Multicultural Nutrition

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Aim: Effectively support and educate families in providing nutritious foods whilst respecting and maintaining their cultural identity.

Key points

Table 1: Key points

<table>
<thead>
<tr>
<th>Point</th>
<th>Description</th>
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<tbody>
<tr>
<td>• It is the responsibility of the health professional to provide the best care that maximises outcomes but at the same time maintains cultural integrity.</td>
<td></td>
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<tr>
<td>• CALD women require the breastfeeding information and skills that all women require however, the strategies used to support them need to be culturally and linguistically specific in order to be effective.</td>
<td></td>
</tr>
<tr>
<td>• There is no universal model of feeding infants aged over 6 months. Cultural, social and medical factors can influence the age at which solids are introduced and different cultures have their own traditions about what food is most suitable to begin with. Culturally-appropriate foods and preparation methods should be encouraged when they are nutritionally adequate.</td>
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Overview

The term ‘Culturally and Linguistically Diverse’ (CALD) was developed to be inclusive of all Australians but has come to mean those who have come from backgrounds which are significantly different from mainstream Anglo-Celtic countries and Australia. It does not include Indigenous Australians or migrants from countries with similar cultural and linguistic characteristics to Australia such as New Zealand, Canada, the United Kingdom and the United States of America.

‘CALD’ refers to the wide range of cultural groups that make up the Australian population and communities. The term acknowledges that groups and individuals differ according to religion and spirituality, racial backgrounds and ethnicity as well as language. The National Health and Medical Research Council (NHMRC) states that “for people who come from other lands to live in Australia, the impact of settlement and acculturation varies widely depending on their experience and situation” and other determinants of health and wellbeing outside of the health system; thus factors affecting the health and wellbeing of CALD communities can be diverse and complex. Developing cultural competency is important to address the myriad of “social, economic, environmental and individual risk and protective factors” pertinent to CALD people.

The Department of Immigration and Citizenship reported that the main groups of people settled under Australia’s Humanitarian Program in 2012-13 were from Iraq, Afghanistan, Myanmar, Bhutan, Ethiopia and the Democratic Republic of Congo. Other common CALD groups in Australia are from India, China, Vietnam, South Africa, Sri Lanka, Malaysia and the Philippines.
Australia’s diversity brings significant cultural, social and economic benefits to the Australian community in general. Specific benefits to population health include:

- The progressive diversification of the food supply and the associated health protection.
- Introduction of diverse sports and games, which broaden opportunities for physical activity.
- Diversity in the health workforce.

Important definitions

A ‘refugee’ is described by the United Nations Refugee Convention as “owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or owing to such fear, is unwilling to avail himself of the protection of that country, or who not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear is unwilling to return to it”. 4

An ‘asylum seeker’ is a term used to describe someone that has formally applied for protection as a refugee. Some refugees do not seek formal protection (asylum) and not all refugees that apply for asylum will be granted it. 4

A ‘migrant’ refers to a person who has made an informed decision to leave their home country and is free to return home if the immigration does not work out. A distinct difference between a migrant and a refugee is that, a refugee moves country due to human rights concerns as opposed to gain economic advantage, as is often the case for a migrant. 4

Recommendations for practice

It is the responsibility of the health professional to provide the best care that maximises outcomes but at the same time maintains cultural integrity. In order to adequately support, effectively communicate with and access CALD communities; health services and professionals are encouraged to develop a high level of cultural competence. 5

Health professionals working with CALD families should:

- Develop a knowledge base regarding cultural and religious practices around food and nutrition, health beliefs and accessing health services.
- Build skills in accessing and using multilingual, translated materials and professional interpreter services to improve the quality of service and effective transfer of health information.
- Build relationships with clients based on trust and mutual respect.
- Provide culturally tailored and sensitive advice consistent with dietary guidelines for breastfeeding, infant feeding, introduction of solids and childhood nutrition.
- Promote exclusive breastfeeding until around 6 months of age when solid foods are introduced, and that breastfeeding is continued until 12 months of age and beyond, for as long as the mother and child desire. 6
- Identify potential common dietary issues among refugee families. These include but are not limited to:
  - Food insecurity.
  - Vitamin and mineral deficiencies
- Be aware of prolonged breastfeeding in some communities.

