Hospital food services in a multicultural Australia: assessing the needs of the Middle Eastern community in South Western Sydney Area Health Service

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ABSTRACT

A hospital food service department is responsible for providing appropriate meal choices for all its clients. Evidence exists that such choices are not equitably extended to Australians from non-English speaking backgrounds. The development of a new food service system has provided South Western Sydney Areas Health Service with the opportunity to address the issue and develop a culturally appropriate food service.

The aims of the study were to:

(1) assess the food needs and preferences of the Middle Eastern community as they relate to notions of health and illness, within a cultural and religious context
(2) collect recipes from participants in the research, and make recommendations to South Western Sydney Area Health Service which can be trialed for acceptability among the Middle Eastern community.

Five focus group discussions were conducted with members of the Middle Eastern community in the Area. Ethnic Health Care Workers assisted in recruiting for, and facilitating the sessions with their respective communities.

The results include discussions of the participants notions of health and illness, and their perceptions of the appropriateness of the existing practices of hospital food service, in meeting their food related preferences and perceived needs, with suggested modifications. The preferred foods identified by participants are summarised into tables for each group, and an interpretive discussion of the characteristic aspects of the cuisine is presented.

The discussions present a critical analysis of the cultural beliefs of the target population, implication for future food service practice and the policies relating to health care of people from non-English speaking backgrounds which provide a context for recommendations for South Western Sydney Areas Health Service. The significance in using the focus group method as the research tool is realised through the discussions.
CHAPTER 1

INTRODUCTION

This study aims to investigate the hospital food preferences and perceived needs of a sample of members of the Middle Eastern community in South Western Sydney Area Health Service (SWSAHS).

This chapter will introduce the issues associated with the feeding of hospitalised patients highlighting the role of hospital food services. Predicaments specific to the feeding of patients from Non English Speaking (NES) backgrounds are explained. A brief overview of the demographic profile of SWSAHS is provided, from which an explanation of the origins of this research is recognised. Reasons for choosing the Middle Eastern community as the study population are given. The specific aims and objectives of the study are stated and a brief explanation regarding the methodology is provided. The end of the chapter summarises this information into the justification for the research.

The feeding of hospitalised patients poses special problems not encountered in other institutional feeding situations. Their taste sensations and appetite are influenced by many factors including: the reasons for hospitalisation, the type and severity of each individual's illness, the individual's mood, the length of their stay, lowered level of physical activity and being on medication. Further, some patients may be on special therapeutic diets which are restrictive in some way (Mailer et al, 1980).

The past responses of food services in meeting clients needs add to this problem. It is the role of the hospital food service to provide all clients with their food related needs. The hospital menu is the heart of the food service operation and has a major role in this.
In developing their menus institutions need to seriously consider their patients food preference in addition to nutrition principles (Arney and Tiddy 1992a, b). Yet until recently there has been no investigation of what Australian hospitalised patients like to eat and evidence exists that there has been little change in New South Wales (NSW) hospitals catering departments (Dollis, 1993). Moreover past service delivery has been designed to meet the needs of the institution not the clients it is servicing (Williams and Brand, 1988). Collectively this has generally resulted in the dissatisfaction of clients and consequent poor reputation of hospital food (Inguanzo and Harju, 1985; Maller et al, 1980).

Culture influences which foods are acceptable, particularly during times of illness. The feeding of patients from NES backgrounds is complicated by socio-cultural issues. Even less is known about the acceptability of hospital food services for clients from NES backgrounds than is known for the general population because of the lack of ethno-specific health research, particularly relating to food habits and preference.

South Western Sydney Area Health Service is characterised by the largest ethnic minority and refugee population in NSW. The population is expected to grow by 200,000 in the next ten years making it the largest and most culturally diverse Area Health Service in the state [Health Services Development Unit, South Western Sydney Area Health Service (HSDU, SWSAHS), 1993]. In order to cater for the needs posed by these demands SWSAHS is currently upgrading its services and facilities.

One aspect of the redevelopment plan is the construction of a new catering processing facility. This provides the area with the opportunity to review and redevelop their entire food production and delivery system. The objectives of the system are to provide an efficient food service for all clients till 2001 with specific reference to increase product and menu range for the clients from NES backgrounds (SWSAHS, 1993). The need for research was indicated to meet these objectives as there is substantial variation both
between and within cultural groups in classifying food and understanding how they relate these needs to times of health and sickness. Due to the cultural diversity of the SWSAHS client base an analysis of the Area’s major ethnic groups in the community was deemed appropriate.

The Middle Eastern Community comprise one such group in the area. They are significant consumers of the Area’s Health Services and it is speculated that the significant difference in their culture and religious beliefs from that of the Anglo-Celtic culture predisposes them to high levels of inequity and dissatisfaction with the present food service in hospital. There is a demand for Middle Eastern menus to be developed for institutional settings [Hunter Area Health Service, Migrant Health Unit (HAHS, MHU), 1991] and the local community have expressed a similar demand (The Torch, 1993). I share a common cultural heritage with the group which is a significant factor assisting communication and consequently effect the quality of the data collected in the study. Webb and Manderson (1990) and Lipson and Meleis (1983) support this. Collectively these are the reasons for choosing this group for this research.

My study forms part of an eight phase project (Appendix 6) designed by the SWSAHS Food Service Project Implementation Steering Committee. The aims of my study are:

1. To assess the hospital food preferences of the Middle Eastern community as they relate to notions of health and illness, within a cultural context and;

2. Collect recipes from the participants and, make recommendations to SWSAHS which can be trialed for acceptability among representatives from the Middle Eastern community.

Focus groups have been chosen as the mode of inquiry. Access to the community was available through Ethnic Health care Workers (EHW). They also assisted in facilitating
the sessions. This qualitative technique was chosen for its flexible, open-ended structure, allowing for exploration of the issues and providing a greater depth of understanding than closed surveys. Focus groups address the social nature of the study and there is evidence that it is a culturally appropriate research method (Lipson and Meleis, 1983; Meleis, 1981). The results from this kind of research cannot be generalised for larger populations but will provide useful information of service needs.

To summarise, the study is warranted because it is well documented that patients from NES backgrounds are presented with a range of problems when it comes to eating in hospital as they are faced with unfamiliar food, feeding practices which are incongruent with their cultural beliefs, and religious factors which prohibit the consumption of many foods (Madhock et al, 1992; Samolsky et al, 1990; Webb and Manderson, 1990). It is an issue of care and the responsibility of health services to provide equitable care in a Multicultural context. South Western Sydney Area Health Service is well placed to be at the forefront of responding to this need. This research is the first step in redressing the food service gap for the Middle Eastern community.
CHAPTER 2

BACKGROUND INFORMATION

2.1 DEMOGRAPHIC PROFILE OF SOUTH WESTERN SYDNEY AREA HEALTH SERVICE

The South Western Sydney Area spans over 3548 square kilometres. The Areas Health Service comprises six Local Government Areas (LGA) of Bankstown, Fairfield, Liverpool, Campbelltown, Camden and Wollindily. Figure 2.1, Appendix 1 provides a map of SWSAHS (cited in HSDU, SWSAHS, 1993, p. 4).

Currently, SWSAHS is the second largest Area Health Service in terms of population. Population projections for the next 10 years estimate a growth of greater than 30 per cent (representing 220,000 people), making it the largest Area Health Service in the state.

South Western Sydney has a unique demographic profile which differentiates it from other health areas in NSW. The area has the largest immigrant and refugee population than anywhere else in the state (HSDU, SWSAHS, 1993). They are concentrated in the LGAs of Fairfield, Bankstown and Liverpool. According to 1986 Census data, major ethnic groups in the area were Vietnamese, Italian and Yugoslavian and Lebanese. The major languages spoken at home were, in order, Italian, Arabic, Chinese and Vietnamese. Twenty five per cent of NSW's Aboriginal population live in SWSAHS (cited in HSDU, SWSAHS, 1993). Population projections indicate a further growth in the population of residents from NES background (Mathews, 1993-pers. comm.).
The Area is generally recognised as one of socio-economic deprivation. Residents have lower socio-economic status than NSW as a whole. Characteristically, residents have low incomes, low education and low levels of private health insurance cover. Unemployment rates are high as are the levels of public housing and the number of welfare recipients (HSDU, SWSAHS, 1993).

The birthrates are 9.6 per cent higher than the general rates for the state. Vietnamese (5.6 per cent), Arabic speaking (5.3 per cent), Central and South American (2.6 per cent) and Khmer (2.1 per cent) women had the highest number of births in 1988. Consequently the age profile is characteristically youthful, but the rate of growth of the aged population is faster than any other age group in the area (HSDU, SWSAHS, 1993).

The health status of the residents is poorer than elsewhere in NSW. The mortality rate is four per cent above the states rate. The Area also has a high resident peri-mortality rate and low birth weight infants (HSDU, SWSAHS, 1993).

In meeting the health care needs of the SWSAHS population consideration must be given to the diverse cultural, linguistic, socio-economic, and age profile of the areas residents (HSDU, SWSAHS, 1993, p. 1). Yet the Area is presently severely under resourced to meet the needs of the current population or demands posed by the excepted population growth. There is a shortage of services, facilities and funding. South Western Sydney Area Health Service only has a 70 per cent self sufficiency rate in the provision of hospital services. Their aim is to increase this to 90 per cent by the year 2001. To achieve this they are currently undertaking a massive service and facility development program. The aim of the program is to improve the type, range, quality and accessibility of health services (HSDU, SWSAHS, 1993).
2.2 REVIEW OF HEALTH SERVICES

South Western Sydney Area Health Service have identified four key strategic issues as crucial in the development and operation of health services within the area (HSDU, SWSAHS, 1993, p. 45).

1. Improvement in the health of the area's residents
2. Provision of appropriate and accessible health services
3. Maintaining the staff necessary to deliver the broad range of health services required by the residents of SWSAHS and,
4. Management of financial and physical resources.

The health of immigrants is a priority in the Area's Health Promotion Plan. Evidence of the commitment is demonstrated by the development of Multicultural committees at both the Area and Sector levels, the appointment of ethnic health advisers at the Area level and, the development and implementation of the Area's Ethnic Affairs Policy Statement (EAPS). Major service strategies in force include: the establishment of SWSAHS Health Care Interpreter Service and the employment of EHW and bilingual counsellors. Appendix 2 outlines the goals and objectives of the areas Ethnic Health Services Plans, 1992 (HSDU, SWSAHS, 1991). The principles and philosophies of the plan embody those enunciated by the governments Mainstreaming Policy focusing on Access and Equity objectives (HSDU, SWSAHS, 1991).

South Western Sydney Area Health Service realise that concomitant to the above strategies it has implemented, a change in mainstream health services and structure is required for effective service planning. As a consequence they are implementing these philosophies in their facilities re-development plan and reorienting services to focus on community health promotion.
Other priority areas include women’s health, and community education in which nutrition and increasing awareness of health service are major areas of concern.

2.3 REVIEW OF THE FOOD SERVICE SYSTEM

Although a principle aspect of SWSAHS development program is to update clinical and primary care services, it is aware of broader issues effecting health, and recognises the importance of non-clinical aspects of service in effecting health outcomes of clients. The literature supports this perception and documents the importance of hospital administrators to consider this issue in planning for high quality care to clients (Parsons, 1992c; Lutz, 1989; Inguanzo and Harju, 1985). Consequently they have included an upgrade of the Areas support services. Comprehensive reviews of these areas identified catering services as the most significant area for upgrading.

In response SWSAHS has bought a factory site in Wetherill Park, which is being refurbished to house a Central Production Unit (CPU). The CPU will utilise the cook-chill technology to provide central production of most hot foods for all hospitals. The exercise has been carried out to achieve three objectives:

1. to meet the SWSAHS’s catering needs until 2001.

2. to improve product quality which includes a consistent food quality and increasing product or menu range especially for NES background patients, and

3. to improve the efficiency of operations”

(SWSAHS, 1993, p. 1)

Many challenges exist in realising the second objective. In response to this a Food Service Project Implementation Steering Committee has been established to ascertain the best solutions.
The first strategy in achieving these objectives is to allocate part of the CPU to include an Ethnic Food Bank (EFB). The EFB is proposed to store a range of specific foods for the major Ethnic-cultural subgroups in the Area. In this way, culturally appropriate diet related preferences will be available for these clients when they are admitted to hospital.

The second strategy was to undertake research with the Areas ethnic groups to determine their preferences for hospital foods. Due to the cultural diversity of the areas residents a group by group analysis was deemed necessary. The following four guidelines were used to determine which group to assess first:

1. The number of people going to hospital (based on 1990/91 hospital separation statistics for people living in South Western Sydney).
2. Acculturation of the group.
3. Present menu items.
4. Gaps in our knowledge regarding suitability of certain foods in a cook-chill system.

The results identified the Middle Eastern and Vietnamese communities as priority target groups. Master of Science students (Nutrition and Dietetics) undertook both of these studies.

The third strategy pertains to implementation of the research findings. Issues of mainstreaming versus ethno-specific services arise in considering this.

On the one hand, in order to attain equity in health improvement strategies there is a need to establish the desirable health outcomes, and to determine in consultation with community groups the most appropriate strategies to achieve these objectives. On the other hand in order to attain equitable health provisions the major need is to promote access to existing (specialist) services (HSDU, SWSAHS, 1992 p. 46).
It was decided that recipients of this service would receive two menus. The hospitals main menu and a culturally specific sub-menu, listing the preferred foods identified by the research process for each respective group. The sub-menu will list the foods in both English and the cultural groups major languages. For example, Arabic and Assyrian translations will be available to the Middle Eastern Community.

Implementation in this way raises other areas of concern. For example, what about smaller groups who do not read in either English or the translated version? What if the client writes on the menu in their own language? How will this effect dietetic and catering staff? Are the institutions employees, including the health professionals, aware of the changes to the system? Do they know about the food? Will they be able to respond to patients’ questions? Many of these areas require political, social, and organisational responses. A sub-committee has been developed to address these issues as they arise.

2.4 THE COOK-CHILL FOOD PRODUCTION SYSTEM

This is a ready prepared food production system. Cook-chill may be defined as “a catering system based on the full cooking of food followed by fast chilling and storage in controlled low temperature conditions above freezing point (0 to 3°C) and subsequent thorough reheating close to the consumer close to consumption” (Mason et al, 1990, p. 525).

Menu items in this system are prepared in bulk and are chilled for three to 45 days. Foods are initially prepared as they would be in conventional methods. However, foods may be slightly under cooked to avoid overcooking in the re-heating phase. In order to minimise microbiological growth the temperature must come down from 70 to 3 degrees Celsius in less than 90 minutes. The chilled food is then plated cold or reheated in bulk pans and plated hot (HAHS, MHU, 1991).
In South Western Sydney's case the bulk food will be transported to each of the hospitals receiving kitchens in refrigerated trucks. The receiving kitchens are responsible for plating, storing, reheating, and distributing respective clients meals. Cooks at the receiving kitchens also will be responsible for the production of such items as salads, sandwiches, specialised diet items and some vegetable and egg dishes. They also will do the food preparation for bulk reheating of meals for staff and cafeteria guests (SWSAHS, 1993).

Theoretically, the cook-chill system allows for reduced labour costs, better food quality and improved ward service. It also decreases wastage by increasing accountability for food preparation and ability to be more flexible in meal provision. This reason makes the system more attractive in times of cost cutting (Mathews, 1992; HAHS, MHU 1991; Williams and Brand, 1988; Fusco, 1987).

Many authors identify that institutions utilising cook-chill can expect to plan their own menus to increasing choice, and to serve patients at times which are convenient to them, rather than to the hospital. In this way the constant varying demand of clients can be met. This includes meeting clients, ethnic, religious and dietary needs (Mathews, 1992; Williams, 1990; HAHS, MHU, 1991; Williams and Brand, 1988; Fusco, 1987). Moreover the advantage such a system has in retaining the temperature of the food also overcomes previous problems related to meal temperatures (HAHS, MHU, 1991). Other advantages boasted by the system extend to revenue raising potential, that is "meals can be marketed to off-site locations, to varying groups including commercial enterprises" (HAHS, MHU, 1990, p. 24). Examples include, Meals On Wheels (MOW), day care centres and, other Area Health Services.
The literature cites many institutions where cook-chill systems have been adopted to improve the food services and deal with the many challenges faced by their departments. They also cite increases in profits [Food Management Staff, (FM Staff), 1992, Lutz, 1989]. Madhock et al. (1992) report success improving satisfaction of both 'Asian' and 'non-Asian' clients when they were provided 'Asian' food prepared in a cook-chill system even at a time when the system was faulty.

While it is evident that cook-chill provides many potential benefits, Fusco (1987) identifies that it is not a catering panacea. Lutz (1989) identifies that not all catering diversification efforts have been successful. Locally, at least one major teaching hospital converted back to a conventional system (Kokkinakos, 1993-pers. comm.; Williams and Brand, 1988).

It has been identified that some foods do not respond well to the reheating process (HAHS, MHU, 1991). Fried foods, egg dishes, baked fish, toast and liver have been cited as being particularly poor in this regard (HAHS, MHU, 1991). Some recipes containing starch separate on rethermalisation and require modification. Others require the addition of stabilising agents (Mathews, 1992). Suggestions to overcome the issue include deleting them from the menu or preparing these foods in conventional methods.

Other problems associated with such systems relate to food safety issues. It has been identified that there are increased potential for microbiological growth. Attributing factors include: increased handling of food, issues relating to storage time and the process of reheating involved in the food production. New standards regarding food production methods and improvements in technology are assisting in overcoming these problems (Kokkinakos, 1993-pers. comm.).
While the system boasts many possible potential benefits the system will only be as effective as the time and effort put into implementing it (Mathews, 1992; Fusco, 1987). Three primary issues which need to be considered when implementing a cook-chill system. These are:

1. The development of a master plan for the systems operations. This needs to identify the department's needs and desires based on projected populations and customer basis for the next 10 years. Any additional needs must also be considered and included in the plan (Mathews, 1992, p.39).

2. Revision of the existing menu is essential to a smooth running operation (Mathews, 1992, p. 39).

3. Training of CPU cooks. New methods of preparing for, handling, and cooking food for a cook-chill system require cooks to be retrained. A specific set of guidelines is available for the preparation of many dishes. Mathews (1992, p. 39) firmly states that .."(cooks) must be made to understand consistency is the key ...and they) must be instructed to use the same series of steps each time an item is prepared.....In addition, preparation short cuts must never be taken." She recommends using films, written material, field trips and experimentation as appropriate education strategies.

The development of both efficient and effective culturally appropriate food service goes beyond knowing a cultural groups culinary preferences. Samolsky et at (1990) identified that careful consideration must be given to cultural influences on food and food related habits, population demographics and health care usage patterns for the target group. To assist SWSAHS in preparing their culturally specific menus for the Middle Eastern community, the remainder of this chapter presents what is known about the population demographics, and health care usage patterns for the Middle Eastern community in the Area. Chapter 3.3 and 3.4 outlines information regarding food related habits.
2.5 THE MIDDLE EASTERN COMMUNITY IN SOUTH WESTERN SYDNEY

2.5.1 WHO ARE THE MIDDLE EASTERNERS

"The countries of the Middle East include Egypt, Iran, Iraq, Israel, Jordan, Lebanon, Saudi Arabia, Syria, Turkey, and the countries of the Arabian Peninsula" (Kittler and Sucher, 1989, p. 312). Although these nations appear to comprise a monolithic block, each have social, religious, dietary and economic patterns which characterise them. Thus the term Middle Eastern, though convenient, hides many differences among this group. Even the languages and dialects differ among these countries. Arabic is the major language spoken others include: Kurdish, Armenian, Persian, Assyrian, Berber, French, Azerbaycan Turkish and Hebrew. Islam is the major Arab religion, however other religions include "...Christian sects like the Eastenrite churches, Coptic, Maroite, Melkite, Druze and, Syrian Chaldean Catholic. Iranians may be Moslems, Zoroastrians, Chaldeans, Bahais or Jews" (Lipson and Meleis, 1983, p. 856). The socio-economic status of Middle Easterners is also wide and diverse, traditionally based on the country of origin and whether they are from urban or rural backgrounds. There is real diversity amongst this group of people.

This very diversity compounds the already complex and difficult process of measuring ethnicity and hence estimating the real size of the Middle Eastern community in Australia (Donovan et al., 1992). Although they comprise one of the largest ethno-cultural groups in Australia in total, each birth place group comprises a small proportion of this population and they are scattered all across the nation.

Statistical indicators commonly used to measure ethnic origin, such as Country of Birth (COB) or language spoken at home, do not necessarily equate with ethnic origin, or the individual's self identity of their ethnicity. In addition smaller cultural or ethnic groups are usually aggregated together for convenience.
The data related to people from Middle Eastern countries are usually aggregated and collected on the basis of Arabic speaking or "other". Country of birth is commonly aggregated as Middle East or into the larger ethnic groups of the region such as Lebanese or Egyptian, the rest are classed as "other Arab" or "other Middle East". This does not adequately describe the real diversity of this cultural group in Australia. Such generalisations have resulted in the stereotypes, and inappropriate service delivery responses of the past (Webb and Manderson, 1990). Donovan et al. (1992) assert that this grouping process is often subjective, consequently influencing the reliability of the description, size and distribution of ethnic groups in Australia.

Finally, many of the new arrivals to Australia from the Middle East are refugees the methods of collecting statistical data do not account for these individuals.

