The role of health literacy in reducing health disparities in rural CaLD communities

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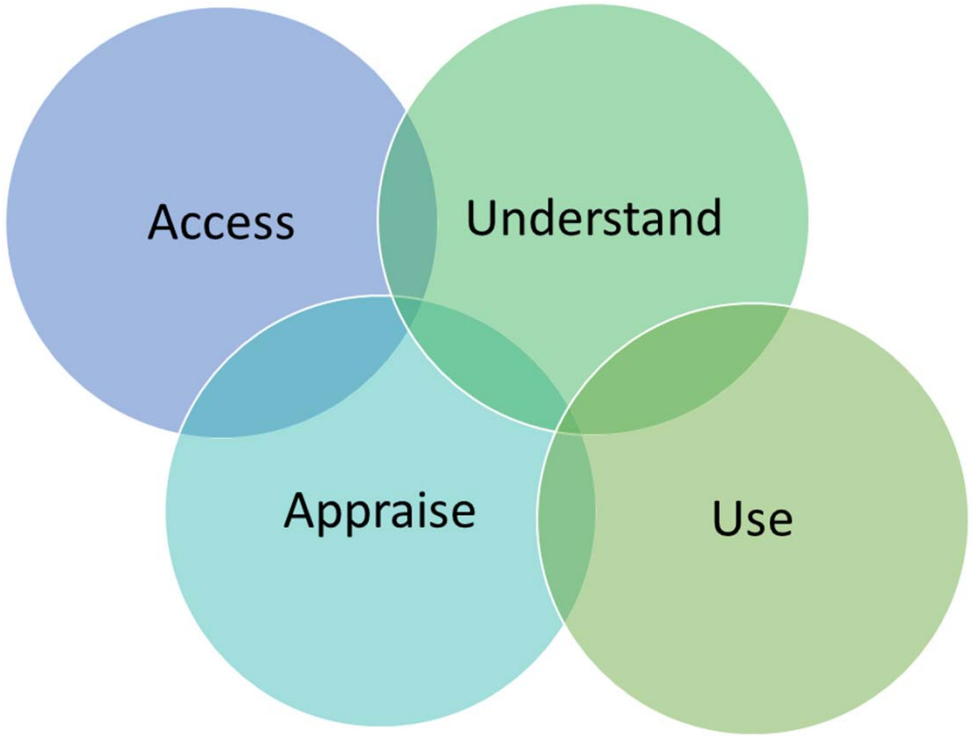
What is health literacy?

The **cognitive and social skills** which determine the motivation and ability of individuals to gain **access** to, **understand** and **use** information in ways which promote and maintain good health

(World Health Organization)



Why is it important?

Low health literacy is associated with:

- increased hospital admissions (preventable)
- poorer medication adherence
- less participation in prevention activities (screening)
- poorer self-management of chronic diseases and poorer disease outcomes
- less effective communication with healthcare professionals
- increased healthcare costs
- increased mortality

However, it is modifiable!

Berkman, N. D., S. L. Sheridan, et al. (2011). "Health literacy interventions and outcomes: an updated systematic review." Evid Rep Technol Assess (Full Rep)(199): 1-941

Health literacy in CaLD groups

74% of the CaLD population within Australia have low health literacy, compared to the general Australian population (59%)

Health literacy in CaLD population impacted by multiple factors:

- Language barriers
- Access issues
- Past health experiences in country of origin
- Reduced access to culturally appropriate healthcare services/information
- Physical barriers such as low income
- Religious and cultural values
- Beliefs about health and illness
- Patterns of communications

CaLD groups in regional and rural Australia

CaLD groups living outside of metropolitan areas face **increased stressors:**

- **Lower quality human service infrastructure** (eg settlement services and mainstream services providing assistance targeted to diverse community needs)
- **Social isolation** (for both individuals and small communities)
- **Racism**, discrimination, labelling and stereotyping
- **Difficulty with finding employment** and avoiding exploitation (particularly for seasonal workforce)
- **Limited access** to the cultural and religious institutions necessary for the preservation and celebration of heritage and identity

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Study aim

To explore the **barriers and enablers** migrant and refugee groups in Australia experience, **in accessing, understanding and using** health information and healthcare services.

- What are the health literacy needs of Somali, Chinese and Indian migrant communities in Australia?
- How can healthcare providers and organisations more effectively respond to the health literacy needs of migrant communities?

Study overview

A multi-phase, mixed method study using a Grounded Theory (GT) approach over a three phase period was used:

- Semi-structured interviews
- Cognitive interviews
- Questionnaire

Sampling frame

Participants drawn from three CaLD communities;

- **Chinese**
- **Indian**
- **Somali**

Inclusion criteria

- Over the age of 18 years
- Identify with the cultural target groups
- Born overseas
- One or more chronic disease

Phase 1

Health conceptualisations

How do different migrant groups see/understand health

Data collection method: Semi-structured interviews n=45

Phase 2

Health literacy needs

of migrant and refugee communities

Data collection method: Cognitive interviews n=20

Phase 3

Health literacy needs and strengths

of three distinct migrant and refugee communities in Australia.

Data collection method: Administer HLQ n=240

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Results & health literacy profiles

Somali Health Literacy Profile

Low levels of:

- engagement with preventative health services
- engagement with mental health services
- engagement with written sources of health information
- trust in preventative health – vaccination and cancer screening

High levels of:

- social support

- *Health information from international sources (Somali diaspora, UK TV)*
- *Inter-community diagnosing and sharing of medications*
- *Visit religious leaders for healing instead of seeking conventional care*

Chinese Health Literacy Profile

Low levels of:

- lifestyle acculturation
- engagement with mental health services

High levels of:

- participation in preventative/screening services than other CaLD groups
- use of traditional medicine for chronic health issues (however, often do not disclose this to HPs)
- developed health networks used to process external health information

- *Very reliant on HPs to recommend testing*
- *Return home for specialist care rather than wait*
- *Access health information on the internet in Chinese*

Indian Health Literacy Profile

Low levels of:

- lifestyle acculturation
- engagement with mental health services
- social support (lower than other CaLD groups)

High levels of:

- use of traditional medicine
- participation in preventative/screening services (that other CaLD groups)

- *Access health information on the internet in Indian language*
- *Many pregnant women return home for pre- and peri-natal care due to mistrust in the Australian health system*

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Health Literacy Barriers (across CaLD groups)

- poor access to contextualized health information
- healthcare system puts emphasis on individual agency/ doesn't make allowances for CaLD persons who need to go back to the family and community to discuss the decision
- Marked difference in health beliefs between CaLD persons and the general Australian population
- it can take up to two years before being able to navigate the system from the point of migration

Health Literacy Enablers (across CaLD groups)

- low cost
- provision of outreach health information and education services that contextualise and recognise distributed decision making networks and alternate health beliefs

Mistakes we are making

- Key focus on language translation of health promotion materials, however;
  - poor standardization of translation material
  - many do not read in first language/dialects
  - limited access of translated materials

- One size fits all approach health promotion (all CaLD the same)
- Fragment health – physical, emotional, mental etc.
- Assumption that all clients share bio-medical view of health
- Not checking in on health beliefs

Further information

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