**Communication across cultures**

Health professionals need to demonstrate understanding and diplomacy as some CALD groups may not have good English proficiency. Some may be required to work with interpreters to facilitate meaningful communication. For information on interpreter services, refer to your area health service policy. The language service policy from Office of Multicultural Interests may also help. Interpreting services are generally available in most languages and Auslan (Australian Sign Language of the deaf community).

Health professionals can also choose from the services listed in the *Translator Services* section of this chapter or may have an in-house service available.

**Tips to effective communication and using interpreters**

Ineffective communication can lead to inadequate care and raise ethical concerns. Miscommunication can occur with clients from non-English speaking backgrounds. Professional interpreters should be used to bridge the cultural and linguistic gaps between the health provider and the client. Avoid using family, friends or untrained personnel as interpreters as confidentiality may be compromised or material of a sensitive or traumatic nature may be exposed.

When organising an interpreter the correct language and cultural sensitivities must be taken into consideration. The following points provide guidance when using interpreters:

- Ensure that the interpreter and client understand each others’ language.
- Ensure that the client is comfortable with the interpreter. In small communities or where there are potentially political and ethnic divisions, confidentiality can be compromised.
- When talking through an interpreter, address the client not the interpreter and speak in the first person e.g. do not use “…ask him how he feels…”
- Sit facing your client.
- Speak in a natural tone of voice; it is a language difficulty not a hearing problem.
- Avoid extended use of jargon and slang words.
- Keep sentences short where possible. Allow time for the interpreter to speak.
- Provide regular summaries of the information presented to ensure comprehension.
- Rephrase where there is poor understanding.
- Refrain from extended conversations between yourself and the interpreter.
- Reassure the client of their rights to confidentiality.
Dietary considerations

This section highlights some of the cultural considerations for CALD families relating to infant feeding, introducing solids and child nutrition. Other sections of the Child and Antenatal (CAN) manual provide more detail on each of the above mentioned topics.

The WA ‘Association for Services to Torture and Trauma Survivors’ (ASeTTs), coordinates a program entitled Good Food for New Arrivals. The program provides information on nutrition education programs, cooking classes and background papers on such topics as healthy eating, poor appetite, iron deficiency and poor dentition. It can be accessed from http://goodfood.asetts.org.au or through the contact details listed in the Resources for Families section at the end of the chapter.

Breastfeeding

Women from different CALD backgrounds are not uniform in their breast feeding practices. Some women from different cultural groups are more likely to breastfeed than Australian born women, and some are less likely to breastfeed. Additionally, there is little research that exists on the initiation and duration of breastfeeding among CALD women in Australia; thus, it is important to not make any assumptions about individual cases. It is better to assess each case on its own merit.

Research has shown that certain factors strongly influence women’s breastfeeding practices, especially those from migrant or refugee backgrounds. These are:

- A lack of support, such as family and/or peer networks.
- Perception of cultural norms, such as breastfeeding is a shameful act because of its low visibility in Australia.
- Traditional belief systems, such as discarding the colostrum or eating certain foods.
- Poor knowledge e.g. on infant nutrition or using breastfeeding as a form of contraception.
- A lack of accessible information, such as CALD sensitive support services and resources in their language of choice.
- Constant movement with unstable food supplies and shelter as well as other economic difficulties often associated with moving to a new country.
- Pressure associated with continuing English language classes, study or work.

Breastfeeding information and skills that all women require are also necessary for CALD women; however, the strategies used to support them need to be culturally and linguistically specific in order to be effective. Health professionals should source information and resources appropriate for specific populations and be aware of stereotyped assumptions that may not be true of the cultural group or individual.