Despite these deficiencies in data collection it is evident that this group comprise a sizeable portion of the ethnic communities in Australia (Moussa, 1991). According to the 1986 Census, 10.6 per cent of the population who spoke a language other than English at home were represented by those who spoke 'Arabic'. The actual size of the community in 1991 was estimated to be 150,000 - 200,000 in NSW (Moussa, 1991). Consistent with most immigrant trends, Sydney Metropolitan Areas are the choice of residence for the majority of this group. Moussa (1991) cites that in 1991, 93 per cent of the 'Arabic speaking community' in NSW lived in the Sydney Metropolitan Area. Hayes (1993) identifies that 72.6 per cent of Lebanese migrants have made Sydney their home.

Immigration to Australia by people from the Middle East has occurred in waves. The earlier groups were mainly comprised of people from Lebanon after the outbreak of the civil war there in the 1970s. Indeed migration data from 1976-77 indicate that people from Lebanon comprised the second largest migrant group to Australia that year (15.1 per cent of total migration) (Department of Immigration and Ethnic Affairs, 1977, cited in Greenfield et al., 1980, p, 578). Migration patterns since the 1980s still indicate a significant shift toward people from the Middle East (Hayes, 1993), these include a lot
more people from other nations such as Iran and Iraq (Dollis, 1993; Britain, 1993- pers. comm.; Talia, 1993-pers. comm.; Webb and Manderson, 1990).

In this study, the term Middle Easterners has been used to describe representatives from all nations languages and religions included above. Participants have been recruited on the basis of whether they identify themselves as such. Initially I used the term “Arabic background” to define the characteristics of the target population in this research. However, I found that this definition implied a heritage of the Arabic language. Such an implication excluded many other groups of Middle Easterners who are significant to assess.

2.5.2 DEMOGRAPHIC AND HEALTH PROFILE OF THE COMMUNITY

NOTE: It must be noted that a number of sources have been used and pieced together to present this data in an attempt to encapsulate a better representation of the health care usage of all people from Middle Eastern backgrounds. Thus the information must be interpreted cautiously, due to factors associated with measuring ethnicity data (Chapter 2.5 and Chapter 3.1). Further, morbidity and health care usage statistics for South Western Sydney residents are unreliable since currently the area is under resourced to meet the health care needs of its residents (HSDU, SWSAHS, 1993). Consequently 30 per cent of South Western Sydney residents seek health care outside of the area due to the lack of access to the full range of services required. Moreover, it is suggested (HSDU, SWSAHS, 1993) that the low socio-economic situation of most of the population influences them to place health at a lower priority to other needs such as work, hence influencing under utilisation of health services. It is well documented elsewhere, how cultural and linguistic issues bias mortality data (Dollis, 1993; Donovan et al., 1992).

South Western Sydney is among the most populated areas for people from Middle Eastern backgrounds. Data from the 1986 census indicate that people from Lebanon comprised one of the four major ethnic groups in the area. Further, Arabic was noted as the second major language group other than English, spoken at home (HSDU,
SWSAHS, 1993, p. 7). The majority of these residents live within the local government areas of Bankstown, Liverpool and Fairfield.

The age profile of the community reflects a young population. No data are available for under five year olds. It can be speculated that they comprise a large number since Arabic women represent the second highest birth related admissions (5.2 per cent) in the area. A large proportion of the community are aged between five and 20 years of age. The remainder are evenly distributed across the ages of 20-64 years of age. The aged population is not very large at present however, it is suggestion that it is increasing (Mathews, 1993-pers. comm.). The gender distribution is relatively even with slightly more males than females (Ethnic Affairs Commission of NSW and Department of Housing, 1988).

There has been very little attention paid to the health care needs of this group in the past despite long residence and size of the group in Australia. Two recent initiatives in local Western Sydney attributed this to past neglect of health services. The results of these initiatives indicate the priority issue of addressing the health care needs of this community and to educate them in health care issues (Moussa, 1991; deCosta, 1988).

In order to present a more accurate indication of the health status of people from Arabic speaking backgrounds in South Western Sydney, hospital morbidity data based on NSW separations for 1990/91 (NSW Department of Health, 1991) are presented. So too are data based on clinical progress separations. To illustrate to what extent the services of South Western Sydney Area are used, the data base on hospital separation (HCODE) were used (NSW Department of Health, 1991).

From this data a reported 5845 people from this target group were hospitalised in 1990/91 across 32 facilities in NSW. Bankstown Hospital was recorded as the most utilised hospital by this group (N = 840, 14 per cent). Fairfield and Liverpool Hospitals were the third and fourth most utilised respectively (N = 684, 11.7 per cent; N = 604,
10.3 per cent respectively), whereas Campbelltown Hospital rated ninth in the state (N = 314, 6.6 per cent). It appears that Camden Hospital is very under utilised by this group, with only 28 (0.5 per cent) admissions at this time (NSW Department of Health, 1991). These data are consistent with the pattern of population distribution of this group in South Western Sydney. It also indicates that a high proportion are using the area's services, hence special considerations of their needs is justified.

Separations based on clinical progress indicate that major causes of morbidity relate to obstetric and gynaecological needs. This is a consistent pattern among Middle Eastern women across the state. Donovan et al. (1992, p. 101) identify that "women born in the Middle East experience the highest level of hospitalisation for all causes. This level however is highly influenced by pregnancy related admissions". However, it has been documented that Lebanese born women in Western Sydney have some very serious and disturbing obstetric problems. The principle reason for these problems was attributed to neglect of the health system to provide these women with equitable care (deCosta, 1988).

Other major causes of morbidity pertain to general surgery, dialysis and orthopaedic, cardiology and urology (NSW Department of Health, 1991). Table 2.1 (Appendix 3) presents data for the top 15 reported causes of illness, and the utilisation of the South Western Sydney area facilities for these services (they are not based on sex separations).

These data indicate that the need to assess this group's beliefs, preference and habits pertaining to food related behaviours pre and post natal, during major life threatening illness and in convalescence. With a view to the future, which is important in health and menu planning, the data presented here indicated that the needs for infancy and childhood and the elderly also need to be addressed. This has been used as the basis in defining the selection criteria of participants for this study.
CHAPTER 3

LITERATURE REVIEW

3.1 HEALTH CARE SERVICES IN A MULTICULTURAL AUSTRALIA

Today's health care environment is in a state of change, rapidly fluctuating in response to industry challenges and societal demand (Sol, 1989). Industry challenges are perpetuated by political, economic and technological trends while societal demands include the aging of the population, health conscious consumers and the increasingly diverse cultural mix of the population (Ollinger-Snyder and Mathews, 1990). The impact of these trends are forcing health care institutions to become more business orientated and to think in strategic marketing terms (Ollinger-Snyder and Mathews, 1990, Williams, 1990; Bonk and Bensky, 1989).

Bonk & Bensky (1989) argue that excellence in clinical care or the best piece of equipment is now an insufficient basis for competition. They contend that health care institutions today are required to do more than upgrade facilities, it is essential for them to upgrade their entire service orientation.

Sol (1989) asserts that attaining and sustaining a competitive advantage in today's health care environment demands that each institution use their own array of products, programming and services to position themselves within their market in a unique and distinctive way. All initiatives should adopt a customer based perspective focusing on customer's satisfaction.

In a Multicultural society the provision of services responsive to all clients' needs requires that experiences and expectations of all health care encounters be examined across all
areas of the community (Dollis, 1993; Madhock et al, 1992; Moussa, 1991).

Australians from NES backgrounds are not afforded such services (Dollis, 1993; Moussa, 1991; Duke, 1988). Among the demands affecting the rate of change in the industry, health services have been unable to match those posed by the nuances of the changing face of Australia's society. Census figures for 1991 indicate that 22 per cent of people living in Australia were born overseas (ABS, 1993-pers. comm.). Today, 15 per cent of the Australian population comprise people speaking another language other than English at home representing an 11 per cent rise since the last census [Multicultural Marketing News, (MCMN), 1993 a].

Defining or estimating the real size of the non Anglo-Celtic population in Australia is difficult because of the inconsistencies, and other methodological, issues associated with measuring ethnicity (Dollis, 1993; Donovan et al, 1992).

Price (1989) explains that a clearer indication of the real size of the ethnic minority population in Australia can be made by measuring "ethnic strength". This measure incorporates fractions for people of mixed origins and caters for children born in Australia with one or both parents being born overseas. Using this measure, the size of the population who are non Anglo-Celtic increases to 26 per cent (Price, 1989, cited in Dollis, 1993).

New South Wales has the largest population of people from NES backgrounds in Australia. In the Sydney metropolitan area, 91 per cent of the total increase in Sydneys population between 1986 and 1991 is accounted for by people who are born in countries other than Australia (Hayes, 1993, p.5).

Hayes (1993) identifies that this growth can be partly attributed to the stable economy of the state, greater opportunities for employment, and most significantly the strong
emphasis of NSW government to assist in placing migrants and new arrivals in proximal areas to friends and family. This exemplifies the greater need for NSW hospitals to develop culturally sensitive service.

Politically, the changes in community perspectives from consensus to moderate plurism demonstrates that society has recognised the diverse ethno-cultural mix of Australia's population (Bates and Linder-Pelz, 1990). Historical evidence also indicates that the health system has not responded well to these nuances and demands posed by the rapid political changes. Bates and Linder-Pelz (1990) discern that prior to the early 1970s the delivery of health services were made on a totally mono-cultural model.

Parsons (1990) identifies that it is the generalisations and stereotypes of the past that have resulted in the disregard of the changes in society that take place and hence stagnation in health service responses. Moussa (1991) suggests that, if nothing else, statistical facts necessitated governments and institutions to increase their awareness of migrant health issues.

Bates and Linder-Pelz (1990) contend that changes have been quite rapid since then. They further contend that the proliferation of policies and plans demonstrates this. However leading health authorities argue that the paucity and quality of the data available regarding ethnic health issues do not provide sufficient foundation for evaluation planning or policy development (Dollis, 1993).

Indeed a key theme identified at the National Health Policy Conference (1988) was the priority for ethno-specific research and data collection so that valid and useful recommendations for a health component of the National Agenda For a Multicultural Australia could be developed (Donovan et al., 1992). The same key themes are still being called for today, suggesting the slow responses (Dollis, 1993).
Donovan et al (1992) acknowledge that only recently has there been a suitable indication of Australian institutions regarding health care issues within the political framework of Multiculturalism. The most recent initiative in realising health service needs of people from NES backgrounds include, Medicare, Australia's commitment to the universal policy of Health for All, the National Agenda for Multicultural Australia, the Access and Equity Strategy and the Social Justice Strategy (Dollis, 1993).

Evaluation of many of these initiatives have yielded criticisms for their single cited focus on health care issues. Namely, concentrating on issues of access (Dollis, 1993, Moussa, 1991). However, access barriers are not the only ones influencing the quality of services to Non English Speaking clients (Dollis, 1993; Donovan et al, 1992; HSDU, SWSAHS, 1991; Moussa, 1991).

Issues of language, culture and communication underlie all health care encounters and barriers to good health care arise because many services remain unresponsive to these key issues. Dollis (1993) suggests that the review of the government Access and Equity Policy to reorientate its focus from access issues towards service delivery, may be taken to indicate an increase of awareness regarding this.

Moussa (1991) cites that assessment of many past policy and program responses indicate that ignorance, negative attitudes and neglect of the different needs of people from NES backgrounds has resulted in barriers to equitable health care. He further cites that some authors suggest that such barriers have placed Australians from NES backgrounds as second class citizens. Jonston and Kanitaski (1990, cited in Dollis, 1993) add that such barriers have (and continue to) subject Australians from NES backgrounds to injustices and/or discriminatory behaviour.
Bonk and Bensky (1989) note that the availability of research and policy documents or services alone do not equate success. Sol and Wilson (1989) assert that future institutional viability now depends on new methods of generating revenue and patient referrals, and that success is all in the delivery.

Parsons (1990) identifies that lessons must be learnt from the past regarding health service delivery to non-English speaking clients in order to avoid expensive mistakes, and continued inequities. Madhock et al (1992) explain that this means that health care institutions should aim to provide minority groups with the same levels of care as the majority.

3.1.1. Culturally Appropriate Food Services in the Health Care System.

The Victorian Health Department (1991, cited in Dollis, 1993, p. 140) identify that "culturally unacceptable food in hospital meals is another example of lack of responsiveness of health services".

The lack of response is further exemplified by the dearth of ethno-specific food related data (Webb and Manderson, 1990). The under representation of people from NES backgrounds in food related research is a further example (Arney and Tiddy, 1992 a, b; Williams, 1988).

The need for culturally appropriate food services is probably one of the most significant to attend to in considering high quality health care for people from NES backgrounds as culture and religion influence what is eatable, particularly during times of sickness, and convalescence (Madhock et al., 1992; Samolsky et al., 1990; Webb and Manderson, 1990; Duke, 1988; HAHS, MHU, 1988).
It is well documented that people from NES backgrounds are presented with a range of problems when it comes to eating in hospital. They are faced with unfamiliar foods; feeding practices which are incongruent with their cultural beliefs, and religious factors which prohibit the consumption of many foods (Madhock et al., 1992; Samolsky et al., 1990; Webb and Manderson, 1990; Lipson and Meleis, 1983; Meleis, 1981). Further, language and literacy barriers may impede their ability to read the menu, limiting their ability to select food items from the menu.

It is very difficult to justify the lack of response particularly since policy statements exist identifying the need for consideration of culturally appropriate food service. For example, one of the key policy measures of the NSW Department of Health (1987) to improve the health services to the needs of people from NES backgrounds is to:

Modify hospital service such as food services...where this is important for cultural or religious reasons (cited in HSDU, SWSAHS, 1991, p. 50).

The NSW Ethnic Affairs Policy Statement makes provisions for ethno-specific services where it is apparent that mainstream services are not providing adequate health care (cited in HSDU, SWSAHS, 1991). Madhock et al. (1992) confirmed that the provision of culturally suitable food is one strategy required by hospitals if they are to provide equitable health care for ethnic minorities.

The National Food and Nutrition Policy (NFNP) is the most recent health policy initiative. Whilst not specifically related to institutional food services, its focus on social justice and its priority stand to "...matters affecting access to a nutritious diet by socially, economically or geographically disadvantaged Australians" (Rae, 1992, p. 4), its objectives provide a framework for the development of a culturally appropriate food service in hospitals. Unlike the other policies the foundations and objectives of the NFNP are innovative and identify Australia as leaders in this area. This should encourage food service providers and dietitians to consider it more than just another health policy.
Hospitals food services are not the only ones which do not 'cater' to the needs of the non-English speaking clients. There is evidence that the foods in nursing homes; Meals On Wheels (MOW) and day care centres are predominate by "Australian" meals (HAHS, MHU, 1988). McCallum (1990) found that the food available in nursing homes was a significant influence regarding complex negative attitudes towards institutional care expressed by migrant communities in Australia.

There has been some real attempts to address the food related needs of people from NES backgrounds. The Ethnic Food Kit is one example. This was designed by the HAHS, MHU (1988) to assist in facilitating the development of ethnic food services in health related institutions. It contains information and recipes for main courses and accompaniments, for the "Australian", Italian, Greek, Polish, Macedonian, Chinese and, Vietnamese, communities in Australia. It also provides information about the acceptability rating for the menus.

Sydney's Royal Prince Alfred Hospital [RPAH] has developed a model to cater better for the food related needs of their ethnic clients. Royal Prince Alfred Hospital services a sizeable ethnic minority population in total, however the number of specific ethno-cultural groups is small. Therefore the development of ethno-specific menus like SWSAHS is not feasible for them (Kokkinakos, 1993-pers. comm.).

Instead inpatients at RPAH are offered a variety of cultural staple, "ethnic salads", Asian style soups, and a selection of universally acceptable meals such as lasagne. Kokkinakos (1993-pers. comm.; Kokkinakos, 1990, cited in Webb and Manderson, 1990, p. 195), describes that, in this way some familiar food is likely to be available at each meal for clients from different ethnic groups.
Additionally RPAH stock a range of ethno-specific frozen meals for clients who specifically require or request these meals. For example Kosher meals or Halal meals (Kokkinakos, 1993-pers. comm.; Kokkinakos, 1990, cited in Webb and Manderson, 1990, p. 195).

Initiatives also are being undertaken overseas. Madhock et al (1992) reports the development of a food service for "Asian" clients in a British hospital.

While these strategies are commendable in their attempts to meet the food related needs of people from NES backgrounds. They do not adequately address other factors which influence eating in hospital for many of these individuals such as language barriers, or the taboos pertaining to the religious or cultural perceptions of health related food needs.

Interpreters may be used to overcome language barriers, however not all hospitals in Australia have comprehensive interpreter services (Dollis, 1993), further indicating the inequality of health care offered to people from NES backgrounds. Dollis (1993) confirms that the lack of interpreter services do have a negative impact on the quality of health care of these individuals.

The lack of food service response has predisposed people from NES backgrounds to a broader range of inequities than not having culturally appropriate food. Samolsky et al (1990) note that the potential for effective diet education and counselling is lost for patients from NES backgrounds because the menus in hospital fail to meet their food related needs. These clients have no example of appropriate eating practices for health because of the dissonance between what is eaten at in hospital and that which is eaten at home.

Further, classification of food is culturally influenced. In Australian hospitals diet education messages are based on Anglo-Celtic classification and knowledge of food and

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how it relates to health, such as the Australian Dietary Guidelines and The Five Food Groups and the Healthy Diet Pyramid. Webb and Manderson (1990) identify that such methods of food classifications are invalid to other cultural groups. Moussa (1991) confirms that cultural factors are likely to render diet education messages inappropriate for Arabic speaking people.

3.2. THE ROLE OF FOOD SERVICES

The NSW Department of Health (1989, p. 1) stipulates that the primary objective of a hospital's food service is "....to provide nutritious palatable, attractive, hygienic meals according to individuals needs".

The hospital food service is a critical component of patient care (NSW Department of Health, 1989; Williams and Brand 1989). It is the primary food source for the majority of inpatients (Williams and Brand, 1989) and it is the service that patients have most contact with during their entire hospital stay (Kokkinakos, 1993-pers. comm.).

Despite this, hospital food suffers from a poor reputation and is associated with negative stereotypes (Lutz, 1989; Maller et al, 1980). Williams and Brand, (1989, p. 195) note that "today concern is still being expressed about the quality of hospital catering both from the point of view consumer acceptance and, nutrition quality".

A number of studies (Wood et al, 1985; Todd et al, 1984, cited in Williams and Brand (1988, p. 37) have identified that patients frequently consume inadequate intakes of food while hospitalised, and that many patients in NSW hospitals are under nourished.

The literature cites many common areas of objection expressed by patients regarding the food service during their hospital stay. They include: no taste (Madhock et al, 1992;
Samolsky et al; 1990, Inguanzo and Harju, 1985; Meleis, 1981), lack of choice (Madhock, 1992; Williams, 1990; Lomaz, 1988; Inguanzo and Harju, 1985), familiarity with the food, similar food served too frequently/repeatedly (Madhock et al, 1992; Williams, 1988; Maller et al, 1980), the smell of the food (Maller et al, 1980), the temperature of hot meals being insufficient (Lutz, 1989; Lomaz, 1988; Williams and Brand, 1988; Maller et al, 1980), the need to supplement food (Madhock et al, 1992; Meleis, 1981; Maller et al, 1980); poor presentation of meals (Madhock et al, 1992; Lomaz, 1988); and meals being unsuitable for religious or cultural needs (Madhock et al, 1992; Meleis, 1981).

One must ask why such situations persist, particularly in light of the role of food services. Evidence exists that these results are a consequence of hospital food services being designed and implemented to suit the needs of the institution rather than the clients it is supposed to be servicing. For example, William and Brand (1988) assert that hospital meal times are more likely to have been planned according to the cost of food service staff, convenience to other services such as nursing, and old habits. Coote and Williams (1993) identify that efforts to provide financial saving such as eliminating hot meal options at breakfast, may have detrimental effects on both patient nutrition and satisfaction.

Some authors attribute the problem to traditional methods of food service production and management. The pressure to cook and serve foods for every meal every day restricts the flexibility of the service that can be offered. Mathews (1992) and Fusco (1987) note that crisis management is the order of the day in traditional set ups.

Other authors cite that temperature control has been a primary aspect that is effected by traditional methods of food production (Mathews, 1992; HAHS, MHU, 1991; Williams and Brand 1988; Fusco, 1987), which may raise questions about microbiological safety of foods.

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Beyond the food other menu planning issues of past that may account for poor reputation of food and lack of acceptance of food service include; lack of nutrition or food standards resulting in the poor nutrition quality of meals (Williams and Brand, 1989), unimaginative and difficult to read menus (Williams, 1990), not offering choice of serving size (Williams and Brand, 1989), the times of meal service (Williams and Brand, 1989), limited variety and choice (Coote and Williams, 1993), patients not being able to select what they want to eat (Williams, 1990) and unpopular, old fashioned items on the menu (Williams, 1990; Lutz, 1989)

Williams and Brand (1988), conducted a review of NSW hospitals food services departments. Their findings suggest that many of the characteristics of these departments are likely to give rise to many of the above mentioned areas of patient concern about hospital food.

For example they found that a striking number utilised conventional food production systems, a large proportion were found not to conform with the Australian Council of Health Standards (ACHS) for meal times, many smaller hospitals did not have sufficient systems to retain heat of plated meals, more than 25 per cent do not have provision for patients to nominate the serving size of their meal.

