Fat, rich and beautiful: changing socio-cultural paradigms associated with obesity risk, nutritional status and refugee children from sub-Saharan Africa

André M.N. Renzaho*

School of Health Sciences, Deakin University, 221 Burwood Highway, Burwood, Vic. 3125, Australia

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Abstract

There has been an increase in Australia’s intake of refugees and migrants from sub-Saharan Africa over the last two decades. These refugees have been exposed to nutritional risks prior to migration, which, together with changes associated with acculturation, impact on their health and nutritional status post-migration. However, there is a paucity of data in Australia that has examined the health and nutritional status of this ethnic minority in Australia. Despite basic research assessing the nutritional status of children, none have specifically concentrated on the health and nutritional situation of sub-Saharan refugee children. In the absence of such studies, this paper explores issues relating to obesity in sub-Saharan African refugee children within a cultural and public health framework. We begin by outlining the history of obesity and its cultural meaning. We then move to a consideration of predisposing factors for obesity and how these factors translate into obesity risk contexts of sub-Saharan refugees post-migration. We argue there are a number of key challenges related to culture and the relationship between socio-economic factors post-migration that require addressing by health professionals, dieticians and health educators to ensure the delivery of successful health outcomes.

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Background

Critically addressing the nutritional risks of sub-Saharan African children post-migration is a complex exercise. A comprehensive analysis identifies a broad range of interacting social, economic, cultural and nutritional factors including the sub-Saharan African cultural environment prior to migration, family relationships, dynamics and values, food habits and coping mechanisms in a new environment. Consequently, this paper will adopt a multifaceted strategy to address this question using several perspectives: (1) an examination of the authors own sub-Saharan cultural origin and migration experience, (2) the author’s professional contribution in refugee public health nutrition and experience implementing nutritional programs for children in refugee camps in sub-Saharan Africa and (3) a comprehensive literature review. In exploring the Sub-Saharan cultural construction of obesity, this analysis may provide critical information for researchers, health professionals and educators attempting to address overweight and obesity issues in sub-Saharan African refugee children.

Obesity: its history and cultural meaning

Obesity has been a significant public health issue over the last three decades in developed countries (Dietz and...
Grivetti (2001, p. S5) notes that: his paper “psychology and cultural aspects of energy”, countries at the turn of the 20th century. For example, in were also reported in white people from developed prevalent today in people from developing countries not active and happy. construct an overweight child as sick only when he/she is the same authors report that Hispanic parents culturally be healthier than children with lower percentiles. The (2001) found that Hispanic parents perceive children (1) when he stated: “persons who are naturally very stout are more liable to sudden death than are thin persons”. Hippocrates often preached dieting, physical activity and exposure to sun as preventive and curative measures for obesity. However, during Hippocrates’ time, obesity was not a well-known medical state and it is only in the late 19th and beginning of the 20th century that the condition received increased attention. Various definitions of obesity currently exist, but the most commonly cited is that of Burton and associates (Burton et al., 1985). In this definition the authors consider obesity to be an overload of body fat often resulting in a considerable deterioration of health.

There is no such definition for obesity in developing countries such as those in sub-Saharan Africa nor is obesity seen as a disease. Instead, in some parts of sub-Saharan Africa, overweight and obesity have been historically been considered to be a sign of success, wealth, good health and indeed optimism and happiness. Such views have also been reported in Hispanics living in America (Crawford et al., 2001). Crawford et al. (2001) found that Hispanic parents perceive children whose weight for height is above the 85th percentile to be healthier than children with lower percentiles. The same authors report that Hispanic parents culturally construct an overweight child as sick only when he/she is not active and happy.

These cultural preferences for larger body sizes prevalent today in people from developing countries were also reported in white people from developed countries at the turn of the 20th century. For example, in his paper “psychology and cultural aspects of energy”, Grivetti (2001, p. S5) notes that:

At the turn of the 20th century in North America obesity was admired; wealthy consumers exhibited their wealth around their waist. Fat cheeks and ample stomachs were visual cues that individuals were healthy, not infected with the dreaded slim tuberculosis. Photographs of American executives taken during the late 19th and early 20th centuries reveal that dietary intakes of wealthy gentlemen regularly exceeded calories expended

After the Second World War, this preference for larger body sizes observed in Americans at the turn of the 20th century disappeared and was replaced with the preference for lean body size, a situation that has become so prevalent in young women in developed countries. This shift in body size preference observed in the developed world has been enthusiastically promoted by the media, especially in television advertising. Some professions such as ballet dancing (Grivetti, 2001) have indirectly portrayed a preference for lean body size candidates.