Infant feeding

Infant feeding choices are embedded in the context of ethnic and cultural beliefs; therefore, it not surprising that these will be influenced by moving to a new country.
Beliefs and practices observed amongst both Australian born and CALD families that may require health professional advice include:

- Feeding bottles used well past the age of 12 months.
- The perception that cow's milk is a good food source for children and used instead of solid foods.
- Sugar commonly added to milk bottles.

Information that may help parents in making decisions on feeding their child:

- Discourage the practice of placing food or thickeners into bottles.
- Discourage the addition of soft drink or sweetened drinks to bottles.
- Ensure and encourage the correct use of formula. Understanding label instructions on how to make up infant formula may be difficult for families who do not speak or read English. A demonstration of how to prepare infant formula may be required.
- Discourage use of condensed milk for infant feeding.

**Starting solids**

There is no universal model of feeding infants aged over 6 months. Cultural, social and medical factors can influence the age at which solids are introduced and different cultures have their own traditions about what food is most suitable to begin with. Culturally-appropriate foods and preparation methods should be encouraged when they are nutritionally adequate.

**First foods**

The introduction of solid foods at around 6 months should start with iron-containing foods, including iron-enriched infant cereals, pureed meat, poultry and fish (all sources of haem iron), or cooked tofu and legumes. Vegetables, fruits, and dairy products such as full-fat yoghurt, cheese and custard can then be added. Other than recommending the use of iron-rich first foods, there are no recommendations on the order in which foods should be introduced or the number of new foods that can be introduced at a time.

Other helpful tips include:

- Educate families about the preparation and consistency of both iron-fortified rice cereal and pureed/mashed vegetables.
- Encourage safe food safety practices regarding storage of rice porridge.
- Encourage the introduction of other foods that are culturally appropriate and make the transition from smooth to lumpy to finger foods.

Be aware that rice porridge, prepared from rice grains with the addition of vegetables and meat juices, are often used as a first infant food by some cultural groups. However, it is important to inform families who prepare homemade rice porridge that:

- Rice porridge alone has insufficient iron to meet the infant’s needs.
- Cooked rice cooled and stored at room temperature can be contaminated with Bacillus Cereus. This bacterium is found in dry rice and grows in cooked rice.
If the rice is cooled and stored at room temperature it can cause food poisoning.

**Food safety**

Families can also be made aware of other potential hazardous foods that contain pathogens which may cause food poisoning. Bacteria thrive on foods that are high in protein and perishable, such as dairy, egg products, seafood, meal and poultry. 

Appropriate preparation, cooking, storage, refrigeration and hygiene are recommended.

**Dental care**

A number of CALD communities have issues relating to poor dentition. The causes are varied but can include:

- lack of dental care practices in country of origin
- lack of public health measures relating to dentition in country of origin
- high consumption of sweetened beverages
- vitamin deficiencies
- torture and trauma
- lack of affordable dental service for 0-4 yr old groups.

WA Dental Health Services can arrange interpreters to help explain services and dental treatment is provided at no cost to patients. For further information on interpreter services, call the local Dental Health Services. Refer to Refugee Support Services for contact details.

A background paper for health professionals on the health of refugee children covers information on specific nutrition issues.


**Religious dietary restrictions**

The religious dietary practices adhered to in religions such as Islam, Judaism, Hinduism and Sikhism (also Jainism and Buddhism) are briefly described below.

How strictly each individual adheres to the rules or laws varies. Assumptions cannot be made that each religious community is the same nor that each individual within that community practice similarly. Ask the client how strictly they practice and observe the dietary laws.

There may be different levels of observance for different communities and exceptions for special considerations. For example Ramadan, the fasting month may not necessarily need to be fully observed during pregnancy and lactation but the client may choose to fast.