More recently Coote and Williams (1993) identified that few hospitals offer recommended additional items on their continental breakfast menus, resulting in limited variety and choice. There is a suggestion that very few follow standard recipes (Kokkinakos, 1993-pers. comm.), and the HAHS, MHU (1991) identify that microbiological standards are not commonly observed in practice.

This raises the question about the overall quality of the food being served to, and the resultant satisfaction of Australian inpatients, especially those from NES backgrounds based on the previous discussion. Subsequently indicating the need for new strategies.
While these reports suggest that patients are dissatisfied with the food they receive in hospital other reports note that they are satisfied (Kokkinakos, 1993- pers. comm.). Lutz (1989) and Maller et al (1980) suggest that patients have low expectations of hospital food, and when they actually have it they are pleasantly surprised. The apparent paradox is difficult to explain.

Kernish et al (1988) and Carvey and Pasovac (1982) attribute the paradox to methodological issues. Most of the data related to hospital patients satisfaction with the food is extrapolate from independent hospitals inpatient opinion surveys, thus it reflects the bias of those institutions. Rosich and Garey (1990) also ascribe the paradox to methodological issues. They proclaim that 82 characteristics of the dining experience influence patient satisfaction, yet these are rarely identified and evaluated separately by researchers and practitioners when assessing patient satisfaction.

The context in which these surveys are administered also influences the validity and reliability of the data. For example, Lutz (1989) and Maller et al (1980) identify that being ill negatively influences peoples appetite and taste buds and therefore the palatability of the food. Consequently hospitalised patients rate the food poorly. Other authors assert that some clients may provide "good" answers because they are reluctant about expressing negative opinions about the food. This is particularly evident among migrant communities (Madhock et al, 1992; Lipson and Meleis, 1983; Meleis, 1981). Maller et al (1980) suggests that dissatisfied clients voice their opinions more than satisfied clients.

All the relevant literature cites that efforts should be made in order to increase acceptability and encourage patients to eat their food (Arney and Tiddy 1992a, b; Williams, 1990; Maller et al, 1980). Inguanzo and Harju (1985) identified that many of these areas of dissatisfaction are tangible and can be overcome.
This is a greater reality now with the proliferation of new food production and service technologies such as cook-chill and cook-freeze (the advantages and disadvantages of the cook-chill system was provided in chapter 2.4). These systems provide some potential for improvement in areas such as meal temperature and times, and further flexibility and choice in meals (HAHS, MHU, 1991). Other problem areas such as serving sizes, lack of choice, and poorly designed menus rely on effective menu planning (Arney and Tiddy, 1992 a, b).

3.2.1. Menu Planning

The menu is the core of all food service operations (Arney and Tiddy, 1992; Williams, 1990). Williams (1990) identified that it controls all other aspects of the food service and can be primarily responsible for its reputation. Principles and guidelines for menu planning exist and can be sought elsewhere (NSW Department of Health, 1987).

The essential basis for all good menu planning is knowing your client's food preferences. All the current literature in the area is now recognising the importance of assessing local needs and preferences for the basis of designing patient menus and using this information to plan nutritionally adequate meals (Arney and Tiddy, 1992 a,b; Williams, 1990: Lutz, 1989; Maller et al, 1989).

Kokkinakos (1993- pers. comm.) confirms this, she contends that effective menu planning should consider the patient first, then the meal then the nutrients. In this way patients are likely to get their nutritional requirements because they are encouraged by the availability of their preference and the attractiveness of it.

Benefits of such efforts include enhancement of both dietary "compliance" and patient satisfaction, minimised wastage, and cost containment (Arney and Tiddy, 1992 a, b; FM Staff; 1992; Parsons, 1992 a, b; Maller et al, 1980).
Yet the literature suggests that until recently menu planners have relied on "gut feelings" and personal tastes to develop their menus (Williams, 1990). Alternatively the choice of menu items has been extrapolated from results of overseas foods preference surveys of healthy college, military personnel, the majority of whom are males (Williams, 1988).

Very few data exist on what Australians like to eat, and even less for Australian hospitalised patients, despite the fact that their tastes and needs differ (Williams, 1990; Maller et al, 1980). Williams (1988) undertook the first assessment of Australian hospitalised patients food preference to provide a more appropriate bases for menu planning in Australian hospitals.

While this is an improvement on the existing data base, it was biased by under-representation of people from NES backgrounds and those aged over 80 years. In light of Australian aging population trends (Arney and Tiddy, 1992a; HSDU, SWSAHS, 1993; HAHS, MHU, 1991) and the increasing cultural diversity of the society (HAHS, MHU, 1991; HSDU, SWSAHS, 1991; Williams 1990; chapter 3.1), the validity of these results in fostering increased inpatient satisfaction in Australian hospitals is uncertain. This indicates the need for more representative research of Australian inpatient food preferences.

Recent studies reflect this recognition. Arney and Tiddy (1992a) assessed the food preference of older inpatients at a Repatriation General Hospital to assist in designing more appropriate menus. The HAHS, MHU (1988) developed the Ethnic Food Kit.

There are many challenges associated with achieving effective menu planning. Firstly individual food preferences are influenced by a variety of factors including age, gender, habit, ethnicity, tradition and physiological health (Arney and Tiddy, 1992a, b). Additionally, Williams (1988) cites that individuals are more likely to reject foods that they dislike than accept foods that they like.
Secondly, an array of factors beyond the food itself, influence patient satisfaction with their dining experience and resultant food selection. Rosich and Garey (1990) identify the following six major categories; understanding and meeting patient needs, overall evidence of competence, tangible evidence of quality, guest relations, convenience and the physical environment. Other authors further note: the seasons, degree of hunger, extent of nutrition knowledge and state of health (Williams and Brand, 1889; Williams, 1988), psychological image, social status and the nutrition and sensory value of the food (Arney and Tiddy, 1992 b) influence what is accepted and rejected. This indicates that offering popular or preferred foods alone is not enough to ensure satisfaction.

Considering ethno-cultural preferences intensified the challenges of developing effective, efficient menus. However, Webb and Manderson (1990) indicate that changes can be made simply and inexpensively, and that it is a matter of care for hospitals to modify their menus in some way to cater to the needs of their ethnic clientele.

3.2.2. Diversification of Menus To Improve Food Services

Food service departments are undertaking diversification efforts in order to improve the standard and effectiveness and efficiency of their service (Arney and Tiddy, 1992 b; FM staff, 1992). This has been influenced by the increased awareness of the role of hospital food services as a key area influencing both the well being of patients and the resultant satisfaction with their hospital stay (FM staff, 1992; Williams, 1990; Lutz, 1989). Further the recognition that it is the most utilised service in the hospital, coming under the scrutiny from the widest variety of sources including all staff, patients, visitors, health inspectors and policy makers (FM staff, 1992; Arney and Tiddy, 1992b; Williams, 1990). Williams (1990) asserts that hospital administrators are considering food service diversification efforts as both a way to enhance the image of their institution and to contain costs.
Concerns about the nutritional quality of food and consequent nutritional status of patient, have prompted Health Authorities to develop nutritional standards and guidelines for planning menus (Williams and Brand, 1989). Most recently hospital accreditation standards stipulate that a dietitian be involved in development of new menus to ensure that the nutritional needs of all patients are met including those on special therapeutic diets, such as for diabetes, renal disease and heart disease (Williams, 1990).

Menus are now being designed to incorporate these guidelines, so that patients can make healthy choices easily (Williams, 1990). In this context patient menus are increasingly being recognised and used as an education tool (Williams, 1990).

Menu planning strategies adopted to facilitate these standards and efforts include: printing nutrition messages on the menu regarding the Diet Guidelines or the Five Food Groups, using more descriptive labelling of menu, items and using symbols to indicate healthy choices (Williams, 1990). Many authors also note that these strategies are effective in increasing patient satisfaction with their dining experience (Arney and Tiddy, 1992b; Williams and Brand, 1989; Maller et al., 1980).

Williams (1990) notes that the development of healthy menus alone do not ensure that the food patients receive are healthier. He recommends that a simple diversification effort, feasible for all departments is to adopt healthier cooking methods and recipes to ensure nutritional quality.

Diversification efforts regarding the acceptability of the food service to clients are numerous. The most common diversification trend appears to be the adoption of ready prepared food production systems such as cook chill and cook freeze, because of the potential to over come many of these problems (these were discussed in chapter 2.4). In conjunction with the implementation of a such systems many hospitals are adopting a la carte, or restaurant style menu services. These efforts are designed to provide patients
with increased choice and variety of the food they receive in hospital (Parsons, 1992a; Williams, 1990). Institutions that have adopted these strategies report increases in patient satisfaction and cost containment (Parsons, 1992a). A Melbourne based institution has reported a significant improvement in energy and protein intakes of oncology patients by introducing an a la carte menu with wine service, they also reported no increase in cost (Roberts, 1982, cited in Williams, 1990, p. 2).

More elaborate efforts are adopted by our American colleagues. There, fast food chains (Parsons, 1992b) and gourmet chefs (Lutz, 1989) are being introduced in some hospitals. Others offer hotel style services such as 24 hour room service (Lutz, 1989), hostess delivery services (Parsons, 1992b) and, two tiered patient service systems in which patients have the option to pay extra for gourmet or special foods (Stephenson, 1988, cited in Williams, 1990, p. 2).

Not all institutions can afford to undertake such efforts, particularly without the technological advantage. Many authors identify that small changes can have a significant impact in increasing patient satisfaction. Examples include: providing more descriptive menus (Arney and Tiddy, 1992b; Williams, 1989; Maller et al, 1990); providing patients with a choice of entrees, decreasing the repetition of meals and varying item combinations (Maller et al, 1980), and those noted earlier regarding menu design.

The literature regarding diversification efforts in Australian hospitals is conflicting. In her research into service delivery responses in Australian Hospitals, Dollis (1993) found no changes in catering services. While, Williams and Brand (1988) report that 94 per cent of Australian hospitals centralised their food service systems over the past decade, and many report regularly reviewing their menus (Williams and Brand, 1989).
Williams and Brand (1989, 1988) identify a range of strategies that could be undertaken by Australian institutions to improve the food service delivery to clients. Menus could be improved by investing in heat retention systems to control meal temperature; meal times to conform to recommendations of the Australian Council of Hospital Standards (ACHS) and preferably to be more consistent with eating times at home; patients should be given the opportunity to select both the size and content of their meal themselves (Williams, 1990; Williams and Brand, 1988); revision of menus every two years incorporating results of objective studies on their clients food preferences (Williams and Brand, 1989). Williams (1990) asserts that efforts should be more attractively designed since they advertise the department and the institution.

Ultimately the choice of diversification depends on catering managers and hospital administrators to consider innovative ways to provide clients with their food related needs, within the available resources (Lutz, 1989). However, recognising the many challenges involved in undertaking diversification efforts, experts in the field are advocating that Food Services managers adopt new roles in order to be a player for the funds in such a competitive market (FM staff, 1992). They advise that food service managers extend their responsibilities past their own departments and take positions at the institutional level which allows them to be involved in decision of care. These experts believe that organisational management and negotiation skills, plus knowledge of Industrial Psychology and accounting are imperative to deal with administrators, equipment sales representatives and the demands of organisational and societal change (FM staff, 1992).

Williams and Brand (1988) appear to agree with these principles. They recommend that a minimum standard of qualification be adopted for employment of food service managers in Australia, as currently a high proportion of food service staff in NSW hospitals lack qualifications and, no structures or opportunities exist or necessitate the need to gain qualifications. They further contend that these issues "raise some questions about the level of sophisticated management skills being applied to the administration of
3.3. CHANGES IN DIET PRACTICES ON MIGRATION

Immigration brings with it many changes in dietary patterns. The reason for and the extent of these changes are multi-factorial and include such influences as social, environmental, physiological, economics, time and culture (Webb and Manderson, 1990; Axelson, 1986). The extent to which immigrants from Middle Eastern backgrounds in Australia have changed their dietary practices is not well documented. However, as Axelson (1986, p. 357-358) highlights:

Cultural sub-groups in a population tend to adopt food habits which are neither similar to those of their culture of origin or culture of residence.

Hertzler (1982) notes that one way of assessing acculturation is to observe whether cultural sub-groups in a population are acceptors or donors to food behaviour.

Greenfield et al. (1980) note that in 1979 Lebanese food represented the second largest market growth in the restaurant trade in Sydney alone. Since then the growth of restaurants from other Middle Eastern nations has unfolded with continual expansion and popularity of Lebanese restaurants and take away bars (Anthony et al, 1993). More recent examples of these expansions are evidenced in the increasing prevalence of specialty food stores supplying many imported traditional foodstuffs, Halal butcheries and traditional bakeries (Anthony et al, 1993; Rogers, 1990).

These observations collectively suggest that this sub-group are 'Donors' to Australian food behaviours, and further that people from Middle Eastern backgrounds are retaining their traditional preferences and habits.
Recent initiative in the Bankstown/Canterbury areas of the Muslim Women's National Network lend support to this assertion. This group sought to educate food manufacturers and retailers about the exact dietary requirements of the Muslim community. They did this in an effort to find more foods for their menu after finding that many foods did not meet the needs of their community (The Torch, 1993). The issues support the need for SWSAHS to clearly ascertain the preferences of the Middle Eastern community as a base for effective and efficient hospital food service development.

3.4. DIET, HEALTH AND ILLNESS: MIDDLE EASTERN PERSPECTIVES

3.4.1. Middle Eastern Cultural Perspective Relating to Health Care

Although the nations of the Middle East do not comprise a monolithic block (Grivetty, 1975), many authors identify that there is a core of Middle Easternism which prevails and manifests itself in various values and behaviours of all people from these nations (Kittler and Sucher, 1989; Lipson and Meleis, 1983; Meleis, 1981; Barr-Stein, 1979; Grivetty, 1975).

There is very little literature available on the cultural beliefs and practices of Middle Easterners in Australia particularly relating to health care needs and beliefs or diet related needs. Even less is available on the effects of migration on these beliefs and practices, regardless of the length of time these groups have been here.

Lipson and Meleis (1983) and Meleis (1981) have done some research regarding the cultural beliefs of this group in America (probably due to the larger size of the Middle Eastern population and the longer history of migration there). Based on their clinical and consultation experiences they assert that common needs in providing services to Middle Easterners are related to the importance of affiliation and family, time and space...
orientation, interactional style and understanding their attitudes toward health and illness. Problems arise when these cultural, social and psychological needs are not considered resulting in difficulty in obtaining adequate information, perceived demanding behaviour by patient's family, conflicting beliefs about planning ahead and differing patterns of communicating bad news (Lipson and Meleis, 1983 and Meleis, 1981).

Kittler and Sucher (1989), Lipson and Meleis (1983) and Meleis (1981) identify that Middle Easterners fear hospital admission and their expectations and encounters with physicians are culturally influenced. They have great respect for Western Medicine and authority figures. They are reluctant to ask questions and their behaviour and responses are designed to please and appear good.

Moussa (1991) and McCallum (1990) both confirm that the Arabic speaking population in Australia have the same characteristics. Moussa (1991) identifies that the lack of education regarding their health care rights, language and cultural factors including fear and shyness, are significant barriers in meeting the health needs of the Arabic speaking communities.

McCallum (1990) found consistent notions among Arabic speaking women in Australia. He asserts that these woman experience more difficulties and greater barriers in seeking government services, than other groups, because of language difficulties and cultural sensitivities about asking for any help at all. Lipson and Meleis (1983) and Meleis (1981) report consistent data from their experiences with the Middle Eastern population in America.

Moussa (1991) suggests that this problem is exacerbated for Arabic speaking population in Australia by the existence of prejudices toward them evident in the Australian health care system. He notes that slanderous medical jargon such as the 'Lebanese back' syndrome, and labelling by hospital staff as difficult and aggressive patients as examples of such prejudice toward this population, which influence the quality of care they receive.
Moussa (1991) also suggests that issues related to health care experiences in their own country may influence Lebanese people's response and expectations of health care in Australia. For example, the alleged universality of Medicare offering free or inexpensive health care implies equitable care relative to the expensive, privatised system at home. Therefore they respect and accept the level of care provided here.

These characteristics also influence eating in hospital for people from Middle Eastern backgrounds. Moussa (1991), Kittler and Sucher (1990), Lipson and Meleis, (1983), and Meleis (1981) note that people from Middle Eastern backgrounds do not tend to complain or ask for different foods because they have a high respect for authority and fear rejection. They simply may lack awareness of their right to ask for different meals or other options for receiving food in hospital (Lipson and Meleis; 1983; Meleis, 1981).

3.4.2. Illness and Food

Food plays a significant role in the lives of Middle Eastern families. All food related practices intertwine love and care, where the complexity of time and effort taken to prepare the food is considered a reflection of the degree of care (Meleis, 1981). Hence it is not surprising that food plays an important role in beliefs about illness and health in Middle Eastern cultures.

Deprivation of food or an inappropriate diet is thought to cause weakness or illness. "Poor appetite can be regarded as a disease itself or as a symptom indicating that life is not as it should be" (Meleis, 1981, p.1182). Indeed a physically robust person is considered more healthy than a thin person (Lipson and Meleis, 1983).

Many perceptions appear to be based on humoural theory in the use of hot, cold foods. Meleis (1981) notes that these perceptions are based on food temperature not pungency. However, later research by Lipson and Meleis (1983) identify both pungency and
temperature basis. Meleis (1981) states that overall, Middle Easterners believe that "the entire digestive system has to be given the opportunity to adjust to either hot or cold foods before introducing its opposite"

Lipson and Meleis (1983) note that herbal teas such as 'Gole gov zabon' are used by Iranians to settle nervous upsets and concentrated sugar is used for stomach upsets. Armenians consume only fresh foods to prevent illness as canned or frozen foods are believed to cause illness.

Muslim dietary laws recommend pure honey, milk, dates, seafood, and sweets as healing foods for all mankind. Vegetable oil, particularly olive oil, is also recommended both as a food (Twaigery and Spillman, 1989; Sakr, 1971) and an ointment for the skin (Sakr, 1971). Twaigery and Spillman (1989) further identify figs, olives, and buttermilk as foods having special health benefits and religious significance as they are specifically ordained in the Qur'an.

Lipson and Meleis (1983) note that the people of this culture have a strong belief that illness will be the consequence of any disruption or imbalance in the preparation, presentation, and eating of food. This indicates that eating in hospital presents an area of concern for people from Middle Eastern backgrounds beyond those recognised earlier. Lipson and Meleis (1983) support this view.

This is further exacerbated by the religious constraints on dietary patterns. As mentioned, Islam is a major religion of the Middle East. Twaigery and Spillman (1989) and Sakr (1971) identify that Muslim clients must know the ingredients of any food or drink before using it. Consequently when placed in an institutional situation where they do not have access to this information, Muslim clients often go hungry out of fear of eating food which many contain pork or any derivatives of pork. Twaigery and Spillman (1989), state that Muslim dietary laws must be observed at all times including periods of
hospitalisation for illness or pregnancy.

Other religions have diet laws influencing choices of eating patterns that conflict with menu planning principles used in Australian hospitals. For example many people choose not to eat meat on certain days for religious reasons, yet there is suggestion that very few hospitals in NSW offer vegetarian options as regular items on their menus (Kokkinakos, 1993-pers. comm.). Even if they did, they are unlikely to conform with the cultural preferences of these individuals (Anthony et al., 1993).

3.4.3. Traditional Middle Eastern Food Habits

The importance of food as expressed through the gracious and generous display of hospitality and pride in food traditions is common across all Middle Eastern nations (Anthony et al., 1993; Barr-Stein, 1979). However each nation has its own characteristic dietary pattern (Kittler and Sucher, 1990).

Kittler and Sucher (1990) identify 3-5 regional divisions in Middle Eastern culinary practices those of: Greek/Turkish, Iranian, North African, Arabic and Israel. They assert that the recipes and cooking methods of each are unique to the respective region. However, they also identify that there is a striking similarity throughout the regions. Other authors also identify this (Anthony et al., 1993; Barr-Stein, 1979; Grivetty, 1975).

Following is a summary of the characteristic traditional food habits of the Middle East. Webb and Manderson (1990) assert that such information is necessary in designing culturally appropriate care and preventative approaches for respective ethno-cultural groups. Samolsky et al (1990) support this.

Generally speaking, the use of spices and flavours dominate the cuisine right throughout the Middle East (Anthony et al., 1993; Kittler and Sucher, 1989; Barr-Stein, 1979;
The most commonly used seasoning agents are coriander, cinnamon, cumin, aniseed, nutmeg and various peppers. Herbs are also extensively used, the most popular being mint, parsley, marjoram, sesame seed and sim'meh.

Other flavouring agents include yoghurt, lemon juice, olive oil, tomato, pine nuts, almond, rosewater, orange blossom water and ghee. The pungent flavours of garlic and onion also are extensively used (Anthony et al., 1993; Kittler and Sucher, 1990; Barr-Stein, 1979; Grivetty, 1975).

The people from these cultures also have a tendency towards very sweet flavours. The desserts and sweets of these nations are heavily laden with honey, sugar, molasses and syrups. They enjoy home made candies such as Turkish Delight and fruit preserves. Even the traditional bitter coffee and tea is significantly sweetened unless religious occasions such as funerals dictate that bitter coffee is served. (Anthony et al., 1993; Kittler and Sucher, 1989; Barr-Stein, 1979; Grivetty, 1975; Sakr, 1971). Religious people also drink bitter coffee.