Chronic infectious diseases such as Human Immuno-deficiency Virus (HIV) (Clark et al., 1999; Nahlen et al., 1993) or tuberculosis (Grivetti, 2001), prevalent in sub-Saharan Africa, could have contributed to the current preference for big body size among sub-Saharan Africans and among migrants from sub-Saharan Africa who find refuge in developed countries. In their study of ethnic differences in body image attitudes and perceptions among women infected with HIV, Clark et al. (1999) found that 18% of African American women infected with HIV (versus 4% of non-African Americans) tried to put on weight; while 6% (versus 23% of non-African Americans) tried to lose some kilos. One percent of African Americans (versus 19% of non-African Americans) selected a low BMI (underweight) as their ideal body size while only 4% (versus 24% of non-African Americans) thought that their partners favoured an underweight body size.

This preference for big body size observed among HIV patients of African origin in the United States is also prevalent in the general population of Africa. Sub-Saharan Africa is known for its chronic poverty, population displacement due to war, ethnic conflicts and natural disasters and subsequently high levels of malnutrition (undernutrition). Consequently, the cultural exposure of sub-Saharan Africans to this suffering is likely to have a major influence on the way body weight is socially constructed and positioned. This predilection for larger body size among Africans appears to date back to antiquity (Grivetti, 2001). For instance, Darby et al. (1997) reports that Egyptian tomb art c. 2423 BC portrays the obese noble linguistically referred to as “Meru-ka-ra”. The same reasons (famine, poverty, malnutrition) that shape the current African preference for larger body size were likely to be shared by their ancestors. Famine and wasting in Africa were also reported back in antiquity (Darby et al., 1997; Grivetti, 2001) and during that era, one of most dominant figures in history, the Egyptian King Rameses II was reported to be stunted by current standards, despite being as tall as 159 cm (Grivetti, 2001; Harris and Wente, 1980).

Unlike the developed world that has shifted from preferring larger body size to lean body size, sub-Saharan Africans have maintained their preference for larger body size even after migration to developed
countries regardless of the length of stay in the host country (Powell and Kahn, 1995). For example, despite having lived in America for centuries, studies of black African-Americans indicate that black women prefer larger ideal body sizes compared with their white counterparts, and black men prefer women with larger body sizes and are more inclined to date women exhibiting heavier than ideal body size (Powell and Kahn, 1995; Rucker and Cash, 1992; Thompson et al., 1996).

In this sense, for sub-Saharan Africans, big body size characterises social rank, status and power and such views determine how food rules are defined and sustained. For example, whilst in the western world thinness in women is desirable and associated with beauty, in Sub-Saharan Africa pejorative words for such physical states are prolific. Terms such as “umuguta” in central Africa and “mkonda” in Kenya mean a malnourished or thin lady or “caato quruntay” in Somali (a skinny lady) are used with negative connotations. In the horn of Africa, thin women are understood to be “smelly” or suffering from tuberculosis, whilst in central Africa thinness is undesirable and is seen as a sign of poverty, despair and deprivation. Women, who may otherwise be called “fat” in the western world are often desirably described as “nzele ya vendese” in central Africa; meaning a lady with a good bottom or “mmono” in Kenya or “hilbi fiican” in Somali to mean a lady with presence or simply literally a lady with good meat or good flesh.