Understanding the religious tenets relating to food is essential in effectively providing food and nutrition information and services to families. When hosting parenting groups, serve a selection of vegetarian and meat foods on separate trays at opposite ends of the table. If you are expecting people who practice the Islamic or Jewish faith, it is good practice to ensure a selection of Halal and Kosher foods are set aside from other foods.
Islamic

‘Halal’ is a Quranic word meaning lawful or permitted. In reference to food, it is the dietary standard, as prescribed in the Quran - the Muslim scripture. General Quranic guidance dictates that all foods are Halal, except those that are specifically mentioned as ‘Haram’ (unlawful or prohibited).  

A strong emphasis is placed on both physical and spiritual cleanliness within the Islamic religion. For a food or drink product to be approved for consumption, it must conform to the Islamic dietary laws.

Ramadan is a fasting month for all Muslims. No food or drink may be consumed during daylight hours, from the break of dawn to sunset. Fasting is only obligatory for Muslims who have reached puberty and are healthy. The chronically ill (e.g. those with diabetes) and the elderly, are not obliged to fast.

Judaism - Kosher

Kosher food is food that conforms to Jewish dietary laws. As with all religious laws, there is a wide spectrum of observance, ranging from strict adherence to total disregard. Some Jewish people will not eat pork but will disregard other laws. Others will only eat Kosher meat but will eat food cooked with non-Kosher utensils. 

Deciding whether ordinary processed products have been prepared in a manner that complies with the standards of Jewish law is a complex matter. This is done by a Rabbinic organisation who publish the Australian Kosher Food Bulletin. A strict observer of the kosher laws will only eat products listed in the Bulletin.

Summary table of religious food requirements

It is important to note that there are varying degrees of orthodoxy and people who follow particular faiths may follow these food requirements fully or in part. A summary of food requirements of different religious groups are listed in Table 1 below.

For more detailed information, religious fact sheets are available from: http://www.omi.wa.gov.au/omi_guidelines.cfm

Table 2: Summary of religious food requirements

<table>
<thead>
<tr>
<th>Islam</th>
<th>Buddhism</th>
<th>Hinduism</th>
</tr>
</thead>
<tbody>
<tr>
<td>According to the Islamic faith, Muslims must not:</td>
<td>Some Buddhists can be vegetarian. There may be days during the year when they fast.</td>
<td>Vegetarianism is common amongst Hindus. In eastern India fish is a staple food.</td>
</tr>
<tr>
<td>• Eat or handle any pork or pork products. This includes foods such as biscuits, cakes and bread that may have pork fat added.</td>
<td></td>
<td>• Most Hindus do not eat beef or beef products.</td>
</tr>
<tr>
<td>• Eat food prepared in pots or with utensils used for cooking pork.</td>
<td></td>
<td>• Prefer to use separate dishes and utensils for vegetarian and non vegetarian foods.</td>
</tr>
<tr>
<td>• Eat meat not killed in the lawful</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date Issued: 1997
Date Reviewed: January 2014
Next Review: January 2017
NSQHS Standards: 1.7
way i.e. non-halal meat.

- Drink any form of alcohol or food containing alcohol e.g. sherry trifle, plum or Christmas pudding made with wine or spirits.

<table>
<thead>
<tr>
<th>Judaism</th>
<th>Sikh</th>
<th>Seventh Day Adventist</th>
</tr>
</thead>
<tbody>
<tr>
<td>• All meat must be killed and prepared in a special way and only be purchased from a specialist butcher.</td>
<td>• Observant Sikhs do not eat meat and do not consume alcohol.</td>
<td>• Follow ovo-lacto vegetarian diet and avoidance of stimulants such as caffeine and alcohol.</td>
</tr>
<tr>
<td>• No food can be eaten that contains or comes in contact with any non-kosher meat, including utensils and facilities.</td>
<td>• Sikhs who do consume meats prefer meat slaughtered with a single blow and not left to bleed to death.</td>
<td></td>
</tr>
<tr>
<td>• Must not eat or handle pork or pork products, fish without fins or scales and substances extracted from forbidden meats or fish, for example oil and gelatine</td>
<td>• In multigroup functions it would be prudent to place beef or other meats in separate locations.</td>
<td></td>
</tr>
<tr>
<td>• Meat and milk products are to be prepared and eaten separately.</td>
<td>• Some observant Sikhs do not eat egg.</td>
<td></td>
</tr>
<tr>
<td>• Fasting during the year for various festivals and historical events.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fact sheets regarding cultural food practices of groups from Afghanistan, Burundi, Congo, Ethiopia and Iran are available from AS/TTs at the following weblink: Traditional Eating Patterns.