Cereals, fruits and vegetables make up the basic of the diet throughout the Middle East. Bread is the staple food in everybody's diet. A meal is not considered such unless bread is served. Rice and crushed wheat (Burghul) are the other two main cereals. Both these foods form the basis of many meals. Burghul is commonly used in salads, gruels and porridge. Rice is most often eaten with a range of legumes or spiced up with minced meat or chicken and nuts. It is also used as the basis of fillings for stuffed vegetables (Anthony et al, 1993, Kittler and Sucher, 1989, Barr-Stein, 1979, Grivetty, 1975).

The use of legumes is very common across these cultures. A wide variety of beans and peas are used to make soups, dips or are boiled and spiced up with yoghurts, lemon juice, tomato and onion bases. These dishes may be eaten hot or cold, and at any meal, including breakfast (Hamdan, 1993-pers. comm.; Hasn, 1993-pers. comm.; Webb and
A wide variety of both fruits and vegetables also are important staples in the diet of Middle Eastern people. They can be eaten quite simply raw or they may be exotically pickled, preserved or sweetened.

Vegetables form the basis of most hot meals, stuffed, stews, broths, baked. They also comprise many exotic salads such as Tabouleh and Fatouche (Anthony et al., 1993; Kittler and Sucher, 1989; Barr-Stein, 1979). Additionally, "no meal is complete without a platter of crisp salad vegetables or tossed salad" (Anthony et al, 1993, p. 89).

Fresh fruit is eaten between meals or as dessert. Commonly a piece of fruit is eaten at the end of each meal to cleanse the palate and complete the meal. The favourite fruit across all nations is the olive, which provides the major source of fat in the diet of these people (olive oil) (Anthony et al., 1993; Kittler and Sucher, 1989; Barr-Stein, 1979).

Traditionally meat, including fish and chicken did not contribute a great deal to the diet of the people from the Middle East. Usually because of economic reasons, but also many religious beliefs and practices may dictate the type and amount to be eaten, for example Muslims are prohibited to eat pork or any derivatives and many Christians choose not to eat meat on certain days, although some eat fish. However many traditional and ceremonial meals involve the exotic preparation of meats (Anthony et al., 1993; Kittler and Sucher, 1989; Barr-Stein, 1979). Anthony et al. (1993) identify that mutton or lamb are the most commonly used meats across the Middle East.

The main protein source then is provided by legumes and milk based products. Milk is not usually consumed on its own (Kittler and Sucher, 1989), it is more commonly fermented to make yoghurts and cheeses (Anthony et al, 1993; Kittler and Sucher, 1989; Barr-Stein, 1979). These products are eaten extensively across all populations in the
Middle East at any time of the day, Anthony et al. (1993) identify them as staples in the diet. They may even comprise a main meal with bread and fresh vegetables and olives (usually breakfast or dinner).

To summarise Anthony et al. (1993) identify that the art of Lebanese cooking lies in having the basic mixtures always on hand, they include rice, stuffings, yoghurts, cheese, sauces, pastries, bread, pickles, olives, nuts, grains, herbs and spices. In this way a large variety of food can be prepared at very short notice by varying combinations of these mixtures.

A very beneficial aspect of this style of cooking relating to incorporation into the hospital food service is that meals store and reheat well. In this way large amounts of food can be made and then stored for future meals. Anthony et al. (1993) note that such methods are also time and labour saving as much of the work can be done ahead of time. A further benefit relates to cost and wastage. Anthony et al. (1993, p. 16) identify that "nearly every part of the raw product is utilised. In fact there is so little wastage that a small selection of raw food is sufficient to create a large variety of substantial dishes".

3.4.4. Traditional Middle Eastern Meal Patterns

The above description highlights the extreme difference in traditional food choices of people from Middle Eastern backgrounds from that of the Anglo-Celtic diet. The literature suggests that the meal patterns also differ.

Kittler and Sucher (1989) and Barr-Stein (1979) assert that Middle Easterners tend to enjoy their main meal in the middle of the day, with smaller meals in the morning and evening. Anthony et al (1993) reports contrary citing that the evening meal is the main one.
Despite the disparity, it can be said that there is less structure than the three meal three snack edifice, present in Anglo-Celtic institutional culture. Perhaps this disparity is due to Anthony et al (1993) reporting more recent practices of Lebanese in Australia were as the previous two authors are American and their information is also older and describes the practices of a broader population of Middle Easterners.

Although the reports about the timing of the main meal differs among these authors, the content and structure of the meal is consistent. The main meal starts with mezza (hors d'oeuvres), these are finger foods placed in the small individual dishes and nibbled. This part of the meal has an important social role. It is a time for chatting and relaxing. Often the time for mezza extends for many hours. In such cases the main meal is either served at a much later hour or not taken at all (Anthony et al, 1993).

The main meal then follows. This usually consists of at least three dishes (many more in times of celebration and entertaining) comprising a meat dish, a cooked vegetable and grain dish, together with the staple accompaniments of yoghurt, salad, bread and olives.

Food is not plated up and served as familiar in the Anglo-culture. It is placed in the middle of the table in bowls and serving dishes and individuals plate up combinations as they please. Fresh and dried fruit is always served at the end of the main meal. Again these are placed in the centre of the table. Coffee is also served at the completion of the meal. Water is most commonly drunk during the meal (Anthony et al., 1993).

The breakfast meal is quite standard. It always includes traditional coffee bread which is accompanied by all, or some of the following foods: olives, cheese, zaartar (a herb mixture), yoghurt, eggs, fresh fruit and jam (Anthony et al., 1993; Barr-Stein, 1979). An early morning beverage of tea may be taken before breakfast with home made tea cakes (Barr-Stein, 1979), in this instance the breakfast meal is then later in the morning.
A lighter meal, usually taken in the evening, this is supper for those who have a late main meal and dinner for those whose main meal is in the afternoon. Generally this meal includes a small portion of the main meal, most commonly a cooked vegetable and grain dish, or a bowl of soup. Whichever is chosen, accompaniments of cheese, olives, salad, vegetable, yoghurt and bread always complete the meal and may even comprise the meal (Anthony et al., 1993; Barr-Stein, 1979).

While the account presented here provides a good background indication of some of the food related habits of this group it cannot be used as the basis for planning. Indeed, Webb and Manderson (1990) assert that reliance on anecdotal, unrepresentative and simplistic accounts of the cuisine and food habits of immigrant groups have the potential for bias, inaccuracies and cultural stereotyping.

Moussa (1991, p. 15) specifies this for the Arabic speaking community in Australia. He identifies that, due to the lack of research regarding the health care needs of this community and the uniqueness of the population "community based research is of paramount importance" in undertaking any initiatives for them.

3.5. APPROACHES TO THE STUDY OF FOOD HABITS

Webb and Manderson (1990) identify that there are many difficulties in assessing the food habits of immigrants, and this is one of the reasons for the lack of information. The diversity of the Middle Eastern culture in Australia (Moussa, 1991; McCallum, 1990, chapter 2.5) compounds this problem. Grivetty (1975) agrees and asserts that an understanding of individuals country of origin, urban and rural background, length of stay (in Australia), religious background as well as each person's choice of ethnic identity and degree of acculturation are important aspects to consider and understood in order to enhance acceptance of new foods and flavours.
Classic methods of studying food habits, for example food recall and recording methods, food frequency questionnaires, do not attend to these areas. Further, language and literacy barriers also influence the ability to use such techniques with migrant groups (Webb and Manderson, 1990, Hunt, 1886). Hertzler (1982) identifies that a chief concern in obtaining cultural food habit information pertains to asking the right questions. For these reasons, qualitative techniques are recommended as appropriate methods to attain relevant diet information for migrant groups (Webb and Manderson, 1990).

The Focus Group technique is one such method. The technique has a strong history in the areas of market research, however Krueger (1988) notes that all organisations in today's society (both profit and non profit) are faced with competitive markets, therefore there is an increasing need for service providers to tailor their 'products' to meet consumer needs. The competitiveness of today's health care environment (chapter 3.1) suggests the relevance of using this technique in health care research. Merton (1987), one of the founders of the method, considers the technique as a generic research method which can and should be applied to every sphere of human behaviour.

It is now being advocated that health professionals increase their awareness and understanding of the potential benefits of this technique as a means of developing effective service delivery; especially if they are working with clients from NES backgrounds (Hawe et al., 1990; Webb and Manderson, 1990; Hunt, 1986).

Indeed the health field has recognised the potential benefits of utilising this technique and it has hence been used extensively with great success in the area of public health (Bowler, 1992; Hawe et al., 1990; McCallum, 1990; Webb and Manderson, 1990; Krueger, 1988; McCarthy, 1987).
McCarthy (1987, p. 36) asserts that:

by providing for the inclusion of the consumer viewpoint and expertise into the hospital planning process, both of the level of general operation and specific projects, their hospital can ensure the level of appropriateness of policy, planning and services to the changing needs of their clients.

Other authors support the use for such a technique in collecting food habit information. Williams (1990) notes that such tools of modern market research should be capitalised on in assessing the food preferences of a hospital's client base, to keep in touch with their needs and wants so that a more effective and efficient food service can be developed. This is particularly indicated with an increasingly diverse cultural society.

Webb and Manderson (1990) cite other benefits in using this technique in assessing food habits of different cultural groups. They assert that it provides an avenue to collect information and understanding of "words used to describe foods and cooking methods, beliefs about food, dining and snacking behaviour, and similar information that a questionnaire may not be able to provide" (p.186). Moreover, by conducting such interviews the researcher can "become part of the community" and discover first hand why, and how, people purchase, produce, prepare and eat certain food. Additionally they can increase their awareness about the life context in which personal decisions are made. In this way the technique serves as an ideal preliminary analysis to collect data for more quantitative techniques or to clarify results or understanding other research results (Webb and Manderson, 1990).

Murcott (1988, cited in Webb and Manderson, 1990) asserts that the unfamiliarity of nutrition and other health professionals with the focus group method limits our understanding of food related behaviour especially in cultures different from our own. Therefore the proceeding section presents a brief review of the focus group technique as this was the mode of research used in this study.
3.6. **FOCUS GROUPS**

The focus group interview is a qualitative research technique created to accomplish a specific purpose through a defined process. It is a carefully planned group discussion designed to obtain perceptions on a defined area of interest in a permissive non-threatening environment. A group dynamic is formed through group members sharing ideas and perceptions. Clues and insights into how a product service or opportunity is perceived are identified through careful and systematic analysis of the discussion (Hawe et al., 1990; Hayes and Tatham, 1989; Krueger, 1988). Indeed Krueger (1988) cites that the procedure allows professionals to see reality from the clients point of view. (Appendix 7.1 provides a summary of the Focus group technique as given to the EHWs as part of their training as co-facilitators in the current study).

There are many inherent difficulties in planning, conducting and analysing focus group data (Bowler, 1992; Minichiello, et al, 1990; Hayes and Tatham, 1989; Krueger, 1988). The literature suggests that in selecting participants for focus group research, homogeneity of the target audience is preferred. Further, that sessions are continually conducted with groups of homogenous representatives from the target audience till no new information on the research issue is attained (Hawe et al, 1990; Krueger, 1988). Krueger (1988) adds that homogeneity can be both broadly and narrowly defined.

There is no ideal number of groups needed for the technique, however Morgan (1988, cited in Bowler, 1992) asserts that one group is never enough. Other authors recommend that three groups are a good number to initially plan for, then one should consider more based on the variability of the data (Hawe et al, 1990; Krueger, 1988).

It is recommended that participants in focus groups not be known to one another as familiarity may inhibit open disclosure due to participants basing responses on known experiences and relationships with other members [Bach, 1987; Caldes 1977 (cited in Bowler, 1992); Krueger, 1988].
Krueger (1988) further asserts that there is danger in conducting focus groups with existing groups as members may have formal and informal ways of relating to each other which influence their responses, particularly when supervisors are present. He does however state that the issue of anonymity is one for the analyst, as participants familiarity with each other makes it difficult to assess what influenced their responses. From this he suggests that familiarity among participants may be acceptable in some circumstances. Bowler (1992) found in her research that familiarity among participants encouraged them to concur.

Traditionally six to twelve participants per group are recommended (Hawe et al, 1990, Krueger, 1988). Less than this it may not provide a sufficient basis for gathering data and may put pressure on participants to perform, particularly if there are dominating members among the group. Smaller groups are effective if the participants have a great deal to share about the topic. Larger than this makes facilitating the group difficult. It is difficult to obtain trust among all participants if they feel that their views will not be given enough attention or, alternatively, they may feel intimidated by the size of the group and consequently they may become passive. Large numbers also may cause the group to fragment into smaller conversations. Generally larger groups have the potential to effect the overall quality of the data by having the potential to lose participants opinion. Larger groups are appropriate if the researcher wants to gain insight into a range of opinions.

The issue of selecting an appropriate number of participants is confusing. On the one hand Krueger (1988) asserts that people are often honoured to be asked to present their opinions for research. Hawe et al (1990) also note this. On the other hand he contends that getting enough participants to attend focus groups is a common problem. Additionally Hawe et al (1990) suggest over recruiting as a precautionary step to avoid this possibility. Yet this presents the possibility of having to large a group. This is an inherent complication of social science research and has to be managed by the facilitator at the time.
The significance of the moderators/facilitators role in influencing the outcomes of the focus group is well documented (Bowler, 1992; Hayes and Tathem, 1989, Krueger, 1988). The moderator must have skills in developing a safe non threatening environment, where participants feel safe to divulge personal information. They must be able to constantly monitor the dynamics of the groups and to respond to issues as they arise including disagreement among participants, dominating or passive participants, time management and issues relating to the size of the group (Bowler, 1992; Krueger, 1988).

Krueger (1988) asserts that the use of an inexperienced person as a moderator is risky and could negatively influence the quality of the results. Yet Bach (1987, cited in Bowler, 1992) states that expertise in the method is best done through practice. This includes conducting the entire process from participant selection to analysing data and writing the report.

The literature regarding the choice of the moderator also is conflicting. Murphey (1992, cited in Bowler, 1992) contends that the primary researcher should not moderate the focus group to avoid the risk of the session being influenced by their preconceptions. Murphey's (1990) recommendation is only feasible if resources allow. Conversely, Krueger (1988) recommends that the same person adopt the same roles. He contends that the familiarity with the process allows for more consistent bases for data control and management.

Traditionally questions in a focus group are designed to achieve a funnel effect (Hawe et al, 1990; Hayes and Tathem, 1989, Krueger, 1988). The first question introduces the topic and breaks the ice. Krueger (1988) states that specific questions should be avoided as they do not allow the context to be set. Subsequent questions become more focused with the final one addressing the most sensitive issues. The sequence of the questions should appear natural and logical to the participants which takes considerable thought and consideration by the researcher (cited in Bowler, 1992; Hawe et al, 1990; Hayes and Tathem, 1989; Krueger, 1988).
Piloting the proposed questionnaire is essential in determining the logical flow of the questionnaire and the ability of the probes to elicit the information required. Additionally it gives the facilitator an insight into the interactional style of the participants and the facilitator is able to practice her/his skills (Krueger, 1988).

The focus group method has many advantages over other more quantitative research techniques. They include:

1. It is socially orientated, hence placing people in their natural real life situation, allowing people to relax and respond openly.

2. The format allows for probing, and explanation of responses. In this way the issues can be clarified and better understood.

3. The results have high face validity and can be easily understood by anybody needing them as they are presentations of people’s thoughts, not sums and numbers.

4. The technique can be used for a number of reasons (1) before a program begins to ascertain community needs, (2) during a program, e.g. customer surveys, formative evaluation, recruiting new clients for existing programs, (3) after programs, to assess programs, provide summative evaluations and analyse what went wrong.

5. They are cost and time effective as more people's views can be assessed per research initiative. The sample size can be increased dramatically without increasing the cost or time to the same degree.
Like all research techniques the focus group method also affords some limitations which may influence the quality of the results.

(1) The control of the group is shared among all members as a result avoiding irrelevant discussions and maintaining focused on the issue may become difficult.

(2) The data are hard to analyse as the results must be considered in the social content in which they were expressed.

(3) Skills in open-ended questioning, probing, pausing and moving into different target areas require expertise. Hence the technique is best conducted by a trained interviewer.

(4) Groups vary considerably and it is recommended that many sessions be conducted to overcome idiosyncrasies.

(5) They are difficult to assemble.

(Krueger, 1988)

McCallum (1990) identifies two other disadvantages: (1) the generalisability of focus group results is impeded by the smaller numbers of respondents relative to sample surveys. This was also identified by Merton (1987) who was partly responsible for the origins of the method (2) a two hour session limits the number of topics or questions that can be examined. However this very restriction also provides an advantage in that the topic of discussion can be concisely defined and examined.

While the technique has many obvious strengths it is not applicable to every situation. Indeed Krueger (1988) identifies that using the technique in inappropriate contexts will yield invalid results. Hayes and Tatham (1989) agree and further add that valuable
Insights from the technique will only be gained if it is not implemented as an afterthought or in an unempirical fashion.

Deviating from the principles of the focus group method is thought to raise the issue of validity. However Krueger (1988, p. 41) stipulates that "validity depends not only on the procedures used but also on the context". He further suggests that some situations may necessitate modification of the technique, citing Linda (1982, p 98) to support this.

'The technique is robust and hardy and can be twisted a bit and still yield useful and significant result'.

In this research, the focus group technique has been used to address the food preference of a sample of members from the Middle Eastern community residing in SWSAHS to gain insight into their preferences for hospital food. The proceeding chapter reports the process under taken in this research.
CHAPTER 4

METHODOLOGY

The Focus group process was used to gain insight into Middle Eastern hospital food preferences in two ways (1) through the session protocol questions, and (2) through participant selection. Five sessions were conducted in total, one pilot group and four study groups. Participants were representatives from the Lebanese and Assyrian communities in SWSAHS.

This chapter presents a descriptive account of the methodology undertaken as it is difficult to separate the theoretical methods planned from those which actually occurred.

4.1. **THE SESSION PROTOCOL.**

This was the set of questions used by the facilitators to guide the group discussion. Two preliminary drafts of the protocol were developed before compiling the final draft which was used in the major study. The first draft was developed to include questions of interest requested by SWSAHS. Additionally Middle Eastern EHW were consulted regarding their perceptions of appropriate questions for members of their community.

4.1.1 **The pilot study**

An epidemiologist was consulted to refine this draft which was then piloted among a sample of elderly Middle Eastern men. The questions in this initial protocol relates to the following areas [see Appendix 4 for full protocol used. Krueger (1988); and Hayes
and Tatham (1989) provide detail discussion on the process involved in this initial stage.

* the importance of eating during sickness
* perceptions of special or preferred foods required during illness
* perceptions and opinions about the current food and food service in hospital
* food and beverage preferences for each meal, including mid meals
* suggestions for changes (if any) of the current food service in hospital to make it more acceptable
* preferred meal combinations and beverage combinations
* eating, cooking and serving utensils used in food preparation and eating
* perceptions regarding common foods across Middle Eastern nations
* the role of religion in influencing their eating practices during illness and in hospital

The results of the pilot study provided the information base to further refine the protocol to use in the major study.

4.1.2 **The major study**

The same areas of interest were maintained in compiling the protocol for these groups. However, the results of the pilot session indicated that cultural and linguistic factors necessitated modification to the style of questioning and some content changes. These modifications relate to the following areas (see Appendix 5 for the session protocol used).

* Questions relating to cultural practices and hospital food preference for lactation, childhood and infancy were not considered culturally appropriate to ask men. Consequently the protocol for the woman's groups specifically included additional questions regarding these issues. These questions were eluded to throughout the course of the discussion with the men's groups but they were not specifically asked.
* The questions regarding utensils were eliminated. The participants perceived these questions as out of context in discussions about hospital food preferences. It was felt that these questions will be more appropriate in the next phase of the study when the participants will assist in training the CPU cooks.

* The questions and prompts were made more specific. Language barriers, lack of culturally equivalent terms, and differences in interpretation and perceptions of words by participants necessitated this. Prompts, probes and examples had to be very specific to trigger responses.

* Participants had to be empowered to respond to questions regarding hospital preferences. Better responses were attained when they were asked about practices and preferences at home, then using these responses to lead into hospital preferences.

A short demographic questionnaire (Appendix 7.4, Attachment 5) also was developed in consultation with an epidemiologist. The information was used in the analysis phase to assist in considering how the variables influenced the results.

4.2. PARTICIPANT SELECTION

In order to canvass a broad range of opinion regarding Middle Easterners food preferences and habits, a large cross section of people needed to be interviewed. Selecting participants and arranging the focus groups was deliberately designed to seek diversity and range in the target groups responses. Four subgroups were identified as being instrumental in providing appropriate information for the study purpose. Participants were selected because they were considered to represent an important population in terms of their health service utilisation patterns, life experiences, and culture.
4.2.1. The pilot study

We wanted to pilot the protocol with a sample of participants with the characteristics of one of the four sub groups for purposes of validity and consistency. This also gave us the opportunity to apply the theoretical recommendation of conducting subsequent groups until no new information is attained (Hawe et al, 1990; Krueger, 1988), which otherwise would not have been feasible within the resource constraints of this research.