Interestingly, these constructions fall across gender. However, at a sociological level, application of Foucault’s notion of power and sexuality (Best and Kellner, 1991; Foucault, 1965, 1980; Kurzwelil, 1983) provides an analysis framework that offers some perhaps tempting interpretations to negotiating the experiences of native sub-Saharan Africans in their new western worlds. In their culture of origin, modulations in the social constructions of ‘excessive’ body weight appear strongly culturally linked to power in men. In this sense, body weight is attributed to economic advantage and is symbolised in its close relationship to wealth icons. In this sense, fat equals wealth equals power. For example, for males, a beautiful, rich and envied man is described as “taajir calool weyn” in Somali or “libumu ya bongo” in Lingala to mean a man with a pot belly strolling with a “bokoor” or a walking stick or cane with gold or silver on top. Sub-Saharan African men’s ways of expressing wealth and gaining respect in the community are characterised by being a breadwinner and having the capacity to afford on regular basis what has been termed “chakula wa wazungu” in Swahili, “ibidyo bya bazungu” in Kinyarwanda or “bileyi ya bandele” in Lingala to mean “food of white people”. These luxury foods assumed to be “foods of white people” include meat, fried foods such as chips or fried eggs, soft drink (Fanta or Coca-cola), margarine, butter, sugar, mayonnaise, chocolate, biscuits, bottled beer, salt, tinned food such as tomatoes or sardines, cheese, and vegetable oil. Often these food items are very expensive, but are known to assist with reaching a desirable weight. Men will often proudly report their diet as “naka kizunguni” to mean, “eating like a white person” when consulting their general practitioner.

‘Eating like a white person’ includes eating meat and animal products -often accompanied with a glass of beer- on a regular basis, with reduced consumption of vegetables, legumes and fruit which are often less desired and seen as survival food for poor people. Hence, culinary practices and eating habits become tools for displaying wealth and power. Frying becomes the most popular cooking method among wealthy people in sub-Saharan Africa, as being able to afford vegetable oil or meat on a regular basis demonstrates their wealth. Such practices fit well what Elias (1978/82 [orig.1939]) has described in his essay “the Civilising process”, as the competitive social display associated with eating meat. Sub-Saharan African food rules and preferences for “food for white people” are in line with what Simmel (1910) describes in his essay “The sociology of the meal” as “aesthetic stylisation” of the food that does not take into account the actual nutrient content of the food. Indeed Kottack (1978) and Goodman et al. (2000) provide some insight that could explain the sub-Saharan African preferences. To Kottak (1978), the success of advertising for corporations such as McDonalds and other take-away food shops is proportional to the extent to which it mirrors what it means to be “American”. Similarly, Goodman et al. (2000) report that there is a high status associated with the consumption of soft drinks such as Coca-Cola in developing and poor countries. Such food commodities are seen as “Western items” and therefore confer superior social status to those who are struggling economically.

**Relationships to western models of health and well being**

These observations clearly identify the cultural relativities of body weight and the extent of its social construction as mediating powerful symbolic differences between western and African cultures. Indeed, while ‘thinness’ is enviable in the western world, paradoxically it is reviled in sub-Saharan Africa and positioned as highly socially undesirable. From a health perspective, these observations strongly identify the ‘culture-bound’ nature of western mental health syndromes (Hughes, 1985) in the controversial area of eating disorders, where limited concepts such as anorexia and obesity are located in an often intellectually uninterrogated way as a global phenomenon. Overall, this paradox presents a challenge to health educators and health professionals in
Australia dealing with sub-Saharan migrant families. Viewing these phenomena with greater cultural sophistication may present cultural strategies that understand, rather than pathologise or limit the eating characteristics of sub-Saharan immigrants and guide local service programs in providing a higher quality of services that are culturally appropriate.

**Obesity: paucity of data in sub-Saharan Africa**

Although obesity is well researched in the developed world from physiological, sociological and public health perspectives, it remains an unknown public health problem in sub-Saharan Africa. Trends towards overweight and obesity have been computed in the developed world over the last five decades. These indicate that, for example, the prevalence of overweight and obesity has been increasing in Australia (Magarey et al., 2001), the United States of America (Binkley et al., 2000) and in the Netherlands (Hirasing et al., 2001). However, such data is not available in sub-Saharan Africa where only data on malnutrition is collated, reflecting the cultural aspects of this research. The few studies that have explored overweight and obesity in sub-Saharan Africa indicate that the situation is more complex than in the developed world and is characterised by a complex coexistence of both malnutrition and obesity. These studies indicate that obesity is now emerging as a public health concern despite the poor socioeconomic status prevailing in sub-Saharan Africa (Ansa et al., 2001).