Food stores in Perth that offer the traditional foods of many cultural groups are also available from AS/TTs at the following weblink: Traditional Food Stores.

Influence of Western diet

Australian migrants have enriched the cultural mix and influenced Australia’s food availability, productivity, cuisines, cooking techniques and meal preparation.

The abundance of foods, transition from home land to Australia, reduced or loss of cultural practices and assimilating into Australian way of life may change the way individuals or families traditionally eat and drink. The changes may have lasting health impact for current and new generations.21
Recent migrants and refugees

Dietary issues are a common problem experienced by refugee children and their families before and after resettlement to Australia. On arrival, the health status of a refugee child may be poor due to past food deprivation and prolonged periods with a suboptimal diet. \(^{22, 23}\) Difficulties in accessing familiar foods, unfamiliarity of many fruits and vegetables available in Australia and the cost of familiar foods are added stressors experienced by refugee children and their families. \(^{15}\)

Detailed information regarding the topics summarised below can be accessed from Good Food for New Arrivals website: [http://goodfood.asetts.org.au](http://goodfood.asetts.org.au)

Food insecurity

Food insecurity can be defined as the "inability to access enough food for an active, healthy lifestyle at all times, including culturally appropriate/acceptable foods". \(^{25(p372)}\)

Food insecurity is identified as a major issue for refugees and some migrants with a number of underlying causes. These issues are often not discussed or addressed. The stigma and shame of running out of food is quite strong in some communities and unless the question is asked specifically the information may not be voluntarily given. \(^{26}\)

Do not hesitate in raising this issue in order to resolve it. Practical tips on how to assist families in this situation can be found in the *Money for Food* pamphlet, which is also accessible in a variety of different languages. Available from: [http://pubs.asetts.org.au/nutrition/resources.htm](http://pubs.asetts.org.au/nutrition/resources.htm).

For further information regarding those WA services that can assist families, contact the local migrant resource centre [contact details are included in the *Money for Food* pamphlet.](http://pubs.asetts.org.au/nutrition/resources.htm)

Changing food habits

Re-settling in a new country can be a difficult transition, particularly when huge disparities in living conditions exist with the home country of origin. Coping with a change in food habits is one of those transitional difficulties. Families may need support to find familiar foods and to continue cultural food habits. In addition, they may require information on foods that could potentially be detrimental to health. \(^{27}\)

When advising refugee families, consider that\(^ {15}\):

- Food habits are individual. Not all habits reflect cultural practices.
- Access to familiar foods is important.
- Discussion around unfamiliar foods and potential health effects may help.
- Discussion around the safety of tap water to drink in Australia and best drink to choose when thirsty may also help.
- Culturally appropriate nutrition resources to support families are useful tools for education.
Nutritional deficiencies

Nutrient deficiencies cause significant health problems in refugee populations. The limited food supply experienced by families before arriving to Australia often leads to increased risk of deficiencies with subsequent health problems.\(^\text{15}\)

**Iron deficiency**

Iron deficiency is one of the most prevalent nutrient deficiencies seen worldwide. Pregnant and lactating mothers and children from 9 – 36 months are at highest risk because they have higher iron requirements. The decreased iron stores affect the production of haemoglobin and the oxygen carrying capacity of the blood.\(^\text{28}\)