The choice of which group to use was based on how easy it would be to access two sets of potential participants with the desired characteristics. Group 1 were selected because of access to a large existing community group of elderly Lebanese men was possible through one of the areas Arabic speaking EHW.

4.2.2. The Major Study

4.2.2.1. Men Over 55 Years Old

This group were identified for many reasons. Firstly, it was anticipated that some of them would have had some experience with the hospital system in Australia, hence they could comment on the existing food service system.

Secondly, in Middle Eastern cultures it is traditionally the male who works outside of the home to support the family (McCallum, 1990). It was anticipated that such a situation exposes this group to different foods which then provides the opportunity to experience and develop different tastes, preferences and habits.

Thirdly, it was anticipated that men in this age group could provide information on traditional food habits since the literature notes that older people tend to adopt the food habits of their earlier years (Arney and Tiddy, 1992 a, b) specifically that the ethnic aged retain their ethnic dietary preference (HAHS, MHU, 1991). Depending on their length of
residence it was conceded that these men could provide insight into the degree to which traditional food habits may have changed in response to this.

4.2.2.2. **Females Over 55 Years Old**

These women were considered the most appropriate persons to provide information on food related behaviours since traditionally women from Middle Eastern backgrounds are the principle carers of the family and home (McCallum, 1990). This includes all practices relating to food procurement, preparation and presentation.

Woman within this age group were specifically chosen as it was conceded that they would have experience in bringing up a family. They could provide valuable insight into the food related needs during pregnancy, lactation, health, illness, convalescence and, across the different age groups. It was hoped that women would provide information regarding the degree of acculturation, specifically whether any differences in food habits across generations existed, particularly on the basis of whether children were born in Australia as compared with those born in other countries or in their country of origin.

4.2.2.3 **Women who have been hospitalised within the past four years for gynaecological/obstetric (or other) purposes**

This group were targeted because collectively women from Middle Eastern backgrounds in South Western Sydney are among the highest users of hospital services in the area (HSDU, SWSAHS, 1991; NSW Department of Health, 1991). Their opinions regarding hospital food services and their own diet needs would be paramount in developing an appropriate service.

It was anticipated that discussions with this group would yield information not identified by the other groups since the food related needs and beliefs of a lactating woman would differ to those during illness or convalescence. Generally they are well and they have
increased nutritional requirements (Coote and Williams, 1993). It has been identified that
during pregnancy and childbirth, many woman from NES backgrounds tend to express
and undertake traditional folklore practices (Duke, 1988). The literature cites the need to
obtain this information and provide this group with culturally appropriate food in hospital
(Duke, 1988).

4.2.2.4 Men Aged 15-24 years

This group was targeted for two main reasons. Firstly, 1991 morbidity data for
SWSAHS residents (NSW Department of Health, 1991) based on sex separations
indicate that Middle Eastern men in this age group are high utilisers of the Area’s health
services.

Secondly, the food preferences of younger hospitalised patient populations have been
considered to differ considerably from those of the elderly (Arney and Tiddy, 1992 a). It
was anticipated that age and reason for health service utilisation which differentiates this
group from the others could provide insight into whether needs differ.

4.3. THE FOCUS GROUP PROCESS

4.3.1. The Focus Group Plan

4.3.1.1. Communicating with the Target Groups

Assistance was required from appropriately trained staff to recruit participants, and co-
facilitate the sessions. Ethnic health care workers were used to recruit participants as they
had access to potential participants within the selection criteria through both social and
community networks. The SWASHS Ethnic Health Services Plan, 1992 (HSDU,
SWASHS, 1991) states that this is their role. Arabic speaking health care workers
assisted in recruiting participants for the pilot study and groups one (1) and three (3) as they had access to individuals with the required selection criteria. An Assyrian health care worker assisted in recruiting participants for group two (2). Staff at the Australian Migrant English Service (AMES) in Fairfield assisted in recruiting participants for group 4.

Few of the participants recruited were proficient in the English language or had literacy skills in English. My cultural background is Lebanese. I understand Arabic fluently but my verbal skills in Arabic are less fluent. The Assyrian language differs to Arabic but I can understand some words which are common to both languages, but I do not speak Assyrian. This indicated the need for interpreters to assist in communicating with participants.

We initially considered using professional interpreters to co-facilitate the sessions, as SWSAHS proscribes the use of EHW in this role where interpreters should be used (HSDU, SWSAHS, 1991). Resource constraints precluded this decision and authorisation to use the EHW to co-facilitate their respective sessions was sought and attained (Mathews, 1993- pers. comm.).

The use of the EHW in this role also was a more culturally appropriate decision. Many authors state the proficiency of using a familiar, credible information source to communicate issues of health care effectively with people from Middle Eastern backgrounds (Moussa, 1991; Webb and Manderson, 1990; Lipson and Meleis, 1983; Meleis, 1981). The reasoning goes beyond overcoming language barriers, but includes issues of trust and respect which effect the degree to which in turn effect the communication style and the validity of participants responses. Using the EHW in both roles of recruiting and co-facilitating also provided a more consistent basis for data management and control.
As co-facilitators the EHW read out, explained, and interpreted all written material to the participants. They also directly translated my questions to the group. Where it appeared that participants did not understand the questions they were rephrased or examples, and/or prompts were offered to clarify issues with participants.

I had greater control of this process in the sessions with the Lebanese participants in the pilot study and groups 1 and 3, because of my cultural affiliation with them. In these cases I could understand participant responses and offer some feedback accordingly. In cases where my language skills precluded me directly responding, I asked the EHW to relay the messages. This allowed for free flowing and dynamic communication.

I had less control of the process with the Assyrian participants in groups 2 and 4 because of my lack of the Assyrian language abilities. I had to work very closely with the EHW in conducting these sessions as I had to rely on him to communicate with the participants.

4.3.1.2. Recruiting the Participants

Each EHW was asked to recruit a minimum of six participants and a maximum of 10-12 participants for each group. They also were asked to select an appropriate venue for their respective group based on the ease of accessibility for participants and the availability of appropriate resources (i.e. seating, tables, power points).

A preparation/training kit was developed for each EHW. "The Kit" included preliminary interviews between the researcher and each health care worker and a group training workshop. The interviews were undertaken to familiarise them with the project and negotiate their roles (the information given to participants is presented in Appendix 6). Their opinions regarding both their own food preferences and what they considered those of their community might be during periods of hospitalisation were also determined. This information was used as the basis for developing the session protocol and in the analysis stage of this research to cross check with the data from their respective groups.
The training workshop for the EHW was undertaken with the assistance of a community nutritionist to gain beginners experience in recruiting for, and conducting focus group research. Here the EHWs were provided with the remainder of the "The Kit" (Appendix 7) which included: written background information on the Focus Group Process (Appendix 6); a time table of events and deadlines as it related to their group (Appendix 7.6 Attachment 7); a copy of all the associated material they required, such as the reminder letter for participants (Appendix 7.1, Attachment, 2); a copy of the consent form in both Arabic (Appendix 7.2, Attachment, 3); and English (Appendix 7.3, Attachment 4). Also a copy of the demographic questionnaire (Appendix 4, Attachment 5), and a copy of the session outline (Appendix 7.5) and the session protocol designed for the pilot group (Appendix 4).

4.3.1.3. **The Session**

A time period of two hours was allocated for each session. Thirty minutes was allocated to allow participants to arrive and settle in while enjoying some refreshments. During this time participants also filled out the consent and demographic questionnaire. Due to the importance and necessity of obtaining informed consent, the consent form was printed in both Arabic and English. This was considered necessary to assist participants in understanding their rights and the implications of participating in the research. Translation to Arabic was chosen because it is the most commonly used language in the Middle East (Kittler and Sucher, 1989). An Arabic EHW did the translation. The Arabic version of The Universal Word Package (Wiziwig Cooperation, 1991) was used to type it up. It was not considered efficient or necessary to translate the demographic questionnaire because of its simplicity and purpose.

Eighty minutes was allocated for the discussion session. Participants were welcomed and thanked for their co-operation at the beginning of each session. The purpose of the study was reiterated to them, along with an explanation of the session outline and rules. They
were reminded that the session was being audiotaped and assured of the confidentiality of this process. Finally they were informed that their assistance may be required again over the proceeding months to provide the recipes they identify as being important; to train the CPU staff in the preparation of those foods, and to taste test the results. The same introduction was used at all group sessions, however each group approached the sessions differently requiring the tailoring of information to suit each situation. Thorough discussion of these issues requires an anthropological analysis, which is beyond the scope of this research project. However they are significant in influencing the implementation of the focus groups for this project. Chapter 4.3.2 eludes to this.

In addition to the audio tape both facilitators took notes through the sessions. When the participants left a debriefing session was undertaken between both facilitators to compare notes and assess the success of the session.

Time was allocated at the end of the session to allow for questions and continued discussion; while enjoying refreshments. It was considered appropriate to provide culturally appropriate refreshments to remain consistent with the project theme and funding was provided by the Area Health Service. I made these refreshments.

Each participant received payment of $10 to cover any costs or inconveniences they may have incurred in attending the group. Funding was provided by SWSAHS to pay 5x12 participants. Cheques for the money were written in the names of the individuals who had signed the consent forms at each group. The respective EHW responsible for each group distributed the cheques among these individuals. On receipt of the cheques each individual also was required to sign a letter of confirmation (Appendix 8). This was then attached to the persons respective consent form and posted back to the Area Health Service.
**4.3.2. FOCUS GROUP IMPLEMENTATION**

The process described above was adopted from Krueger (1988). Krueger's process was too formal for the target audience in this research and required modification in practice. The following changes were made:

* Name tags were not used at the sessions for cultural reasons.

* The EHW considered sending a reminder letter (Appendix 7.1, Attachment 2) as culturally inappropriate. They also noted that language barriers made sending a letter inappropriate. They considered that it would be more appropriate to personally invite participants and reminded them periodically about the session until the day before when a telephone call was made to confirm each participant's attendance.

* Completing the consent form and demographic questionnaire was done as a group activity preceding the session to overcome language barriers. The EHW read and explained each form to their group and assisted individuals where required.

A profile summary of the focus groups in this research is provided in Table 4.1. Assessment of this table indicates that the size of the groups were larger than originally proposed and the recommendations of the literature (Hawe et al, 1990; Krueger, 1988). This is attributed to both cultural norms of the target population and the implementation of the theoretical framework into practice. Following is an account of the actual process undertaken with each group.
TABLE 4.1: SUMMARY PROFILE OF FOCUS GROUPS

<table>
<thead>
<tr>
<th>Group (Cultural Heritage)</th>
<th>Focus Group Session Date/Time</th>
<th>Venue</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilot - men aged ≥ 55 years (Lebanese)</td>
<td>7/7/93 1. 9.30 - 11.30 a.m.</td>
<td>78 Restwell Street, Bankstown</td>
<td>≥ 18</td>
</tr>
<tr>
<td>(i) men aged ≥ 55 years (Lebanese)</td>
<td>21/7/93 3. 9.30 a.m. - 12.00 p.m.</td>
<td>78 Restwell Street, Bankstown</td>
<td>≥ 18</td>
</tr>
<tr>
<td>(ii) women aged ≥ 55 years (Assyrian)</td>
<td>15/7/93 2. 9.30 - 11.30 a.m.</td>
<td>Fairfield Community Health Centre Room 1</td>
<td>6</td>
</tr>
<tr>
<td>(iii) women recently hospitalised for obstetric/gynaecological or other purposes (Lebanese)</td>
<td>28/7/93 4. 9.30 - 12.00 p.m.</td>
<td>The Muslim Aged Society Hall 181, Level 1 Wangee Road, Lakemba</td>
<td>≥ 15</td>
</tr>
<tr>
<td>(iv) men aged 15-24 years (Assyrian)</td>
<td>28/7/93 5. 2.00 - 4.00 p.m.</td>
<td>AMES Fairfield Tutorial Room 14</td>
<td>12</td>
</tr>
</tbody>
</table>

4.3.2.1. The Pilot- Session 1

In recruiting for this group the EHW considered it more appropriate to inform the entire community group of the research and invite 12 interested men to attend the pilot group and 12 to attend the major study two weeks later. The men were periodically reminded of the session at their weekly meeting. The EHW did not consider it appropriate to single out participants among the group and he did not perceive that numbers would be a problem as the session was conducted at the community house that they met in weekly. He conceded that as the men turned up for their weekly meeting they would be invited again.
As a consequence of this recruiting method, all men attending the group the day the research session was scheduled attended the session. The group was conducted with all participants, which posed the following problems:

* It affected access to participants for the major study. It is not recommended to conduct subsequent groups with the same participants, as there is an increased chance of the data being influenced by participants developing preconceived responses (Hawe et al, 1990; Krueger, 1988).

* Paying participants, as the budget only accounted for 5x12 payments.

* Controlling the group was difficult and the audiotape of the session was baffled and difficult to transcribe.

Due to resource constraints potential participants for group 1 of the major study were still recruited from this group. The EHW was asked to personally invite only twelve men to the next session. He was specifically requested to invite men who were absent from the pilot session, or to ask the men in the group to recommend friends who may be interested. If this was not possible I considered that the change in the protocol and the two week time period between sessions would reduce the influence of participant preconceptions on their answers.

Only the twelve participants who signed the consent form were eligible for payment.

In order to avoid this situation recurring, I reconvened with the other EHW to inform them of these results and to reinforce the importance of adhering to the selection criteria.
4.3.2.2. **Group 2- Session 2**

This group was the first to convene after the pilot study. The potential for a similar scenario was evident. Initially the health care worker had over recruited a heterogeneous group perceiving it would provide a broader information base. After recounting the results of the pilot study, he corrected this to invite only women within the selection criteria. Six woman convened for the session, which ran very smoothly.

4.3.2.3. **Group 1- Session 3**

As the group convened for this session there was a repeat of the pilot study scenario. Attempts to exclude extra participants proved culturally inappropriate. The men were offended by this attempt and became withdrawn and uncooperative. It was decided to include all the men already present, and late comers as the atmosphere being created in trying to limit numbers was not conducive for an effective session.

In order to restabilise an appropriate atmosphere we explained that the attempt to exclude participants was to avoid interruptions, and instead we would wait for the remainder of the members before reconvening. In this time refreshments were offered, the men contributed suggestions for improving my cooking and they asked me about my cultural heritage. As members continued to arrive they were welcomed in and the atmosphere became more relaxed. This extended the time for the session. Payment of participants was as per pilot study.

4.3.2.4. **Group 3- Session 4**

Scheduling for this group was challenging due to cultural issues regarding participants family commitments. The initial date coincided with school holidays, the EHW had
difficulty getting women to commit their time for this session, therefore the meeting was rescheduled. Most potential participants were only available between the hours of 10.30 and 12.30 am.

Based on past experiences of poor group attendance rates among these woman the EHW intentionally over recruited for this group by asking potential participants to invite other women. The EHW was aware that the women would bring their children. Child care was not organised both because of resource constraints, and the participants cultural beliefs about leaving their children with strangers or out of their sight. Instead, I provided a range of toys and colouring/drawing activities to occupy the children in a corner of the room while the session was being conducted.

Contrary to the EHW perceptions, many woman and their children turned up. No attempt to exclude them was made after the experience with group 1. The same introduction was used as with the other groups, however these participants were intimidated by the research process. Many continually sought reinforcement and clarification of the purpose of the forms and audiotape, others became withdrawn. I had to work very hard at making the women comfortable and to create an appropriate environment. This extended the time for the session. Consequently, participants began to leave at different times through the session. Some chose to leave before we began. Participants were paid as per pilot study.

4.3.2.5. **Group 4-Session 5**

Recruitment for this group was complicated as no pre-established community or social group comprising members with the required characteristics existed. Further, neither of the EHWs had access to or knowledge of how to access such a group. Extensive research and networking revealed the AMES in Fairfield had a large enrolment of Assyrian men within the target criteria. Permission to access these men was sought and granted (Britain, 1993- pers. comm.).
Once access was attained, other issues complicated recruiting these men (1) Not all were enrolled in the same courses, hence they came in at different times through the week, (2) it was between semesters and hence recruitment could not begin until classes at AMES resumed, (3) it was beyond the Assyrian EHWs responsibility to assist in convening and facilitating this group.

The Assyrian EHW volunteered to assist in co-facilitating but his time frame did not allow him to assist in recruiting. As a consequence of all these challenges, recruiting of participants occurred 30 minutes prior to their scheduled session. Staff at AMES toured each class requesting interested participants to attend the session. More than 12 men responded but only the first 12 were accepted, the remaining were thanked for their support and returned to their classes. It was easier to exclude the extra participants in this situation as they did not have expectations of participating as did those in the pilot study and groups 1 and 3.

The introduction for this group was more detailed as participants had to familiarise themselves with the project. Further, an explanation of the Australian health care system and the current food service system in hospital was necessitated as all participants were new migrants (all had been here less than 18 months) and only one of the men had experience with Australian hospitals.

4.4. PROCEDURE FOR DATA ANALYSIS

Information was collected through a number of sources. The audiotapes of each session provided the primary data base. These were transcribed from both Arabic or Assyrian to English by colleagues referred to me by the respective EHW. South Western Sydney Area Health Service provided the funding for this service. The data from the pilot study were included in the analysis as they were very useful.
Other principle data sources included notes taken both through each session and at those made at the end of session debriefing procedure. Other data sources included the information obtained from the initial interviews with each EHW (Talia, 1993-pers. comm.; Hussein, 1993- pers. comm.; Abdel-Razek, 1993- pers. comm.).

Secondary data sources included personal communication with personal and professional contacts from different Middle Eastern backgrounds, literature on traditional food habits (Anthony et al, 1993; Kittler and Sucher, 1989; Meleis, 1981; Barr-Stein, 1979; Grivetty, 1975) and on cultural beliefs during times of illness (Meleis, 1981). This data was primarily used to compare reports and check my interpretation. Literature on food preferences of Australian hospitalised inpatients (Arney and Tiddy, 1992 a; Williams, 1988) also were used as a comparative basis to support the findings.

A combination of analysis strategies were undertaken in analysing the data and writing the report. The four steps of data analysis as described by Krueger (1988, p.114-116) provided the principle basis for analysis. Briefly these are:

(i) The researcher reads all the summaries at one sitting and makes notes of the potential trends and patterns.

(ii) the researcher reads all transcripts many times. Firstly marking out sections that relate specifically to the protocol questions to make comparisons across groups easier. Secondly highlighting participants comments which may be considered useful in preparing the text of the report.

(iii) The researcher listens to the tapes or reads the transcripts concentrating on one issue or question at a time. Attention is focused on identifying the themes or pattern across the
groups and those that relate to respondents with similar characteristics. Five factors are considered when conducting this stage of the analysis:

(a) The words
(b) The context
(c) The internal consistency
(d) The specificity of responses
(e) Find the big ideas

(iv) Consider the purpose of the report. The type and scope of the report will influence the final analysis process.

Latent content analysis also was used to infer meaning from the data (Wilson, 1987, cited in Bowler, 1992).

This process was undertaken many times in compiling this report to make it manageable both within the agenda and time frame of this research.

* Firstly, I transcribed all the tapes, and incorporated the field notes, to compiled summaries for each group. This was necessary as the session transcripts were not done word for word.

* Secondly, the above mentioned process was followed through to identify common themes in the data from which summaries of the above information were compiled accordingly for each group.

* Thirdly, the common themes across all groups were identified and the above information was amalgamated into one summary for all groups.

* From this I developed my own codes and themes to reduce the data into those presented in this report. Consulting the literature (Bowler, 1992; Krueger, 1988; Minichiello et al, 1990) and academics (Tapsell, 1993- pers. comm.; Yeatman, 1993- pers. comm.) assisted this process.
Three common themes were evident underlying the discussions with all groups. These relate to:

- Notions of health and illness;
- Food preference during illness;
- Acceptability of the current food service system, and suggested changes.

4.5. **PRESENTATION OF DATA**

Chapter 5 presents the results and discussion of the research under these thematic headings, each heading is further divided into subheadings.

The implications of these results and discussions are presented for each section. The data presented in this way serve to provide a context for recommendations to SWSAHS in developing their Middle Eastern menus (Chapter 6). It also follows a logical sequence and presents a compelling account of the process. Briefly each section includes:

### 5.1 Notions of Health and Illness

Classifications of illness, foods, and perceived food needs and, the perceived role of the health professional and health care system in effecting the healing process are presented in this section. Implications for health and health system education and equitable health care are presented.

### 5.2 Food Preferences during Illness

This section presents a tabulated summary of the reported food preferences by each group for each meal.. The most distinguishing characteristics of the cuisine are grouped together and an interpretive account of the significance of these foods is presented. These discussions convey what comprises the cuisine of these cultural groups. Implication and recommendations for adoption of these foods onto the Middle Eastern menu is provided, including a discussion of the feasibility of these recommendations.
A discussion regarding common foods across all Middle Eastern cultures also is presented. Implications for the development of the Middle Eastern Menus are presented throughout the entire discussion. An additional discussion regarding menu design is provided.

5.3 **Acceptability of the current Food Service System and Suggested Changes**

Participants perceptions of the appropriateness of the current food service is presented. Their perceptions and my interpretations of what would comprise a more appropriate service are presented, together with the implications for the feasibility of implementing the suggestions.

A comparative analysis of the documented food preferences of Australian inpatients (Williams, 1988) with those reported by participants in this research and documentation of traditional Middle Eastern eating habits (Anthony et al, 1993; Kittler and Sucher, 1989; Barr-Stein, 1979; Grivetty, 1975) is presented to support the findings.