**Post-migration experience: predisposing factors for obesity**

It is not known whether the coexistence of malnutrition and obesity also exists among sub-Saharan Africans who migrate to developed countries such as Australia or the United States of America. Previous work suggests that migrants from the developing world suffer varying degrees of malnutrition at the time of migration and that their nutritional status improves with time post-migration (Yip et al., 1992). This improvement in nutritional status has been shown to have mixed impacts in trends of health outcomes. For instance, Schumacher et al. (1987) followed the growth of immigrant children in the newcomer schools of San Francisco. The target group included children of Chinese, Filipino and Hispanic backgrounds, and other children of Southeast descent. The study found that at the initial assessment, a high proportion of children were stunted or wasted. At the end of the follow-up, the children studied showed a median growth velocity that was close to or exceeded the median of American white children. The authors concluded that immigrant and refugee children accelerate their growth considerably in an adequate health and nutritional environment, and this finding has implications for child and adult obesity after migration. This post-migration improvement in nutritional status is also likely to occur within the sub-Saharan African communities who migrated to Australia. However, no study in Australia has explored the nutritional status of this particular target group. Furthermore, studies of the nutritional situation of Australian migrants in general failed to mention the nutritional status of the Sub-Saharan population despite the obvious nutritional risks to which they have been exposed both before and following migration.

The post-migration nutritional situation of sub-Saharan African children is influenced by many factors. Some of these factors identified in migrants to developed countries (Glanz et al., 1998; Pan et al., 1999; Robinson, 1995; Romero-Gwynn et al., 1993) which are also likely to govern the nutrition of sub-Saharan Africans post-migration include dietary acculturation, cultural beliefs and knowledge of food, exposure to advertising/media, familiarity with food, food prices, convenience, preferences and lifestyle. We discuss some of these factors below.

**Dietary acculturation**

The term “culture” has been defined by Schultz et al. (2000) as “a learned system of beliefs about the manner in which people interact with their social and physical environment, shared among an identifiable segment of a population, and transmitted from one generation to the next”. This system of beliefs can include meanings surrounding food habits, including how food is shared within a household and the feeding patterns or cultural understanding of foodstuff. After migration, there may be a struggle to maintain such cultural values in an often new and radically different cultural milieu. Ultimately, this means that the migrating group has to adapt to the new environment, and this process is known as acculturation (Aldrich and Varyiam, 2000; Berry, 1990).

Sub-Saharan Africans in Australia are significantly advantaged socio-economically compared to their situation prior to migration, although they still remain in the lowest socio-economic quartile in Australia. This improved socio-economic status combined with the abundance and affordability of foods they once knew as “foods for white people” means increased purchasing power and consumption of these foods and consequent dietary changes. It is essential to note that these “foods for white people”, whether consumed in restaurants, via take-away food outlets or prepared at home have great potential to impact on nutritional status since they are largely of low nutritional value, that is, low in fibre but high in saturated fat, sugar and salt. In addition, the current body of evidence suggests that where dietary
acculturation occurs, refugees and migrants may maintain some of their traditional foods while at the same time acquiring both some healthy and some deleterious dietary changes (Lee et al., 1999; McKenzie, 1986; Romero-Gwynn et al., 1993; Stewart and Tinsley, 1995). Studies overseas that have examined the food habits of populations with characteristics similar to that of sub-Saharan Africans in Australia indicate that low-income earners have a higher overall percentage of income expenditure on food. They buy cheaper, higher energy-dense food per dollar spent compared to their middle and high-income counterparts (Swan, 1983). Education also plays a role. Women in female-headed households who did not complete high school spend less per person per month on food than do women in female-headed households who have finished high school (Frazao, 1993). Sub-Saharan African refugees and migrants in Australia share many similarities. For example, a significant proportion of Australia’s humanitarian intake derive from the Horn of Africa and among entrants from this region, those from Somalia predominate. The Somali migrate in significant numbers to Australia each year. In 1996/1997, there were a total of 7,347,554 Somali registered in July 1995 were in the country (Department of State (Office of East African Affairs, Bureau of African Affairs, US Department of State (Office of East African Affairs, 1998) indicates that the literacy rate in Somalia is just 24% (male 36%; female 14%). Only 2.2 million of the 7,347,554 Somali registered in July 1995 were in the workforce and 70% of these were pastorally nomadic. In addition, there has been an increasing proportion of women from Somali entering Australia through the Women at Risk Category of the Humanitarian Program. Many of these women are sole parents with relatively large families (McMichael and Ahmed, 2001). Indeed, Somali immigrants well exemplify a people dealing with the adjustments of migration as refugees and establishing a new life in a country where the lifestyle is more affluent and modern than that of their homeland, predisposing them to obesity and its consequences. The implications for health issues given these population trends is obvious.