Consuming large amounts of tea containing tannin, a natural colouring agent, inhibits iron absorption. However drinking tea contributes to the social fabric of a community and is often enjoyed by all family members including children and infants. In some cultural groups and in areas where water supply is not safe, offering infants and young children boiled water in the form of tea, may be seen as a sensible approach to dealing with an important food safety issue.\(^\text{28}\)

Rather than recommending avoiding tea altogether (not always a realistic option), suggest avoid drinking tea with meals, and to wait at least 2 hours after meals before consuming. This will allow time for maximum iron absorption from foods eaten.

**Vitamin deficiencies**\(^\text{14, 15}\)

Although relatively uncommon among the general population, vitamin deficiencies experienced by CALD groups include:

- **Vitamin A**

  A common deficiency in refugees in their home countries and mainly caused by poor health and low vitamin A content in rationed food. It is particularly prevalent among preschool children causing night blindness and ocular lesions. Growth may also be delayed with impaired bone formation and dental problems.

- **Vitamin C**

  A deficiency most common in pregnant mothers and people who have been reliant on food rations. Deficiency can cause excessive bruising and gum disease.

- **Vitamin D**

  Vitamin D is mainly absorbed by the body through direct sunlight and small amounts through food like salmon, mackerel, tuna and cod liver oil. Vitamin D is essential for the production of the hormone required for calcium absorption, bone development and growth. Vitamin D deficiency leads to rickets in children and osteomalacia or early onset osteoporosis in adults, delayed walking, bowing legs, seizures and failure to thrive. Treatment for tuberculosis may also contribute to low vitamin D levels.\(^\text{29, 30}\)

  Some CALD groups are at high risk of vitamin D deficiency and should be screened for vitamin D deficiency. Those most at risk include\(^\text{29}\):

  - Women and children with dark skin.
Veiled women and their children, such as women who follow the Islamic faith, and those from Africa, Middle East and Central Asia. The children of women who were deficient during pregnancy will also be deficient.30, 31

Those living in institutions where access to sunlight is restricted and recent migrants and refugees arriving from countries of unrest where they may have experienced significant abuse and intimidation.

Prolonged breastfed children where solids have not been appropriately introduced.

Vitamin D levels can decrease during the winter months when exposure to sunlight is restricted. Re-checking levels during winter would be beneficial. Treatment is usually with supplementation. Consult a local medical practitioner or migrant health clinic for assessment and treatment support.29

Poor appetite

Potential causes of poor appetite experienced by refugee children and families include:27:

- coping with a new environment - The child could be facing new experiences such as travelling long distances, learning a new language, and coping with a different urban environment
- physical and psychological causes, such as intestinal worms, Helicobacter Pylori infection, iron deficiency anaemia, malaria, inherited blood disorders and psychological issues relating to family dynamics, depression and stress
- reduced physical activity
- changes in growth patterns
- changes in meal patterns
- excessive juice or milk intake, i.e. more than one litre per day
- increased intake of treats or ‘party’ foods, which provide a large amount of energy (kilojoules) intake and leaving little room for nutritious family foods
- dental caries.

If poor appetite occurs early in the settlement phase, reassure parents that it will take some time for their child to become familiar with their new surroundings and foods. Appetite and interest in foods will usually return as the child becomes more accustomed to his/her new way of life and makes new friends.

School lunches

Children may arrive at school without lunch for a variety of reasons including:32:

- Preparing a packed school lunches may be an unfamiliar concept as attending school may in itself be a new experience. Some children may have been used to going home for the mid-day meal or lunch may have been provided on site.
- Food insecurity. Some families may have insufficient money to access a safe and regular food supply.
- Ongoing mental health issues, including depression and post traumatic stress disorder, may mean that some parents find it very difficult to plan and prepare a packed lunch prior to the school day.
Lunch may have been provided by school in some refugee camps.