### 4.6. PREPARING THE TEXT

Similar questions were used at all sessions, the interpersonal dynamics within each group varied according to the participants responses, with issues of culture, communication and language dominating the discussions.

Underlying cultural themes strongly effected communication style and consequently the tone, interpretation, expression, and mood of responses. It was very difficult to translate the depth and the sensitivity of the comments and the colour of the expression unique to each discussion. Krueger (1988) identifies that this is an inherent limitation of reporting qualitative data.
In order to overcome this limitation the writing style and structure adopted throughout the report diverges from that usually adopted in academic writing. The text was developed adopting the following three strategies.

(1) A descriptive and interpretive account of the data is presented. Both relevant literature and excerpts of participants comments from the sessions have been incorporated throughout the body of the chapter to explicate and support the points being made. The quotes have principally been extracted from my transcripts and notes.

Due to the language barriers and the lack of culturally equivalent terms for many words I have modified some of the quotes. This enables the intent of the speakers to be expressed more concisely. Krueger (1988) asserts that such editing is necessary as people do not speak in crisp statements that result in insightful quotations. He states that it becomes the researchers obligation to make modifications to grammar and expression to capture the intent of the speakers words and present them accurately and fairly as long as the meaning of the words are not changed.

There may appear inconsistencies in my reference to the target group, this is because each authors refers to people from Middle Eastern backgrounds in a variety of ways. I use the term of reference for each author in citing their data, and the above definition in my own references to the target group. Similarly, in reference to the Muslim religion I use this spelling, some authors use the spelling Moslem.

The cultural names for foods and expressions are used throughout the body of this report. A brief explanation of these are offered in the text. Appendix 10 presents a GLOSSARY of food detailing these terms, for easy reference and clarification. The terms typed in capitals in the text indicate those presented in the GLOSSARY of foods. The recipes for these foods are not provided in this report. Appendix 11 presents a GLOSSARY OF TERMS defining the acronyms used throughout the text.
(2) I have adopted the use of the first person in sections where I have expressed my own feelings, opinions, or interpretations of specific occurrences throughout the research process. In this way the significance of both my role as the medium through which the research was conducted and the integral role this had on in determining the validity of the results more clearly be reflected.

This style of writing has been commonly used in qualitative research (Webb, 1992; Swanson-Kauffman, 1986; cited in Bowler, 1992; McCallum, 1990), as it does not dismiss the social nature of the research process.

(3) The structure of the report diverges from that of traditional academic writing. The detail, and the social nature of the study prescribed organising the report to include a background chapter, a descriptive account of the methodology experienced, and amalgamation of the results and discussion into one chapter. I also have used relevant literature throughout the body of the report to explicate and support the points being made. Other authors have adopted this style of presentation in reporting focus group data (Bowler, 1992; McCallum, 1990).
5.1. NOTIONS OF HEALTH AND ILLNESS

5.1.1. Classifications of Illness

Two classifications of sickness (or conditions) were expressed as influencing the food preferences and needs during times of hospitalisation. These pertained to

(1) those which affected the stomach or,

(2) "other" not affecting the stomach.

Illnesses which affected the stomach were considered the most serious primarily because these illnesses effect ones saha (well-being) and consequently ones nafis (appetite). Generally these illnesses include: the loss of blood, a major surgical procedure, problems with digestion, and having a fever. Lipson and Meleis (1983) and Meleis (1981) support these notions, noting that people from Middle Eastern backgrounds believe that a lack of appetite is often considered a health problem in itself, indicating that life is not what it should be.

The use of the term 'other' illnesses referred to those which did not effect ones saha or nafis; or did not result in the loss of blood. Examples, which all groups provided, included broken limbs and minor operations such as eye surgery. Generally, an individual with 'other' ailments is not considered sick. Pregnancy and lactation also are included in this category for the same reason.
Lipson and Meleis (1983) and Meleis (1981) assert that presentation of such vague and global accounts of illness is a cultural trait among people from Middle Eastern backgrounds. They state that this is because the people believe that the body and mind are one and that disease and/or trauma effect the whole body. Hence illness is thought to arise when there is an upset in the body’s balance. Such upsets may arise from food deprivation; hot/cold shifts in dampness; or in some instances through folk notions of the evil-eye. Emotional upsets or perceived carelessness also can cause illness (Lipson and Meleis, 1983). Similar notions were expressed by my participants. In both groups women were more candid in their expression than the men in any of the groups.

Other explanations for the vague descriptions and the difficulty in obtaining information relates to language barriers, lack of health education both in country of origin and in Australia. There also is a lack of culturally equivalent terms for many of these expressions.

Meleis (1981) supports this as she identifies:

A vague description of illness is partly due to a lack of frame work which permits careful description of signs and symptoms and association of them with different parts of the body (p. 1182)

5.1.2. **FOOD NEEDS**

Beliefs about what foods are required for times of illness were unanimous across all groups and can be summarised by statements such as:

"It depends on one,s illness" (PILOT-7/7/93, GROUPS 1-21/7/93, 2-15/7/93, 3-28/7/93, 4-28/7/93 )
It was unanimous that the most significant aspect affecting the healing process is to provide the individual with what their "appetite requests". Requirements were obviously influenced by individual preference. Preferences were reported to be dictated by such factors as:

- the extent of their illness;
- their environment,
- their mood, and
- their personal life circumstances.

The following excerpts emphasises this:

"I was in a ward with very sick people and I just could not eat their food" (GROUP 3- 28/7/93).

"You must maintain your well being by eating in accordance with your appetite" (GROUP 1- 21/7/93)

"When you are sick the most important thing you need is to eat something that you really want, then you will get better once you have satisfied this" (GROUP 2- 15/7/93, 3- 28/7/93)

"My mum just wanted DOLMA. When I bought it for her and she ate it the next day she was much better" (GROUP 2- 15/7/93)

"When we sick we must have a suitable food to match our health" (PILOT- 7/7/93)

Such sentiments are cited in the literature as being consistent with those of many hospitalised patients and provides insight into the difficulties associated with feeding inpatients (Arney and Tiddy, 1992 a,b; Rosich and Garey, 1990; Williams, 1988; Inguanzo and Harju, 1985; Maller et al, 1980).

No specific foods were identified initially because the participants believed completely that food requirements during illness depend on ones condition:

"Each persons lifestyle and condition is different Each person will accept food as they can tolerate it to meet their individual needs" (PILOT- 7/7/93).
"Some people when they are admitted to hospital do not always think about that is good for them, they want what they feel like” (GROUP 4- 28/7/93)

“When one is sick they may not feel like eating a specific meal. They may just feel like snacking on cheese or LABNEY and bread, things like this throughout the day depending on what his appetite desires “(GROUP 3- 28/7/93).

“A sick person eats just to keep them going. By eating what their appetite requests they can regain their strength so that they can eat what they want again “ (PILOT- 7/7/93)

Eventually participants reported classifications of foods in accordance with the classification of illness.

5.1.3. CLASSIFICATION OF FOOD

On the whole participants used two sets of classification systems to describe the food preference and perceived needs:

(i) heavy or light

(ii) their food/our food

Heavy foods are synonymously defined as those high in fat and oil. Spicy food and food made with a tomato base also were considered heavy. Crossiferous vegetable such as, cucumbers cabbage and cauliflower, and legumes were identified as heavy as they distress the digestive system by producing wind. Both women's groups identified citrus foods as heavy for lactating woman as these are perceived to give the baby diarrhoea.

Light foods on the other hand were simply defined as those foods which are not greasy or heavy. Liquid foods such as thin soups and stews also were considered light. Other definitions of light food include dry meals such as grilled meats; fresh foods such as fruit and vegetable with the exception of those mentioned above. Small serving sizes were defined as light on the stomach.
It was universally expressed that light foods are required in times of stomach related illness to avoid distressing the body’s’ digestive balance and to aid in recovery. This was extremely important for sick infants and children. It was believed that their digestive system is more sensitive than adults thus requiring total abstinence from heavy foods.

"The stomach is the house of all illnesses therefore protection is imperative" (GROUP 1- 21/7/93)

Participants in all groups identified that 'protection' is provided by consuming “liquids”. Additionally the majority conceded that all foods should be hot regardless of illness or age. The Lebanese men in the pilot study and group 1 were most inflexible about this 'Never cold food, never'. While the young Assyrian men agreed, they were less adamant and related that they preferred fresher foods considering them lighter and more appropriate. Participants reported that cultural foods are still preferred, however they are modified to be lighter so that they are tolerated better.

Ultimately, whatever the sick person requests is made.

"At home we must make whatever they request this helps them get better “ (GROUP 2- 15/7/93)

People with 'other' illnesses are not considered sick hence their appetite is not effected. The food related needs for these individuals pertain to regaining their strength. The women in both groups noted this belief especially for lactating woman. Heavy foods are indicated for this reason. With the exception of crossiferous vegetables, legumes and citrus foods for lactating woman, individuals with other illnesses have no diet restrictions. In all groups discussions became animated talking about this topic as they reported favourite cultural foods and feeding practices:

"She must eat plenty to get strong again. She can eat any thing she is not sick” (GROUPS 2- 15/7/93, 3- 28/7/93)
"One who has this kind of illness can eat anything. Nothing is bad for them" (PILOT- 7/7/93, GROUP 1- 21/7/93, GROUP 4- 28/7/93)

The terminology, although universally used, did cause some confusion occasionally. The following case study between two Lebanese woman in group 3 (28/7/93) exemplifies this:

*Participant 1:* “Yes a lactating woman must avoid heavy food”.

*Participant 2:* “No she must not. She must eat plenty to get strong. Heavy food, especially olive oil helps to make good milk and makes sure that the baby is healthy.”

*Participant 1:* “Yes that is true, but she must avoid food which produces wind for the baby. These foods are heavy too.”

*General consensus.*

5.1.4. THEIR FOOD / OUR FOOD

The classifications of heavy and light were extended regarding the food preferences in hospital. In this context participants made the distinction between our food and their food. Specifically, our food referred to Middle Eastern cuisine and their food referred to hospital food.

All groups referred to our food as heavy. Many reasons were provided for this. Firstly the bases of the majority of Middle Eastern cuisine comprises those ingredients associated with heavy food. More foods are served, eaten and consumed at each meal. Finally, a lot of time effort and love is put into making the meals elaborate.
Hospital foods are referred to as light by participants in all groups because it is bland, not greasy, serving sizes are small, and that only one meal is eaten at a time unlike our food where many foods are eaten at the one meal and a lot more food is eaten.

In reporting this information participants expressed many conflicting ideas and misconceptions. They reported that Middle Eastern food was not appropriate for hospitalised patients as it was too heavy. This contrasts with previous statements that Middle Eastern foods are healthy and strengthening particularly in times of other illnesses; and that cultural foods are used at home when one is sick however they are made lighter to be better tolerated.

Lebanese woman in Group 3 expressed consistent beliefs when referring to hospitalisation for any reason other than to give birth. However childbirth and lactation are considered a significant time to maintain cultural beliefs. Hence they reported that Middle Eastern cuisine is appropriate in this situation. Duke (1988) supports this belief for all migrant woman.

There was a strong misconception that hospital food was in some way superior to Middle Eastern cuisine. They considered that because the food is available in hospital it is part of their treatment.

"They know what best to feed us and so they do" (PILOT- 7/7/93)

"It is very difficult to provide our food in hospital because it is very heavy. They know what we need and they bring it for us. It must be good" (GROUP 1- 21/7/93)

This caused obvious conflict for many people as it was incongruent with their cultural beliefs regarding food needs in illness (chapter 5.1.2). For example many participants reported asking family and friends to bring in foods that their “appetite requested” so that they could feel better. However they reported not eating it out of fear that it was not good for them.
The following excerpts provide further examples of this conflict.

"My family bought me the food that I wanted but I was scared to eat it" (GROUP 3- 28/7/93)

"I did not eat it [food bought from home] as I feared it may be harmful "(GROUP 2- 15/7/93)

Hospital food should be an endorsement of appropriate eating habits (Kokkinakos, 1993 - pers. comm.; Williams and Brand, 1989). In this sense the participants perceptions about the food in hospital being appropriate for illness is justified. However the perception that hospital food is healthier or nutritionally superior to Middle Eastern cuisine is incorrect.

In a review of patients menus in NSW Hospitals Williams and Brand (1989) found that on average 13.3 per cent of main hot menu choices are high in salt, and 18.8 per cent are high in fat. Both these values are greater than three per cent of the standards recommended for hospital menu items (Williams and Brand, 1989; Williams, 1990). Three quarters of the menus did not have low fat milk options. One third of hospitals did not offer polyunsaturated margarine, and only 14 per cent report using polyunsaturated frying oils, despite recommendations for their use in food service operation (Williams and Brand, 1989; and Williams, 1990). More recently the use of mono-unsaturated oils has also been recommended (Williams, 1990). These recommendations are upheld in light of the suggested protective factors of these oils.

Another indicator that the hospital food is not nutritionally superior is the use of the Australian Dietary Guidelines to plan menus. These are designed for healthy individuals and are not nutritionally adequate in meeting the needs of all hospitalised clients, for example; oncology, malnourished, obstetric or post operative patients.

It has been noted that many patients are put at nutritional risk because they do not receive enough food in hospital (Williams and Brand, 1988). Coote and Williams (1993)
identify that current trends of hospitals adopting continental style breakfasts, which reflect the Australian Dietary Guidelines increase this risk, particularly for obstetric and oncology patients.

Regarding the participants perception of the superior health benefits of hospital food over Middle Eastern cuisine, the conflict created within individuals by eating food which is inconsistent with their cultural beliefs is unhealthy. The participants identified this themselves. Lipson and Meleis (1983) and Meleis (1981) clarify that people from Middle Eastern Backgrounds perceive that emotional upsets cause illness.

Health and nutritional well being are influenced by many more factors than the provision of the Recommended Dietary Intakes (RDI). For people from NES backgrounds cultural biases in experiences and definitions of health intensify this (HSDU, SWSAHS, 1991). Therefore while improvements in the nutritional standards of hospital menus have been cited in institutions which employ dietitians (Williams and Brand, 1989), and hospital accreditation standards stipulating the use of a dietitian in developing menus (Williams, 1990), it does not ensure the nutritional health of these clients. This indicated the need to correct the misconception regarding the superiority of hospital food and to encourage healthy eating habits which are culturally appropriate.

There is a paucity of information regarding the nutritional quality of the Middle Eastern diet however, traditional eating habits (as identified in Chapter 3.4.3, chapter 3.4.4) resemble current nutrition recommendations. That is, vegetables, grain, cereals, fruit and legumes comprise the basis of the diet. Hadj (1988) identifies that the dietary composition of the Lebanese in Australia resembles that of the Australian population. She also found that participants perceptions of the diet changes on migration from traditional eating habits, related well with the differences. My participants recognised that their food was rich in fat, which they also identified as inappropriate for health.
The fact that they noted that fat requires reduction indicates that the potential for effective education exists if appropriate strategies are undertaken.

5.1.5. THE DOCTOR KNOWS BEST

This was another dominating theme reported by participants in this research regarding their notions of illness. They relinquished total control of themselves to the 'doctor', expressing that the 'doctor' had power and knowledge which effected their health outcomes. The following excerpts show this:

"The most important thing is to listen to what the doctor prescribes" (GROUP 4- 28/7/93)

"If these [Assyrian] food were on the menu in hospital I would order them but I am scared to eat home made food as it may not be prescribed by the doctor" (GROUP 2- 15/7/93)

Kittler and Sucher (1989) and Meleis (1981) assert that Arab American clients believe that decisions about health care need to be made by a person who has experience, expertise and knowledge. In the context of the hospital this means the doctor. This offers a possible expatiation for the misconception that the food available in hospital is part of their treatment and hence superior to their cultural cuisine. Participants in this research made statements supporting this view.

This belief appeared almost unconditional, with some participants reporting to have undertaken practices inconsistent with their cultural beliefs about eating what your appetite requests in order to heal (chapter 5.1.2). Participants appeared reluctant to overtly express the conflict and the distress this caused them, however it was obvious in their tone and expression. One participant openly expressed it:

"If the doctor told me I should not have fruit and I feel like having one now this will effect me psychologically. I am not enjoying it and this will delay my stay in hospital longer" (GROUP 4- 28/7/93)
Moussa (1991) states that such conflict is common in Arab Australians because they feel strong ties towards both their home country and Australia. This divided loyalty creates conflict within individuals as they feel pressured to make choices between the two. This was evident in my data and underlines the need this group has for education regarding the health care system and their rights within it. The data are consistent with the reports of the literature regarding Middle Eastern clients in the health care system (Moussa, 1991; McCallum, 1990; Kittler and Sucher, 1989; Lipson and Meleis, 1983; Meleis 1981; chapter 3.4.1).

Interestingly as we progressed through the discussions, a notable shift in the consistency of these reports was evident. Participants increasingly indicated preferences for culturally specific foods. This phenomena occurred after I gave them permission to admit that they had different preferences and that I wanted to know that information. It was a slow process initially but my cultural affiliation with the participants was significant in assisting this. Once one participant opened up, others followed, indicating the strength and appropriateness of the focus group technique as the research tool:

"For example at home we serve BOUSHALA as a main meal we usually make it chunky and heavy. You can no serve this in hospital it is too heavy, but it can be made lighter, like a soup, to make it more appropriate. We do this at home sometimes. This way it can be served as a light meal with bread or a sandwich, or as an accompaniment to a larger meal. This will make many sick people happy"

(GROUP 2- 15/7/93)

"I agree that some of our food is too heavy but some is light and others we can modify to be lighter" (PILOT- 7/7/93)

"Even if it is heavy, if it was on the menu then I would order it" (GROUP 3- 28/7/93)
5.1.6. IMPLICATIONS FOR FOOD SERVICE REVIEW

The need for nutrition education was identified in this research. Other data also indicate this as a priority health promotion strategy for Middle Eastern community in Australia (Donovan et al. 1992; Moussa, 1991).

My data indicate that the participants have a great deal of misconception both about their own food and those in hospital. Rae (1992) identifies that dietitians need to use the principles defined by NFNP to clarify such misinformation to improve the knowledge and skills required by Australians to choose a healthy diet.

Samolsky et al (1990, p. 1707) identifies that;

As service orientated professionals in a Multicultural society, dietitians must be aware of cultural influences on food consumption patterns, population demographics and health care usage by ethnic groups,....(so they can) help hospital patients modify their diet in a way that is both healthful and culturally appropriate.

Lipson and Meleis (1983) and Meleis (1981) identify that suggested or prescribed health regimes (citing an example of dietary advice) which are too inconsistent with cultural beliefs and practices results in only apparent "compliance" by people from people from Middle Eastern backgrounds. Advice given at consultations is agreed to as a face saving strategy, that is, to hide the sense of powerlessness in making such changes and to maintain respect for authority and expertise of the doctor. Similar beliefs were expressed by the participants in this research and indicating the importance of Samolsky et al (1990) advice for this group.

In order for skills and knowledge to be gained regarding choosing a healthy diet (Rae, 1992), example of appropriate eating habits and awareness of cultural influences on food are required. This suggests that current food service and diet education strategies undertaken in Australian hospitals are inappropriate for this population sub-group, exposing them to an inequitable level of health care. Many reasons indicate this.
Firstly, the results of this research shows that people from Middle Eastern background classify food differently from Anglo-Celts, which is consistent with Webb and Mandersons (1990) assertions that food classification is influenced by cultural understanding of food and health. The latter group specify guidelines and food groupings according to scientific notions of the macro- and micro- nutrient composition of foods. My data show that such notions are culturally unsuited for people from Middle Eastern backgrounds. They use a more vague, and holistic classification system. Moussa (1991) agrees and cites that Australians from Arabic speaking backgrounds are disadvantaged in achieving equitable health and diet education because cultural factors render the education messages inappropriate. Language barriers and lack of familiarity with the food (Chapter 5.3) add to this inappropriateness and disadvantage.

Secondly even culturally suitable education strategies will not be effective without the provision of culturally appropriate foods. As long as the hospital continues to fail to meet the food related needs of this community they are reinforcing their misconception regarding “their food/our food”. This will render any attempt at correcting these misconceptions as invalid due to the overwhelming power and influence these participants place in the doctor and hospital, as there is no example of or association between what is practiced at home and what is practiced in hospital. Placing them in unnecessarily agonising situations of having to choose between the two, and reinforcing the perception that food in hospital is part of their treatment.

Thirdly, it is consistently documented that some cultural familiarity and some bilingual skills would obviously enhance the potential effectiveness of work with groups from NES backgrounds (Webb and Manderson, 1990; Lipson and Meleis, 1983; Meleis, 1981). Yet, it appears that health professionals trained in Australia lack the skills and knowledge to deal with migrant groups in a culturally appropriate way, as training schools have yet to catch up with Multiculturalism (Donovan et al, 1992; Moussa, 1991).
Such knowledge is specifically lacking among dietitians and nutrition gatekeepers in NSW. Webb and Manderson (1990) cite that, in a survey of member dietitians at the NSW branch of the Dietitians Association of Australia, many noted that communication barriers and lack of Multicultural knowledge were the most significant problems in working with Multicultural groups.

Additionally migrants, specifically people from Middle Eastern backgrounds, are underrepresented in Australian Medical schools. The field of nutrition and dietetics is especially under represented (Dollis, 1993).