TV watching: food advertising and lifestyle

There is sufficient evidence to suggest that health-related behaviours developed early in childhood are strongly influenced by media exposure, notably TV watching (Cobb et al., 1995; Coogan et al., 1998). Estimates of McNeal’s indicates that more than 4 million children become consumers each year and a child of 10 years old on average effectuates 250 purchases yearly without their parents’ involvement (McNeal, 1991). Stipp (1993) projected that children control $41.5 billion annually of money in the market and most of the $295 billion spent by children’s parents and caregivers is spent on food for children. The influence children have on parents and caregivers’ purchasing power, combined with children’s freedom to make food purchasing decisions means children have become a major target of food marketers. To effectively reach children as consumers, targeted products such as takeaway children’s meals, ice cream (e.g. Paddle Pop ice cream) and sweets are the result of sophisticated marketing strategies designed entirely for children. However, a content analysis research of television-advertised food items consistently shows that they not only lack health promoting or precise information, but that the advertising messages also directly predispose children to deleterious food habits (Signorielli and Lears, 1992; Wallack and Dorfman, 1992). Importantly for this research, recent studies have also demonstrated the adverse role of marketed products on dietary intake in children and the contribution of excessive television watching to childhood obesity (Dietz and Gortmaker, 1985; Robinson, 1995, 1998).

The extent to which television viewing impacts on the health of sub-Saharan African refugees and migrants in Australia is unexplored. However, it is anecdotaly known that, due to chronic poverty, few sub-Saharan Africans could afford television prior to migration. In addition, children are trained to be responsible and to care for themselves and their siblings at an early age with high levels of autonomy. With virtually no public transport in many areas of Africa, children walk miles to go to school, to collect water and cooking fuel, to go to markets and spend hours doing the dishes, washing school uniforms and clothes and so forth. After migration they are liberated for increased pursuit of childhood activities including television watching and use of computers.

The western migration experience offers several environmental and cultural changes that facilitate increased dietary intake. In Australia, there are schools in the vicinity of each suburb, most can afford a television-even those with low incomes- and almost all houses have cooking facilities such as a stove and oven. Hence, sub-Saharan African children come from a physical activity-enhancing environment to adopt a sedentary lifestyle in Australia.

Post-migration changes also facilitate media exposure. For sub-Saharan African refugee and migrant children, television viewing has become the main source of
information and learning social and eating behaviours; it has replaced the traditional method of conveying socialisation skills at the dinner table and the custom of considering meal times as a forum for passing down family knowledge, teaching about religion, cultural norms and family heritage. The advantage of these traditional rituals is that they involved physical activity-enhancing exercises for children: children were expected to perform certain tasks in kitchens or work in farms before dinner, after school or before school as part of their learning exercise. Once in Australia, children often have limited repertoires in their daily lives that centre on watching television, eating and going to school. Most sub-Saharan African refugees and migrants live in public housing and are reluctant to let their children go to parks due to insecurity or fear that their children will be exposed to drugs.

Confusing dietary advice

The notion of dietary guidelines is a new concept for the sub-Saharan African immigrant. Sub-Saharan Africans come from a context where nutrition is the key to survival and where dietary guidelines are non-existent. So, to then be exposed to a new environment with multiple dietary guidelines can be part of an ‘eating culture shock’. After migration, sub-Saharan Africans are more preoccupied with social connectedness, finding accommodation and accessing health care. Nutritional messages occupy a low priority in this hierarchy of needs. This issue is further compounded by natural linguistic barriers and culturally insensitive information.

The complexity of nutritional messages is highlighted by Krebs-Smith et al. (1995) who found that many people believe that adopting healthy dietary behaviour is time-consuming. In their survey about dietary recommendations, they found that 50% of the sample thought that the healthy dietary advice they were exposed to was confusing. Likewise, Morreale and Schwartz (1995) found that 22% of participants involved in their study could not adopt a healthy diet because they simply did not know what was nutritious and healthy due to conflicting published study findings. Moreover, studies that examined dietary change for health reasons over a period of 5 years (Cotugna et al., 1992; Ferrini et al., 1994; Glanz et al., 1993) showed that reasons for not changing diet included the presence of conflicting recommendations such that it was difficult to decide which recommendation was ‘correct’. As before, in this context, confusion over dietary recommendations was predictive of fat and fibre intake. Participants who reported confusion over dietary recommendations were found with higher fat intake but lower fibre intake. This has major implications for the complex informational experiences of recent Sub-Saharan immigrants in terms of their eating behaviours and choices.