Tips for the health professional working with refugee families:

- Run an information session or talk at an informal meeting for parents on how to pack a lunchbox.
- Run hands-on activities for children preparing school lunches.
- Suggest to the school to run a lunch program.
- Support the school canteen in offering a nutritious menu. Encourage a supply of Halal foods from the canteen if a number of Muslim children attend the same school.
- Engage a community dietitian to work with school staff to clarify their policy regarding lunches (as part of a broader health promoting schools policy).

Access resource cards and posters available from the *Good Food for New Arrivals* website

**Related policies, procedures and guidelines**

The following can be read in conjunction with this document.

- **5.5.1 Policy for refugee health in WA**
- **5.5.2 Guidelines for delivering refugee community health**

**References**


Resources for professionals

Western Australian

- Good Food for New Arrivals (ASeTTs)
  Phone: (08) 9227 2700
  www.asetts.org.au/
  http://goodfood.asetts.org.au/

- Office of Multicultural Interests
  Provides advice to State government on policies and programs to improve services to CALD communities.
  Access WA Statistics and Community Profiles, the Language Services Policy 2008, and information sheets on culture and religion from
  www.omi.wa.gov.au

- Perth Coalition for Asylum seekers, Refugees and Detainees (CARAD)
  www.carad.org.au

- Refugee Health Network of Australia (RHeaNA)
  www.refugeehealthaustralia.org

- Useful links to access health information in different languages and relevant publications
  - www.healthnavigator.org.nz/languages/

National and International

- Amnesty International Australia
  www.amnesty.org.au

- Australian Halal Food Directory
  www.halalaustralia.com.au

- Australian Federation of Islamic Councils
  www.afic.com.au

- National Health and Medical Research Council.
  For example, Infant Feeding Guidelines (2012)
  Phone: 1800 020 103 or visit www.nhmrc.gov.au
- Department of Immigration and Multicultural and Indigenous Affairs  

- Food Safety and Hygiene  

- Kosher Australia  
  [www.kosher.org.au](http://www.kosher.org.au)

- RACGP's Refugee and Asylum Seeker Health Resource Centre  
  [http://www.racgp.org.au](http://www.racgp.org.au)

- Refugee Council Website  
  [www.refugeecouncil.org.au](http://www.refugeecouncil.org.au)

- World Health Organization  
  [www.who.int/en](http://www.who.int/en)

- Foundation House  
  Services are provided for clients in Melbourne; however the site has a lot of useful resources and publications  

**Resources for families**

**Translator services**

- On-Call Interpreters & Translators Agency Pty Ltd  
  Level 4, 231 Adelaide Terrace Perth WA 6000  
  Office hours: Monday to Friday 8:00am – 6:00pm  
  Phone: (08) 9225 7700  

- Customised Language and Cultural Solutions  
  Perth WA 6000  
  Phone: (08) 9445 2988  

- National Language Academy  
  Level 1, 10 William St Perth WA 6000  
  Phone: (08) 9481 6166

- Shoji Australia Pty Ltd  
  1st Floor, 25-257 Hay St East Perth WA 6004  
  Phone: (08) 9221 5005

- Translators International  
  Suite 1/ 44 Kings Park Rd West Perth WA 6005  
  Phone: (08) 9321 1960

- Translating and Interpreting Service (TIS) for English Speakers
  An interpreting service provided by the Department of Immigration and Citizenship to provide interpreting services for people who do not speak English and for agencies and businesses that need to communicate with their non-English speaking clients

  Department Of Immigration & Multicultural Affairs
  Phone: 13 14 50 (immediate telephone interpreting)

Translated education materials

- Good Food for New Arrivals
  http://goodfood.asetts.org.au/

- NSW Multicultural Health Communication Service
  www.mhcs.health.nsw.gov.au

- NSW Refugee Health Service

- Royal Women's Hospital, Victoria
  www.thewomens.org.au/MultilingualFactSheets

- The Victorian Foundation for Survivors of Torture (Foundation House)
  www.foundationhouse.org.au