The lack of ethno-specific data and research means that health professionals cannot even resort to the literature for guidance to develop culturally sensitive methods of care. Moussa (1991) cites that the uniqueness of the Middle Eastern culture indicates that in order for health professionals to practice good medicine they can only bridge the knowledge gap by relying on research to extract valid data.

The need for education regarding the communities health care rights has also been identified in this research Moussa (1991) and McCallum (1990) support this result. Written information on admission will not suffice alone, even if it is translated. Resource barriers may preclude the translation to cover all minority groups, languages and literacy barriers may impede the participants ability to read either version, particularly among this community. McCallum (1990) identifies that Arabic speaking women found is particularly difficult to ask for help or seek any government assistance due to cultural and language barriers.

This discussion has shown that the development of an efficient and effective culturally sensitive service requires more than the provision of "Middle Eastern" food. Information and education is indicated at many levels. Health professionals need to understand how Middle Easterners experience and define health and illness so that they can deliver their services in a culturally sensitive way. Staff members at all levels involved with patients
need to be informed about the food service and have some idea of the foods on the menu and the way the service operates in order to offer assistance, and foster an environment that informs patients from this cultural group about the service and empowers them to ask questions, and to respond to any patient queries. Moussa (1991) suggests that one strategy to increase the health status of Arab Australians is to increase the general community's awareness of the Arabic culture.

Education of the community regarding both nutrition and the health care system was also identified. These are priority areas of concern identified by SWSAHS in their review of health services (HSDU, SWSAHS, 1993; HSDU, SWSAHS, 1992). This research indicates that group strategies, and the use of community leaders and health professionals with a cultural understanding and affiliation with participants, are successful strategies in transmitting information to this group. Moussa (1991), Lipson and Meleis (1983) and Meleis (1981) confirm this for people from Middle Eastern backgrounds. McCallum (1990) and Webb and Manderson (1990) confirm it for other migrant groups.

Arabic speaking doctors in Sydney recommend group discussions as one strategy for providing this group with their health education needs. They also identified the effectiveness of other media such as the radio, newspapers and group discussions and videos in delivering these messages. Pamphlets are considered the most inappropriate mode of information dissemination and education (Moussa, 1991).

The doctor is considered to have the primary responsibility of delivering health messages to individuals from this target group in the context of the doctor-patient consolation however, they also identify an extensive list of health and other professionals who may be involved in the community's educational programs.

These measures require both structural and organisational change. It is beyond the scope of this research to address these issues. The challenge is to implement the goals and objectives defined by existing policies developed to address these issues (HSDU,
5.2 FOOD PREFERENCES DURING ILLNESS

5.2.1 Summary of Foods - Tables

TABLES 5.2.1.1-5.2.1.4 (overleaf) summarise the hospital food preferences and perceived needs identified by participants from each sub-group.

The proceeding discussion (chapter 5.2.2.2) groups together the most significant characteristic aspects of the cuisine identified by the participants, and the dominate themes underlying their significance. It serves to put the foods into context of what composes Middle Eastern cuisine, and discusses the recommendations and feasibility of adopting these foods on the Middle Eastern Menus in SWSAHS. Webb and Manderson (1990) assert that such information is essential in developing and implementing health care and preventative approaches for different cultural groups.
**TABLE 5.2.1.1: REPORTED FOOD PREFERENCE FOR MIDDLE EASTERN MENUS IN SWSAHS HOSPITALS BY LEBANESE MEN AGED > 55 YEARS (PILOT STUDY AND GROUP 1)**

<table>
<thead>
<tr>
<th>Breakfast</th>
<th>Soups 1</th>
<th>Light Meals 2</th>
<th>Heavy Meals 3</th>
<th>Desserts</th>
<th>Mid Meals</th>
<th>Beverages</th>
<th>Miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lebanese bread</td>
<td>• RICE SOUP with chicken or meat</td>
<td>• KAFTA Mishweey *</td>
<td>• LOOBI</td>
<td>• CREAMY RICE</td>
<td>• Fresh fruit</td>
<td>• Tea</td>
<td>• LABEN</td>
</tr>
<tr>
<td>Toast</td>
<td></td>
<td></td>
<td>• BAMI</td>
<td>• CUSTARD</td>
<td>• Sandwiches</td>
<td>• Milk</td>
<td>• RICE</td>
</tr>
<tr>
<td>Spread</td>
<td>• LABNEY</td>
<td></td>
<td>• KAFTA</td>
<td>• Jelly</td>
<td>Lebanese bread</td>
<td>• Orange</td>
<td>• Olives</td>
</tr>
<tr>
<td></td>
<td>• jam</td>
<td></td>
<td>• b'sianeeeyh</td>
<td>• Ice cream</td>
<td>fillings 4</td>
<td>• Lemon</td>
<td>• Salad</td>
</tr>
<tr>
<td></td>
<td>• honey</td>
<td></td>
<td>• SPANEECH</td>
<td>• Preserved fruit</td>
<td>- LABNEY</td>
<td>• Coffee</td>
<td>• Bread 5</td>
</tr>
<tr>
<td></td>
<td>• butter</td>
<td></td>
<td>• Chicken or lamb curry</td>
<td>with Lebanese bread</td>
<td>- cheese</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• peanut butter</td>
<td></td>
<td>• Chicken</td>
<td></td>
<td>- egg</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Cheese</td>
<td></td>
<td>(grilled/baked)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Sandwich &amp; soup</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Olives</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Egg Dish</td>
<td>• toast</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• boiled</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• poached</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• fried</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**KEY**

- Items in capital letters are presented in the GLOSSARY (Appendix 10).
- Soups can be served as entrees to main meals or as light meal when eaten with sandwiches or bread.
- Appropriate accompaniments to meat dishes include salad and RICE or boiled/mashed potato and boiled carrots and peas. LABNEYA is an optional accompaniment.
  * Halal meat is most preferred for religious purposes. Mutton and lamb are the most suitable alternatives. Pork meats are prohibited.
** Fish is never served with any dairy products.
  + LABNEYA can be served as a light meal in itself when served with bread. Alternatively it may be served as an accompaniment to other main meals. It may also comprise a main meal when stewed with meat.
- These dishes are always served with RICE, yoghurt is an optional accompaniment. Alternatively LABNEYA may accompany these stews.
- Or served as continental snack as breakfast is.
- Bread is served as an accompaniment to every meal. Lebanese bread is most acceptable. Bread rolls and sliced bread are acceptable alternatives.
### TABLE 5.2.1.2: REPORTED FOOD PREFERENCE FOR MIDDLE EASTERN MENUS IN SWSAHS HOSPITALS BY ASSYRIAN WOMEN AGED > 55 YEARS (GROUP 2)

<table>
<thead>
<tr>
<th>Breakfast</th>
<th>Soups</th>
<th>Light Meals</th>
<th>Heavy Meals</th>
<th>Mid Meals</th>
<th>Desserts</th>
<th>Beverages</th>
<th>Miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Toast</td>
<td>Wednesday/Friday</td>
<td>Wednesday/Friday</td>
<td>- BAMI *</td>
<td>- Biscuits (am)</td>
<td>- CREAMY RICE</td>
<td>- DAWEE</td>
<td>- Bread</td>
</tr>
<tr>
<td>- Rolls</td>
<td>- BOUSHALA #</td>
<td>- Fish ++</td>
<td>- Fresh fruit</td>
<td>- Ice cream</td>
<td>- Water</td>
<td>- Olives (less significant)</td>
<td></td>
</tr>
<tr>
<td>- Spreads: jam (+ cream)</td>
<td>- Vegetable</td>
<td>- Red rice</td>
<td>- Jelly</td>
<td>- Tea</td>
<td>- Tea</td>
<td>- Salad</td>
<td></td>
</tr>
<tr>
<td>- honey</td>
<td>- Lentil</td>
<td>- GERHDO</td>
<td>- Coffee</td>
<td>- Coffee</td>
<td>- Coffee</td>
<td>- RICE</td>
<td></td>
</tr>
<tr>
<td>- peanut</td>
<td>Other days</td>
<td>Other days</td>
<td>- Chicken curry *</td>
<td>- Fresh fruit</td>
<td>- Fresh fruit</td>
<td>- Fresh fruit juices</td>
<td></td>
</tr>
<tr>
<td>- butter</td>
<td>RICE SOUP with meat bones or chicken</td>
<td>RICE SOUP with meat bones or chicken</td>
<td>- CHICKEN &amp; RICE</td>
<td>- Sandwiches</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Cheese</td>
<td>Wednesday/Friday</td>
<td>Wednesday/Friday</td>
<td>- DOLMA ##</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Ricotta cheese</td>
<td>- BOUSHALA</td>
<td>- Fish ++</td>
<td>- BORSH *</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Kraft</td>
<td>- Vegetable</td>
<td>- Red rice</td>
<td>- Spaghetti Bolognaise **</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Cereal</td>
<td>- Lentil</td>
<td>- GERHDO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Egg dishes</td>
<td>Other days</td>
<td>Other days</td>
<td>- Chicken curry *</td>
<td>- Sandwiches</td>
<td>- CREAMY RICE</td>
<td>- DAWEE</td>
<td>- Bread</td>
</tr>
<tr>
<td>- - omelette</td>
<td></td>
<td>RICE</td>
<td>- Fresh fruit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- - fried with tomato</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- - boiled</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- RICE SOUP with meat bones or chicken</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**KEY**

Items in capitals are found in the GLOSSARY (Appendix 10).
Foods classified under Wednesday and Friday may be eaten on other days too but are specified for these days for religious purposes.

1. Soups can be served with bread or sandwiches to comprise a light meal, or may be served as an entree to main meals.
   # BOUSHALA is never served with a fish meal.
2. + Acceptable accompaniments to meat dishes include salad and RICE or potato (potatoes are preferred boiled or chunky mashed) and lightly boiled or steamed carrots and peas.
   ++ Fish is never served with any dairy products.
3. * All served with RICE.
   ** Pasta and sauce made and served mixed together not separate.
   ### Noted as a preference but not recommended as a menu item because of difficulty in making and reports by other participants that it is too heavy for illness.
4. Bread is served with every meal. Lebanese bread or bread rolls are most preferred.
TABLE 5.2.1.3: REPORTED FOOD PREFERENCES FOR MIDDLE EASTERN MENUS IN SWSAHS HOSPITALS BY LEBANESE WOMEN WHO HAVE BEEN HOSPITALISED FOR OBSTETRIC PURPOSES WITHIN THE PAST FOUR YEARS (GROUP 3)

<table>
<thead>
<tr>
<th>Breakfast</th>
<th>Soups ¹</th>
<th>Light Meals ²</th>
<th>Heavy Meals ³</th>
<th>Desserts</th>
<th>Mid Meals</th>
<th>Beverages</th>
<th>Miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lebanese bread</td>
<td>• CHICKEN Soup *</td>
<td>• Grilled steak +</td>
<td>• LOOBI</td>
<td>• Blanched ⁴</td>
<td>• YINSOON</td>
<td>• Fried liver ⁵</td>
<td>• Fried liver ⁵</td>
</tr>
<tr>
<td>• LABNEY</td>
<td>• RICE soup with chicken or meat</td>
<td>• KIBI +</td>
<td>• SPANEECH</td>
<td>• Blanched ⁴</td>
<td>• MUGLE</td>
<td>• Fried kidney ⁵</td>
<td>• Rice</td>
</tr>
<tr>
<td>• Cheese</td>
<td>• Vegetable soup</td>
<td>• KAFTA</td>
<td>• KAFTA b'sianeeeyh</td>
<td>• CUSTARD</td>
<td>• Milk</td>
<td>• Olive/vegetable oil ⁶</td>
<td>• Olive/vegetable oil ⁶</td>
</tr>
<tr>
<td>• LABEN</td>
<td></td>
<td>• Grilled fish **</td>
<td>• CREAMY RICE</td>
<td>• Fresh fruit</td>
<td>• Tea</td>
<td>Laben</td>
<td>Laben</td>
</tr>
<tr>
<td>• Toast</td>
<td></td>
<td>• Boiled CHICKEN AND RICE</td>
<td>• Fresh fruit</td>
<td>• Water</td>
<td>• Water</td>
<td>Salad</td>
<td>Salad</td>
</tr>
<tr>
<td>Egg Dishes:</td>
<td></td>
<td>• LABNEYA</td>
<td>• Sandwhiches or bread</td>
<td>• Orange juice</td>
<td>• Orange juice</td>
<td>• Fresh fruit juices</td>
<td></td>
</tr>
<tr>
<td>• Fried</td>
<td></td>
<td>• Soup and sandwiches or bread</td>
<td>• Continental snack (resembles breakfast - Lebanese bread, labney, olives, cheese, tomato)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Boiled</td>
<td></td>
<td>• Grilled chicken +</td>
<td>• Fresh fruit juices</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spreads:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• honey jam</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

KEY
Items in capital letters are presented in the GLOSSARY (Appendix 10).

1. Soup may be served with bread or sandwiches to comprise a light meal, alternatively it may be served as an entree to other meals.
   * CHICKEN SOUP is essential to serve for 9 days post partum to assist in lactation.
2. Acceptable accompaniments to meat dishes include salad and RICE or boiled/mashed potato and boiled vegetables.
   + Halal meat is most preferred for religious purposes, mutton, lamb or beef are acceptable alternative. Pork is prohibited.
   ** Fish is never served with dairy products.
3. All stews are served with RICE. LABNEYA is an alternative accompaniment.
4. Blanched almonds and walnuts are considered imperative to assist in lactation. They are not feasible within the role of the hospital food service: the cultural significance requires their availability. They are feasible kiosk options.
5. These are considered to have a significant role in recovering from childbirth and assisting in lactation. They were not specified as a preference for any meal. Breakfast is recommended as an appropriate alternative.
6. This is considered to assist in lactation. It is added liberally in food preparation.
7. Bread accompanies every meal.
### TABLE 5.2.1.4: REPORTED FOOD PREFERENCES FOR MIDDLE EASTERN MENUS IN SWSAHS HOSPITALS BY ASSYRIAN MALES AGED 15-24 YEARS (GROUP 4)

<table>
<thead>
<tr>
<th>Breakfast</th>
<th>Soups ²</th>
<th>Light Meals ³</th>
<th>Heavy Meals ⁴</th>
<th>Dessert</th>
<th>Mid Meals</th>
<th>Beverages</th>
<th>Miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Rolls</td>
<td>• RICE SOUP with meat or chicken</td>
<td>Wednesday/Friday:</td>
<td>• BAMI</td>
<td>• Fresh fruit</td>
<td>• DAWEE</td>
<td>• DAWEE</td>
<td>• Vegetables</td>
</tr>
<tr>
<td>• Spreads:</td>
<td>• CHICKEN soup</td>
<td>• RED RICE</td>
<td>• BORSH</td>
<td>• Fresh fruit</td>
<td>• Tea</td>
<td>• Tea</td>
<td>• Salad</td>
</tr>
<tr>
<td>- jam</td>
<td>• Grilled fish +</td>
<td>Grilled fish</td>
<td>Curried chicken</td>
<td></td>
<td>Orange juice</td>
<td></td>
<td>Fresh fruit</td>
</tr>
<tr>
<td>- honey</td>
<td>• Fried fish +</td>
<td></td>
<td></td>
<td></td>
<td>Water</td>
<td></td>
<td>Bread ⁵</td>
</tr>
<tr>
<td>- butter</td>
<td>• GERHDO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RICE</td>
</tr>
<tr>
<td>- cheese</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Eggs</td>
<td>• Lentil soup</td>
<td>Other days:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Olives</td>
<td></td>
<td>• Grilled chicken</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Toast</td>
<td></td>
<td>• Grilled steak</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Soup and sandwich</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• KIBI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**KEY**
- Foods typed in capitals letters are presented in the GLOSSARY (Appendix 10).
- Foods classified under Wednesday and Friday may be eaten on other days too but are specified for these days for religious purposes.
- The data presented represents that extrapolated from the fascillitator's notes and the session transcript. Part of the audiotape of the session was wiped in the transcription process. Therefore it could not be used to clarify. May be underrepresentation or bias report of preferences since transcript not done by either fascillitator and not ward for ward, notes taken at the session are only brief.
- Soups can be served with bread or sandwiches to comprise a light meal, or may be served as an entree to main meals.
  * BOUSHALA is never served with a fish meal.
- Appropriate accompaniments to meat dishes are salad, rice and boiled potato.
  + Fish is never to be served with any dairy product.
- All served with RICE.
- Bread accompanies every meal. Bread rolls or Lebanese bread are most preferred.
5.2.2. **FOOD GROUPINGS**

5.2.2.1. **"Liquids"-soups.**

As identified in Chapter 5.1.3 liquids are considered integral in the healing process.

"As we all know liquids are highly recommended for illness" *(GROUP 2- 15/7/93)*

"When one is sick they require light and watery foods not heavy meals" *(GROUP 4- 28/7/93)*

Liquids specifically referred to watery foods, principally soups. Beverages were identified separately.

Both Assyrian and Lebanese identified common soups and some cultural specific preferences. One young Assyrian man specified a particular commercial brand adamantly expressing his belief in its superior therapeutic properties. (Interestingly, on a recent trip to Lebanon I found that a number of younger people identified the same product expressing the same belief as this participant). However, traditional soups were consistently most preferred to other options by the participants in this study and by my acquaintances in Lebanon.

The most significant soup considered common to both the Lebanese and Assyrian participants was **RICE SOUP** usually made on meat, bones or chicken. Fresh vegetable soup and lentil soup also were identified as common significant preferences common across all groups.

The Lebanese men in both the pilot study and group 1 noted a specific soup which they referred to as **MUSCLE SOUP**. This is soup made by boiling shanks (not pork) and parsley. The men considered it to have significant healing qualities, and essential to offer a sick person. Other Lebanese people agree with this sentiment (Hasn, 1993-pers. comm.).
Chicken soup made by boiling chicken fillets in water with cinnamon bark and serving a piece of the meat with its juices in a bowl was identified by Lebanese woman as imperative in the first nine days after birth. They believed that it has a role in relaxing the mothers "tummy" and helps her produce good milk to rest the baby.

"In our country we must boil the chicken and use the water to make the soup and other dishes for one week and two days after we have the baby, we strongly believe this is essential". (GROUP 3- 28/7/93)

Lebanese men also noted this soup as a preference regarding it as a strengthening food. The Assyrian women did not specify the same cultural belief regarding this soup in times of lactation, however, both Assyrian groups also indicated it as a preference.

The Assyrian women noted BOUSHALA as a specific Assyrian soup preference considering it to be significant in the healing process. The women identified that traditionally BOUSHALA is made heavy and enjoyed as full meal when one is well. However in times of illness it is more watery, and less “chunky” to be lighter and more appropriate for illness. Similarly lentil soup is considered appropriate for illness, but in times of good health it is made with meat and spices to comprise a heavy meal called tlokhi. Rice noodles or some sort of pasta may commonly be added to a variety of soups to increase their substance.

Initially the young Assyrian men in group 4 did not agree that BOUSHALA would be appropriate for illness, they considered it too heavy. They did agree however, that the foods nominated would be preferred by many Assyrian people, particularly the elderly, somebody with a minor illness or somebody who is recovering from a major illness, or who has been hospitalised for a long period of time and needs to regain their strength. One man noted that after his wife had given birth in an Australian hospital all she requested was BOUSHALA. When the men were informed of the modification as identified by the woman, many reported they found this more appropriate for illness and would order it.
Soups were considered an appropriate light meal by these participants, when accompanied by a sandwich or some bread, particularly for somebody with a poor appetite. Alternatively soup can be served as an entree to a larger meal.

**Implications and recommendations as menu items**

Food Service Standards mandate that 180 ml. of soup form part of a hospital's basic light meal options for patients (NSW Department of Health, 1989). However, Kokkinakos (1993-pers. comm.) identifies that it is difficult to plan menus offering a variety of soups. The soups identified by these participants could be adopted on to the main menu to overcome this problem. It is very important that these soups are always available to Middle Eastern clients due to their cultural significance, specifically that relating to Lebanese woman. These will be discussed in more detail in chapter 5.2.4. They should be standard items on the Middle Eastern menus and could be offered periodically as part of the planned menu cycle on the main menu.

**5.2.2.2. Beverages**

Participants were unanimous that water, fresh fruit juices, and tea were the most appropriate beverages for times of illness. Milk was specified as a preference by the older men. Lebanese woman in Group 3 participants reported it as one of the five most significant foods they perceive as essential to have in hospital after childbirth. Some Assyrian woman cited it as a supper preference. Assyrian men in group 4 did not mention milk as a preference.

Perhaps the increased preference among Lebanese participants is due to religious factors. Twaigery and Spillman (1989) and Sakr (1971) note that milk is a recommended food by the **Quran**. This preference conflicts with the common citing that milk is not usually
consumed on its own by people from Middle Eastern backgrounds (Kittler and Sucher, 1989; Hadj, 1988; Barr-Stein, 1979).

Soft drinks were mentioned by the Lebanese men in group 1 as being beneficial for certain digestion problems. There was some controversy and many misconceptions about this, which were finally resolved by agreeing that in such cases the doctor would prescribe it. Assyrian woman identified that children bought up in Australia would prefer soft drinks because this is what they drink now. Lebanese woman and Assyrian men made no specific mention of soft drinks. Overall, they are not a significant aspect of client care for this group.