Food prices

Eating behaviour is also affected by economic factors. Prices of foods play a significant role in determining dietary behaviour of the sub-Saharan African. Two theories can explain this: the supply demand curve and the cost of complying with dietary guidelines. When a certain food item is abundant in the market, a decrease in price is more likely to occur and hence it becomes affordable to low-income earners. Similarly, when there is more demand for a particular food item than can be supplied, an increase in price is more likely to occur meaning that only rich people could afford it. Seasonal fluctuation in fruit and vegetable prices means that when in season, fruit and vegetables are affordable and when not in season certain items are only affordable for affluent people. These notions have been validated by several studies showing that poor people tend to eat fewer servings of fruit than more affluent persons (Patterson et al., 1990; Patterson and Block, 1988). This renders the adherence to dietary recommendations difficult since low-income earners would be less likely to consume healthier foods such as fruit and vegetables on a regular basis. In focus group discussions aimed at understanding factors affecting consumption of fruit and vegetables by low-income families (Reicks et al., 1994) several novel findings have emerged. Firstly, the sum of money that could be budgeted for foodstuffs and insufficient amount of storage space restricted the availability of fruit and vegetable for poor people and hence limited fruit and vegetable choices and consumption. As some participants put it: “some dietary recommendations may go beyond the pocketbooks of large segments of the population” (p. 1310). Additionally, Glanz et al. (1998) reported that the importance of cost in determining food choice was significantly highest for young people, women, and people with lower incomes and ethnicity. These descriptions fit well with the situations experienced by sub-Saharan African migrants in Australia. The majority of them survive on social security, live in high rise-estates and tend to have larger families, and thus have limited storage space (McMichael and Ahmed, 2001).

Food preferences

Due to chronic poverty, animal products such as meat, fish or eggs and condiments and soups, most of which are imported, are very expensive and out of reach for most sub-Saharan Africans prior to migration. This means that most families become vegetarian by default. They often live a nomadic pastoralist lifestyle, characterised by periodic harvest and wild food gathering. After migration they have access to a wide range of food supplies. Instead of nutrition being a key to survival as is often the case prior to migration, they culturally acquire
they are struggling to cope with unfamiliar foods and shop facilities, refugees may find it difficult to adapt to the new cuisine they are confronted with in the new host country (Webb and Manderson, 1990). Additionally, they may not be able to find their traditional or preferred food in the new country of destination, and those familiar foods likely to be found may be unaffordable for refugees struggling socio-economically. Even when these traditional foods are available and affordable, by virtue of their nature, the majority of them (e.g. enjera, maize bread) are not suitable for reheating or carrying in lunch boxes. With the opportunities post-migration for women to join the workforce, they shift from being housewives to becoming breadwinners at a cost: reliance on processed and convenience foods at the expense of traditional food due to time constraints.

Conclusion

This paper highlights the lack of data on the nutritional status and its determinants of sub-Saharan African refugee children in Australia. The paper further identifies the peculiarities of dealing with a population that culturally construct foods, feeding practices and body image when living in a post-modern society where food and body image are influenced by powerful medical and economic discourses. These gaps in knowledge hamper the capacity of researchers, dieticians and health educators to identify factors that affect changes in dietary patterns and work toward preventing diet-related disorders in sub-Saharan African refugees living in Australia. The absence of nutritional data also means that it is difficult to compare the nutritional status of this target group with that of its Australian counterparts. For researchers and health professionals to successfully address the nutrition needs of sub-Saharan African refugees in Australia, they may benefit from the implementation of a cultural competency framework in their health promotion, clinical activity or health education strategies. Cultural competency will improve providers’ reflexive understanding of the nature of sub-Saharan African cultural and historic factors which impact on sub-Saharan African refugees’ health and nutritional status post migration and stressors such as acculturation and migration. Only when attention to these issues is focused into prevention and treatment plans can effective health planning and health outcomes in service delivery be realistically achieved in this target group.

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