- Mothers Direct have multilingual breastfeeding fact sheets available to purchase

Refugee support services

- ASeTTS (Association for Services to Torture and Trauma Survivors Inc)
  286 Beaufort Street PERTH WA
  Phone: (08) 9227 2700
  Fax: (08) 9227 2777
  Email: reception@asetts.org.au
  Website: http://www.asetts.org.au

  ASeTTS is a non-profit, non-government organization which provides treatment and support to people who have been tortured or traumatized by violent conflicts. Many clients are recent arrivals to Australia, although services are available to all survivors whatever the length of their residence in Australia has been. ASeTTS is based in Perth, Western Australia.

  ASeTTS' Services are free, confidential, culturally inclusive and are designed for children as well as adults. ASeTTS services are only for people who have...
already arrived in Australia. ASeTTS are unable to assist with migration to Australia nor provide direct monetary support.

- Metropolitan Migrant Resource Centre
  PO BOX 642 Mirrabooka WA 6941
  Mirrabooka Office (08) 9345 5755
  Clarkson Office (08) 9200 6284
  Email: admin@mmrcw.org.au
  Website: www.mmrcw.org.au

The Metropolitan Migrant Resource Centre Inc. is a non-profit community organisation based in Mirrabooka which provides services across the metropolitan area.

- Edmund Rice Centre Mirrabooka
  Unit 18 Brewer Place, Mirrabooka WA 6061
  Phone: (08) 9440 0625 or (08) 9440 1920
  Email: info@ercm.org.au
  Website: www.ercm.org.au

- Ishar Multicultural Women’s Health Service
  Kevin Smith Community Centre
  21 Sudbury Road Mirrabooka WA 6061
  Phone: (08) 9345 5335
  Email: info@ishar.org.au
  Website: www.ishar.org.au

  Ishar provides clinical antenatal care alongside a women's GP, as well as information and education sessions for pregnant women, amongst other services.

- Community Midwifery WA (CMWA)
  1/40 Pearse Street North Fremantle WA 6159
  Phone: (08) 94306882
  Email: admin@cmwa.net.au
  Website: www.cmwa.net.au

- Centrecare (several locations across WA)
  456 Hay Street Perth WA 6000
  Phone: (08) 9325 6644
  Email: enquiries@centrecare.com.au
  Website: www.centreacare.com.au

  Centrecare is a not-for-profit organisation delivering quality professional counselling, support, mediation and training services.

- Refugee Clinic, Princess Margaret Hospital for Children
  Roberts Road, Subiaco WA 6008
  Phone: (08) 9340 8222
  Email: pmh@health.wa.gov.au
Website: www.cahs.health.wa.gov.au

- Humanitarian Entrant Health Service, Department of Health
  Anita Clayton Centre
  1/311 Wellington Street Perth WA 6000
  Phone: 08 9222 8500
  Email: ACCadmin@health.wa.gov.au
  Website: www.health.wa.gov.au/acc/home/

- Red Cross – Migration Support Programs
  110 Goderich Street East Perth WA 6004
  Phone: (08) 9225 8888
  Email: wainfo@redcross.org.au
  Website: www.redcross.org.au/migration-support.aspx

- Dental Health Services
  Dental Health Education Unit
  43 Mt Henry Road COMO WA 6152
  Phone: (08) 9313 0555
  Email: dheu@dental.health.wa.gov.au
  Website: www.dental.wa.gov.au/

- Personal Health Record (PURPLE BOOK) is available in the following languages: Arabic, Chinese, Indonesian and Vietnamese. Available from Community Health Centres or via order on the CACH intranet 'Forms' page: http://cahs.hdwa.health.wa.gov.au/__data/assets/pdf_file/0007/127276/Translated_PHR_Order_Form.pdf