



*Banyule*  
COMMUNITY HEALTH SERVICE INC

# **EVALUATION OF A SOMALI ORAL HEALTH PROMOTION PROJECT**

**By**

**Banyule Community Health Service Inc.**

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**PROJECT TEAM**

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## **SOMALI ORAL HEALTH PROMOTION PROJECT**

### ***Project Title:***

Promoting child oral health in a newly emerging Somali community.

### ***Rationale for Project:***

A significant proportion of Australia's humanitarian intake is from the Horn of Africa and among entrants from the region, those from Somalia predominate (1). In 1998/99, there were more than 800 Somali families living in North East Metropolitan regional of Victoria (2). In West Heidelberg, Somalis constitute up to 18% of the population, being the largest non-English speaking group (Olympic Village residents survey, 1999 – not yet published).

It has been reported that many refugee entrants are in poor health on arrival, the consequence of lack of access to a safe water supply, prolonged periods of food deprivation and psychological trauma (3). The degree of dietary acculturation and lifestyle changes which occur during the settlement period, have been found to influence the incidence of chronic disease in Somalis (4). A recent food and nutrition study of Somali refugees settling in Australia found significant changes in family eating habits including reduction in fibre intake, increased intake of saturated fat, increased consumption of oils, sugar, cordials and carbonated drinks which participants had reported were cheaper in Australia relative to Somalia (4).

It is hypothesised that the reported changes in food and dietary patterns may be related to the high incidence of dental caries seen in Somali pre-school children when presenting for treatment in community dental clinics. An issue of concern for the Banyule Community Health Service is that Somali pre-school children are not being accessed through the regular venues of Maternal and Child Health Centres and Pre-schools for Dental health screening. Lack of accessibility to this preventative dental health service may be possibly due to both lack of awareness and other cultural and linguistic barriers.

### **1. Target Group:**

Somali parents and family carers of children in the age group 0-5 years living in West Heidelberg.

### **2. The Aim of Project:**

The aim of this project was to improve the target group's oral health by increasing access to timely dental screening and dental care and increasing parental knowledge, skill and supports on nutritional and dental health preventative issues.

### **3. Project Objectives:**

- Improve target group's access to preventative dental health screenings and dental care.

- Increase Somali parental and community awareness of the important links between dental health and healthy diets.
- Improve parental capacity to promote better oral health and related knowledge and skills in the target group.
- Improve relationships between the Somali community and primary health care providers in the Banyule municipality.

#### 4. **Project Interventions:**

- Develop an oral health resource kit in English and Somali languages.  
The resource kit would consist of:
  - i) a Leader's Manual,
  - ii) Participants Information Folder
- Conduct oral health education programs in Somali language (5 programs of approx. 10 parents/carers in each program) using educational material outlined in the resource kit.
- Launch of project and promotion of educational material to the wider community.

#### 5. **Evaluation Methods:**

##### **i) Process evaluation:**

**Recruitment Strategies:** these included the local radio (Somali hour), Somali newspaper, word of mouth, information pamphlet translated into Somali and distributed to Banyule City Council, Maternal and Child Health Centres and the Migrant Resource Centre. It was found that the most effective recruitment strategy was word of mouth and the information pamphlet. Following publicity, 59 expressions of interest were received from parents/carers for project participation.

**Level of community agency participation:** Banyule Community Health Service supported the project by providing a meeting venue, child care facilities, program co-ordination and project management at no cost.

**Oral health education training:** Five programs were conducted over a period of twelve months. Each program consisted of 4 sessions at two and a half hours per session. Participants commented that they found the length of training programs quite adequate.

**Appropriateness of intervention methods used:** the educational material designed exclusively for this project was trialled with the participants in the first two programs prior to producing the resource kit. During the trial, the resources were modified to meet participants cultural and linguistic needs (e.g. there was no word for enamel in the Somali language). Participants commented that they found the educational resources culturally and linguistically appropriate and very informative. Group interventions also deemed to be an appropriate and cost effective method for educating parents. Parents commented that they appreciated the opportunity to have direct

interactions with the Dentist and Dietitian. Information handouts were rated as very helpful.

## **ii) Profile of sample group:**

Forty four female parents/carers participated in this project. Of these participants, 42 had completed the pre-program questionnaire. This represents a survey response rate of 95 per cent. The total number of children reported was 144 (age range 2 months to 19 years). Ninety eight of these children were of pre-school age. Information collected pertained to pre-school aged children only. The majority of the participants (77%) lived in West Heidelberg and the remainder (23%) came from Darebin. The average length of stay in Australia was just over 5 years.

## **iii) Results of Pre-Program Questionnaire:**

### ***Parent self reports on children's oral hygiene practices:***

More than half of the parents in this group (57%) reported that their children cleaned their teeth twice a day, 25% said three times per day, 7% said once a day and the remainder (12%) said their babies were too young (no teeth). The majority of the parents (76%) further said that their children used a toothbrush and fluoride toothpaste (83%) to clean their teeth. It was reported that a small number of children were using both a toothbrush and tree twig to clean their teeth. It was noted that the majority of parents (62%) did not respond to the following question: "At what age did your child start to visit the Dentist?" Twenty six per cent of parents said at the age of 4+ years and the remainder said between the age of 1-3 years (it has already been mentioned that some of these parents had very young babies). When parents were asked "How often does your child visit the Dentist?", the responses were: "never" (40%), "once a year" (24%), "twice a year" (14%), "every 2 or more years" (7%). Parents reported that they had found out about the Pre-School Dental Program at Banyule Community Health Service during their contact with the Somali project worker at the beginning of each program. This may explain the reason as to why Somalis were not accessing the Pre-School Dental service.

