdependence, and compliance with social or group norms.[6,7] A consequence is that there is not necessarily an 'individual view' on health issues. In an individualistic system, the emphasis is on self-reliance, liberty, and above all, personal independence.[6,7] Fulfilling individual needs and personal goals (e.g. exercising to lose weight or look nice), personal excellence and status, and the protection of individual rights are extremely important.[6,7] Cultural differences translate into actual behaviours as well as how migrant community mobilisation and recruitment occurs, and how health promotion interventions should be designed to effectively engage with NES migrants.

Conclusions

Correctly representing NES migrants' views in research by adopting more flexible and inclusive frameworks will not only improve health promotion policies and programs addressing the needs of Australia's ethnically diverse population, but will also promote social inclusion. Improved community engagement through community leaders and organisations, as well as having community members involved in data collection could be used to achieve greater 'reach and penetration'. Furthermore, co-ordination and integration of data collected across various surveys undertaken in Australia will provide a more holistic understanding of migrants' health status and needs. This would enable health promotion interventions to better address NES migrants' health issues and more effectively advocate for integrated policies that emphasise social connectedness and cultural participation. Addressing these methodological issues is

often expensive as it is hard to reach the targeted audience, and will require some reorientation in research and planning. However, the benefits in addressing health inequities means that this investment is warranted, but may need to be better promoted and communicated to funding agencies

Acknowledgements

A/Prof. Andre Renzaho is supported by an ARC Future Fellowship.

References

1. Department of Human Services. *Drugs in a multicultural community: An assessment of involvement.* Melbourne: DHS; 2000.
2. Kennedy S, McDonald JT, Biddle N. *The Healthy Immigrant Effect and Immigrant Selection: Evidence from Four Countries. SEDAP Research Paper No. 164.* Hamilton, Ontario, Canada: Social and Economic Dimensions of An Ageing Population; 2006.
3. Pablos-Méndez A. Mortality Among Hispanics. *JAMA: The Journal of the American Medical Association.* April 27, 1994 1994;271(16):1237-1238.
4. Wendler D, et al. Are racial and ethnic minorities less willing to participate in health research? *Plos Medicine.* 2006;3(2):e19-e19.
5. O'Neil A, et al. A randomised, feasibility trial of a tele-health intervention for Acute Coronary Syndrome patients with depression ('MoodCare'): Study protocol. *BMC Cardiovascular Disorders.* 2011;11(1):8.
6. Triandis HC. *Individualism and collectivism* Boulder, CO: Westview Press; 1995.
7. Schwartz SH. Individualism-Collectivism. *Journal of Cross-Cultural Psychology.* June 1, 1990 1990;21(2):139-157.

Authors

Andre Renzaho, School of Public Health and Preventive Medicine, Monash University, Victoria; Centre for International Health, Burnet Institute, Victoria

Catherine Renzaho, General Practitioner, Doctors of Ivanhoe, Victoria

Michael Polonsky, School of Marketing, Deakin University, Victoria

Correspondence

A/Prof Andre Renzaho, Migration, Social Disadvantage, and Health Program, International Public Health Unit, Department of Epidemiology & Preventive Medicine, Monash University, Level 3, Burnet Building, 89 Commercial Road, Melbourne, Victoria 3004; e-mail: andre.renzaho@monash.edu