### ***Parent self reports on children's dietary/nutritional intake:***

The majority of the parents said that they gave their children both milk and water to drink in between meals. However, only 30 per cent of parents used the cup for their children to drink out of. The remainder used either the bottle only or bottle and cup.

Dairy foods such as milk, cheese and yoghurt were offered to the children more than once a day (95%). Other foods such as vegetables, eggs, and fresh fruit were also reported as part of the children's daily food intake.

Parents reported that the type of drink most frequently consumed by their children on a daily basis was water (81%), fruit juice (66%), cordial (57%) and soft drinks less frequently used (24%).

Parents further reported that they gave their children 1-3 serves per week of biscuits/cakes/pastries (50%), 1-3 serves per week of snack food (43%) and 1-3 serves per week of sweets (38%).

Areas of concern discovered in the parents self reports, such as the reported age of children that were seeing the Dentist (4+ years), the amount of sugar intake in childrens' daily dietary intake, and number of children drinking out of a bottle instead of a cup, were addressed during the education programs.

#### **iv) Results of Post- Program Questionnaire:**

***Program impact on participants knowledge:*** of the 44 parents who completed the “Healthy Teeth Program”, 34 filled out a post program questionnaire. This represents a survey response rate of 77 per cent. Results highlight the benefits of the program to parents/carers and their children as listed below:

- enhanced knowledge in making healthy food choices for themselves and their children;
- learnt different ways of controlling fat and sugar intake;
- enhanced knowledge of the importance of calcium for strong teeth and dietary sources for calcium;
- enhanced knowledge of the importance of fruit, vegetables and water;
- enhanced understanding about serving sizes for different age groups;
- enhanced knowledge of oral hygiene techniques required for the prevention of tooth decay;
- enhanced knowledge of first aid for teeth;
- learnt about the importance of taking their children to the Dentist once a year.

***Access and utilisation of Pre-School Dental Program at Banyule Community Health Service:*** it was observed by staff that by the end of Session 2 of each training program, parents would book their children in to see the Dentist at the Pre-school Dental Clinic.

***Sustainable Links between the Somali Community and Health Care Professionals at Banyule Community Health Service:*** to promote better oral health in a newly emerging Somali community, planning practice needs not only address links between dental health and healthy diets, but also to provide a supportive environment with ample opportunities for people to experience a sense of belonging and community interaction. Strategies for building linkages across different service providers included encouraging and supporting participants to use the occasional child care facility, linking participants with other programs and services offered at the Banyule Community Health Service which were of interest to them, provision of morning tea during training programs and time for social interaction.

***Sustainable outcomes:*** the oral health educational resources developed specifically for this project have been distributed to staff at the Banyule Community Health Service who are in direct contact with pre-school children and also to key agencies in the local community (e.g. Pre-schools, Maternal and Child Health Centres), to encourage and assist them in promoting child oral health. Furthermore, the resources have been publicised on Banyule Community Health Services web site ([www.bchs.org.au](http://www.bchs.org.au)) for sector wide accessibility to assist other organisations incorporate oral health promotion in their strategic health promotion plans or use the resources to promote and support similar projects in other newly arrived communities. The parent information kit on oral

health education (printed in English and Somali), has been highly commended by Somali parents as a valuable resource. It is intended that this resource will be made available to parents as needed.

## **6. Project Barriers:**

- Funding delay resulted in re-scheduling the project and delay in employment of the Somali Project Worker.
- Incorrect Ramadan dates resulted in further re-scheduling of the work plan.
- Intense participant recruitment strategies were required, e.g., initial telephone contact, home visit, pre-program reminder telephone call.
- Initially, the Community Centre's child care facilities were not utilised by participants because of the perceived distant location from the meeting venue (Olympic Leisure Centre).
- Starting time of programs required elasticity due to participants poor time keeping.
- The need to pilot project material for the first two programs caused some disruption to the flow of proceedings.
- Difficulties in translating educational material from English to Somali language resulted in misinterpretation of factual information.

### ***Strategies to overcome barriers:***

- Employment of Somali project worker.
- Meeting venue and day of program were changed to allow participants to be in close proximity of the childcare facility.
- Increased flexibility with program starting times.
- A standard Somali/ English dictionary was used as the referral text for the Translations.

## **7. Conclusion:**

Based on the results from the evaluations completed at the conclusion of each oral health education program and anecdotal feedback, Banyule Community Health Service achieved their aims and objectives within the specified timeframe. There was significant support for the project indicated by attendance numbers, and participants felt that they had enhanced their knowledge and skills in nutritional and dental health preventative issues, to help them make healthier choices for themselves and their children.

## APPENDIX “A”

### *References*

1. Department of Immigration and Multicultural Affairs (DIMA) (1997) *Immigration update*. June Quarter 1997, DIMA, Canberra .
2. North East Migrant Resource Centre, Victoria, 1999.
3. Victorian Foundation for Survivors of Torture (VFST) (1998) *Rebuilding Shattered Lives*, VFST, Melbourne.
4. Burns, C., Webster, K., Crotty, P., Ballinger, M., Vincenzo, R., & Rozman, M. (1999). *Easing the Transition – Food and nutrition issues for new arrivals*. Unpublished.