**Special drinks**

The Lebanese woman additionally distinguished that a special tea, YINSOUN, made of aneese seed is traditionally drunk to assist in lactation and to help produce a milk which is soothing to the baby. MUGLEE, another tea, also was identified. Other Lebanese participants noted that these teas were indicated in times of illness. They conceded that certain herbs have specific therapeutic qualities. The use of fresh herbs and spices in this way is common among many Lebanese people.

Some woman identified that natural blanched almonds and walnuts are also added to the tea as it boils. Almonds and walnuts are considered very important in assisting lactation and warming the milk to soothe both mum and baby. Warm milk was additionally noted to produce the same effect. These practices were clarified by mothers from Middle Eastern backgrounds in Lebanon and Australia that I know personally.

"These teas are very important and adding the almonds and walnuts is very important too" *(GROUP 3- 28/7/93)*
DAWEE, a refreshing drink made by diluting yoghurt, was identified as a specific beverage preference by the Assyrian participants in groups 2 and 4. It is believed to be very important in times of illness.

**The right way to drink**

There appeared to be specific rules about the consumption of beverages. A cold drink should accompany the meal, usually water or fruit juice and DAWEE for the Assyrian participants.

Hot drinks are consumed after the meal. Traditionally Turkish style coffee is preferred (Anthony et al, 1993; Kittler and Sucher, 1989; Barr-Stein, 1979; Grivetty, 1975). My data were consistent with this, however participants reported that in hospital tea is preferred to the instant coffee available. Additionally women in group 3 identified that lactating women should abstain from drinking citrus drinks as they are considered to give the baby diarrhoea. A large number of participants reported that this also was the case for individuals with problems in their stomach. However at other times fresh orange and other fruit juices are considered imperative and highly preferred. The two Assyrian groups also cited that both DAWEE and BOUSHALA should never to be served with fish.

**Implications and recommendations as menu items**

Many of these preferences are consistent with current practices in hospitals. I recommend that in addition to milk being offered as a standard drink at each meal, as recommended by NSW Department of Health (1989), that it be available as a standard between meals. This is not a recommendation for food service but is a nutritionally significant option for all clients, particularly for obstetric patients both in terms of their nutritional requirements and cultural beliefs.
DAWEE also is a nutritionally and culturally significant food. Offering it as a standard option on the Middle Eastern menus is feasible as yoghurt should be a standard food available in hospitals. DAWEE is inexpensive and its preparation is not labour intensive.

I have seen DAWEE sold commercially in Middle Eastern food shops. Whether this product is acceptable to these clients is not known as the participants did not mention this. This offers an alternative of either buying DAWEE, or the kitchen staff could prepare it themselves. In light of the significant role of yoghurt in meal preparation for this cultural group (detailed in chapter 5.2.2.3) it would be more feasible for SWSAHS to prepare this item in the receiving kitchens at each respective hospital.

To provide or not to provide?

There is no documented nutritional advantage of supplying the herbal teas reported by the Lebanese participant, therefore it is not necessarily the hospitals responsibility to provide it. However due to the significant role participants perceive herbal teas to have in their healing process, it becomes the hospitals responsibility to adopt some strategy that makes provisions for offering these teas (NSW Department of health 1989). This is especially indicated for obstetric clients. Though other participants identified similar notions regarding the perceived therapeutic qualities of these teas, the veracity of the belief was not as significant as that considered for lactation. Therefore, it is more desirable to meet the need of obstetric clients.

Where possible access to facilities where the women can make the tea themselves should be offered. Where this is not possible access to heating facilities such as microwave ovens should be available so that woman have the option of bringing it in from home and heating it.
In addition to providing such facilities, patients should be made aware of the availability of such services. Madhock et al (1992) report that 'Asian' patients reported an increase in satisfaction and opinion of the food in hospital and their hospital stay when, on admission, they were informed of the availability of 'Asian' food and reassured that they met dietary requirements. This strategy also begins to address the need for this groups education regarding their rights in the health care system identified in chapter 5.1.6.

While Almonds and Walnuts are not beverages I will discuss them here as this is the context in which they were mentioned and, there is no other appropriate place to include their discussion. Almonds and Walnuts are a good source of energy protein and fibre, though high in mono-unsaturated fat, making them both a nutritionally and culturally significant food. This indicates that the hospital is responsible for making some provisions for their consumption. In light of the realities of hospital practice it is not likely that Food Service can supply these items as menu standards.

However, I suggest that they be made available in the hospital kiosk for clients and their visitors to buy, also to sell them on the patients shop trolley. In this way clients needs are satisfied, the hospitals responsibilities are accounted for and an opportunity to increasing revenue for the hospital is developed.

5.2.2.3 Yoghurt

Yoghurt was identified by both groups as being significant in the healing process for all ages and conditions. Indeed, yoghurt is a staple in the traditional Middle Eastern diet (Anthony et al, 1993). However a regional difference existed between the Lebanese and the Assyrian members in the preferred way to eat it (as described below). Further, in both cases this differed significantly from the preferences of Australian hospitalised inpatients (Williams, 1988). Williams (1988) reports that the latter group prefer the commercially available sweet/fruit varieties of yoghurt. Participants in this research
specifically related that this was not what they are referring to when they spoke of yoghurt. They always prefer natural yoghurt, the following presents the preferences according to both the Lebanese and Assyrian groups.

**Lebanese preferences for yoghurt**

Lebanese participants reported two forms of yoghurt as preferences, LABNEY and LABEN. LABNEY, a thick creamy yoghurt, was unanimously identified as an essential food to have in hospital. Specifically it was identified as an essential breakfast item, served with Lebanese bread and olives. This is consistent with the literature about traditional breakfast meals (Anthony et al, 1993). The same meal was identified as a light continental snack between meals (specifically as a supper option). Other recommendations were to use it as a spread in Lebanese bread sandwiches which could be offered as mid meal options, with a cup of tea, or as accompaniments to soup as a light meal.

LABNEY was noted as a crucial hospital menu item for people from Middle Eastern backgrounds because of the significance it has in the diet of Lebanese people. It was noted that for any Lebanese person experiencing difficulty eating in hospital for any reason at all, the provision of LABNEY with bread and olives, would be sufficient to satisfy them.

"If you are going to bring our food to hospital the most important thing is to have LABNEY " (PILOT- 7/7/93, GROUP 1- 21/7/93)

LABEN is natural yoghurt familiar to the Australian culture. Traditionally LABEN is home made. Home preparation is more economical as it can be made in bulk and then used in a variety of ways, i.e. drained to make LABNEY, added to cooking, eaten as snack with Lebanese bread and tomatos. Home preparation also allows individuals to prepare the LABEN to their desired consistency. One of the EHW also identified that by
preparing it at home Muslim clients are assured that no gelatine or other possible dietary prohibited ingredients are added.

Commercial tub style yoghurt was considered appropriate in hospital. However one of the EHW identified that not all commercial brands are appropriate for Muslim clients. He recommended that if commercial yoghurt is to be provided that a halal product be chosen. Dairy Product- Natural was identified as a product commonly used by Muslim people.

Both the Lebanese men and women also stated that LABEN is appropriate for individuals with indigestion problems or upset stomach (Mugise). In this context it is usually served with plain boiled rice. It was asserted that used for this purpose it is lighter if the yoghurt is not cooked as in the case of LABNEYA. There were suggestions that LABEN may be appropriate for some people as light relaxing meal before bed, as it would not upset the stomach (Group 3; Pilot, post session discussion).

Other preferred uses of yoghurt in this form was in cooking. LABNEYA (yoghurt and rice stew), was identified as an appropriate light meal when served with bread in hospital. Assyrian client identified a similar meal, however they refer to it as GERHDO. Lebanese participants noted that LABNEYA also can be served as an optional accompaniment to other meals such as stews.

This is very versatile, economical and nutritious dish, and can easily be incorporated as a standard menu item into the meal service for these clients. The issue regarding the different names of the meal is something SWSAHS have to consider in developing and designing the menu slips.

The Lebanese women identified yoghurt (both forms) as the five most essential foods in the post partum phase.
Assyrian preferences for yoghurt.

Assyrian participants preferred to consume yoghurt in the form of DAWEE. The women in group 2 most commonly associate it as an accompaniment to RED RICE and DOLMA, completing a nice meal acceptable to have on Wednesday and/or Fridays. Though they did identify that it is commonly enjoyed as a refreshing drink. The young men’s responses were consistent with the latter view. They preferred DAWEE more often as a refreshing beverage, not necessarily associated with specific dishes.

One lady mentioned that plain yoghurt is appropriate to serve to infants under 5 months of age. Natural yoghurt is also used in some cooking. Specifically GERHDO and BOUSHALA were identified as preference in times of illness and as appropriate hospital menu items.

Yoghurt is never eaten with fish

A common notion regarding the use of yoghurt across all groups is its incompatibility with fish. All participants fervently identified that:

"Yoghurt is never served with fish" (PILOT, GROUPS 1- 21/7/93, 2-15/7/93, 3-28/7/93, 4-28/7/93).

This appears to be a cultural trait across the Middle East. Participants identified other groups, such as Egyptians and Iranians, who expressed the same belief. Kittler and Sucher (1989) note that people from Egypt never eat fish and yoghurt together. I also was bought up with the same notion, and on a recent trip to Lebanon I experienced that this same conception is evident there. Anthony et al (1993, p. 27) expound this in describing menu planning for Lebanese cuisine “yoghurt is served in a variety of ways with most meals but never with fish...”.
I was not given a reason for the prohibition. It was simply accepted that they were incompatible foods. This research gave me the opportunity to explore the reasoning behind the belief. No specific reasons were stated by participants but, most identified that it was simply accepted that the two foods are incompatible. One man stated that he could not offer any explanation but he reported that his son could eat the two together however he added:

"Personally if I eat one I can not eat the other within the same 24 hour period or I get violently ill and need to be hospitalised" *(PILOT- 7/7/93)*

another man suggested that:

"It makes poison in your stomach" *(PILOT- 7/7/93)*

while a lady offered that

"It stresses the body too much. It is not good" *(GROUP 2- 15/7/93)*

This explains why the Assyrian participants identified that BOUSHALA and DAWEE are not to be served with fish meals. Many participants additionally identified that the same prohibition existed for any other dairy product and eggs. However the responses were not as animated as they were when discussing yoghurt. All the issues presented above need serious consideration when menu planning for these cultural groups.

**Implications and recommendations as menu items**

Yoghurt is a nutritionally significant food and its consumption should be encouraged. The importance it plays in the role of Middle Eastern dietary pattern indicates the necessity in providing culturally appropriate choices.

Its versatility indicates it is a feasible cost effective option to offer all the dishes identified by my participants as standards on the Middle Eastern menus. For example, it is simply drained to make LABNEY, diluted to make DAWEE or cooked to make
LABNEYA/GERHDO, or simply eaten on its own or with bread. This means that it is appropriate for all meals, across nations for all ages. The participants confirmed this.

The suggestion that home preparation of yoghurt is more economical and versatile is an issue SWSAHS can consider. It can simply be made in each hospitals receiving kitchen and used to prepare any of the associated dishes on demand if required. Alternatively, commercial products of LABEN, LABNEY and DAWEE are available and can be used accordingly. If commercial varieties are to be used, I recommend that products which are free from pork derivatives be used to meet the religious requirements of SWSAHS Muslim clients.

5.2.2.4. **Meats**

All participants identified a variety of meats and meat dishes. Religious and cultural factors determined the preferences. Fish and Chicken were the most preferred meats. Cooking method preferred by all groups were baked or grilled although the young Assyrian men did identify fried options more commonly. Other groups identified these as to heavy in times of illness, particularly the Lebanese men, who strongly report that fried foods are inappropriate for any person aged over 55 years. Fried options were identified as preferences by the woman participants in both group during times of wellness. Some participants preferred boiled meats (group 2- 15/7/93).

**Meats-fish**

Fish was identified as a strengthening food and an essential menu option by all participants in all groups. Assyrian participants were more dogmatic about this due to religious factors. The participants cited that many Assyrian Christians do not consume any meat on Wednesdays and Fridays for religious reasons, though it was stated that some individuals consider fish as the only exception to this.
The Assyrian women cited religious factors more than the young men, but both restated the strengthening properties as an essential reason for their preference. They identified that individuals who do not consume fish on Wednesdays and Fridays still regard fish as strengthening food and would also consider it as an essential hospital menu item for other days.

Lebanese participants did not specify religious factors as a reason for their preference. However, Sakr (1971) notes that seafood is a recommended food according to Muslim dietary law. It then may be speculated that religion may influence their preference. Further, some Lebanese participants expressed that in hospital they avoided selecting meat dishes in order to escape the risk of consuming pork or pork derivatives. Fish is relatively safe in this regard. The Lebanese women in group 3 ranked fish as one of the three most significant foods during lactation.

**Fish as a meal**

The preferred preparation method for fish differed. Lebanese participants preferred to eat fish baked or grilled with lemon and herbs. While the Assyrian woman preferred fish baked with tomato and parsley. Inconsistent with their notions of fried foods being too heavy, some participants identified a preference for fried fish. They also ardently agreed that steamed fish is totally inappropriate. Many of the young Assyrian men simply stated grilled or fried fish as their preferences.

It was consistent across all groups that salad would complete a fish meal. There was consensus among Lebanese participants that additionally RICE would complete such a meal. This was a personal preference among Assyrian participants. Some Lebanese participants identified that lightly boiled vegetables also would be appropriate in place of salad. The men in both the pilot and group 1 most commonly noted this. Few Assyrian participants agreed with this, though many identified that boiled potato would be an
appropriate accompaniment. All participants restated that fish and yoghurt were incompatible.

**Implications and recommendations as menu items**

Though baked, grilled or fried fish may appear as main menu items, religious and cultural factors indicate that fish should be a standard item on the Middle Eastern menu (detailed in chapter 5.2.4.1). The nutritional advantages and recommendations for fish are well documented (Rogers, 1990), further indicating their feasibility as standard choices.

Although only three preferred methods of preparing fish were identified here, this should surface in offering enough variety and still be feasible within the resources of the food service. These recipes may be adopted on the main menu as Williams (1988) identifies that they are highly rated as preferences by a large sample of inpatients in a Sydney hospital. However, my data suggest that the reverse is not appropriate. That is, mornay or steamed fish dishes which also rated highly by Williams (1988) participant sample, suggesting their use by food services, were noted in my research to be inappropriate for a number of people from Middle Eastern backgrounds.

Although one of these options is fried I recommend that it still be offered as a standard. It is documented that there will always be a need for some high fat food items in hospitals (Williams, 1990). Further when consumed with the preferred accompaniments of RICE and salad or vegetables it comprises a well balanced meal. Consideration will need to be given to the amount of fat in the RICE, and olive oil dressing on the salad. I strongly advocate that all fish dishes are prepared by staff at the hospitals receiving kitchens as the literature cites that fish does not respond well to the cook-chill process (HAHS, MHU, 1991).
Meats-chicken

Chicken was identified as an important preference by participants in all groups. Lebanese participants appeared to have a stronger belief in the health properties. The Lebanese women held the strongest preference as they reported a cultural belief of its importance in lactation. They conceded that it has a role in relaxing the mothers "tummy" and helps her produce good milk to rest the baby. As identified in chapter 5.2.2.1, CHICKEN SOUP is considered the most essential food immediately after child birth. Other chicken dishes also were identified, though CHICKEN AND RICE is reported as a significant hospital preference. Others preferences are considered too hard for the hospital to provide, and that the provision of the soup and this dish was most essential.

Inconsistent with the preferred preparation method of other meats, the Lebanese women noted that grilling or baking chicken is considered inappropriate and unacceptable during lactation. Though they consider chicken prepared in this way as appropriate for other illnesses, after child birth it must be boiled and the boiling water is then used in a variety of ways to prepare the soup and other dishes.

"It must be boiled, nice and white, not roasted red like they bring you, this is no good at all" (GROUP 3- 28/7/93)

The fact that these chicken dishes are to be consumed for nine days post partum (chapter 5.2.2.1) is an issue requiring consideration in menu planning for this group (detailed in chapter 5.2.4.1.). The importance in meeting this cultural need is evidenced in the fact that all women reported requesting these dishes to be brought in from home while they were in hospital. Participant reports of undertaking other measures to ensure that this need was met is further evidence of this. For example, one woman states:

"I had the baby that night and I was home by lunch time the next day so I could have the food I needed." (GROUP 3- 28/7/93)
Preferred chicken dishes

The Lebanese men in both sessions and the Assyrian woman also identified CHICKEN AND RICE as an appropriate meal in times of illness. Another common dish is RICE SOUP made on chicken. Participants in all groups reported that a piece of skinless roasted chicken served with similar accompaniments as a fish meal, would comprise an appropriate light meal. One Assyrian man referred to a macaroni dish made with chicken and mushrooms as a preference.

Curried chicken was identified by some participants in all groups as a preference. This was an interesting result as it is not a traditional dish. Some participants identified this and noted that it may be heavy, yet they reported it as appropriate as a menu item and some considered it healthy.

This reinforces the priority issue of correcting this target groups nutrition misinformation through culturally appropriate nutrition education (chapter 5.1.6). While this is a common preference to both groups it is not a necessary choice for the Middle Eastern menu, but it could be adopted onto the main menu to increase variety. The other chicken dishes identified here are both feasible and necessary to provide as standard options on the Middle Eastern menus.

Meats- KAFTA

KAFTA was identified as a very versatile meat dish as it could be prepared in a variety of ways, to suit a variety of illness and was common across both nations.

"If you provide kafta, everyone will eat it regardless of their illness" (GROUP 1- 21/7/93).

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There was consensus among all groups that KAFTA mishwee (grilled) comprises a light meal for some body with a poor appetite when served with salad and Lebanese bread. Assyrian participants identified CUTLETS as a preference to be served in the same way. CUTLETS are made using the same basic KAFTA mixture identified by the Lebanese participants. However, bread crumbs are added to bind the meat together so that it can be moulded into patties and pan fried.

KAFTA b' saineeyeh is a heavier meal comprising KAFTA and sliced potatos baked as a casserole in a tomato sauce. RICE or LABNEYA was reported as optional accompaniments to this meal. This was mostly preferred by Lebanese participants and is considered appropriate for lactating women and those who have 'other' illnesses. It was also considered appropriate as a lunch meal for all illness.

**Meats-KIBI**

KIBI was initially identified by participants as too heavy for hospitalised patients although it is considered an excellent strengthening food. It also was considered too difficult for the hospital to make, especially the fried KIBI balls. However Lebanese participants reported that KIBI would be appropriate when baked with less fat. In addition to the baked KIBI, some Assyrian participants identified a preference for boiled KIBI and kibi hamud. The latter was considered inappropriate as a hospital menu item because as it is too heavy. All groups identified that a piece of baked KIBI with salad would comprise an appropriate light meal.
Raw Kibi was identified as having therapeutic properties by the Lebanese men in both sessions. However, they did not consider this to be a feasible hospital menu item.

**Implications and recommendations as menu items**

The provision of KAFTA and KIBI as standard menu items on the Middle Eastern menu is indicated by this discussion. Both meat dishes are extremely nourishing, particularly KIBI, yet economical, further they are very versatile as they can be prepared in a variety of ways. The participants made statements consistent with this, and it also is confirmed by Anthony et al (1993). This indicates the feasibility of offering them as standard food items.

These foods could also be adopted onto the main menu to increase variety to the broader hospital client base. The hospital cafeteria also offers potential in this regard. In the context of the hospital cafeteria, these foods can be served in the same way as to participants or, simple variations can be adopted using other basic staple ingredients.

For example, KAFTA/CUTLETS can be used as a filling to make sandwiches with Lebanese bread, KIBI can be served in a stew with a tomato or yoghurt based sauce. The popularity of Lebanese restaurants in Australia is documented (Anthony et al, 1993; Greenfield et al, 1980). KIBI and KAFTA dishes are common popular aspects of Middle Eastern cuisine, indicating that these dishes may be well accepted by both other patients and staff, additionally visitors utilising the hospital cafeteria. Arney and Tiddy (1992 b) identify that the willingness to try alternative foods appears to be greater today than ever before, and identifies the importance of hospital food services to consider the differences in food needs and preferences of staff and visitors to the cafeteria.
Considerations in preparing and providing KIBI and KAFTA

The meat used to make KIBI is a leg of mutton. Other meat, especially young lamb is unsuitable as it does not bind well. A substitute alternative, if required, is ground topside beef. Preparing the basic KIBI mixture can be done using a fine bladed electric mincer or the meat may be bought pre-ground from certain butchers (Anthony et al, 1993). Some Middle Eastern butchers in Sydney sell the basic KIBI mixture complete. This is the same for the basic KAFTA mixture, however unlike KIBI, it may be made from lamb or beef, or lean ground hamburger mixture.

The participants did not specify in their sessions whether they ground the meat themselves or bought it pre-prepared, however in their recipes it was noted that the meat was pre-bought. Muslim participants specified purchasing theirs from Halal butchers.

This may have implications for SWSAHS as buying it pre-ground or pre prepared is a labour saving strategy which I recommend. Where possible contracting with a halal butcher to ensure that Muslim religious dietary requirements are met is highly recommended. Such strategies will reflect positively on the areas hospitals, and assist in enhancing the image.

South Western Sydney Area Health Service also need to consider the compatibility of these meats with the cook-chill system. For example, the literature cites that some starch containing products require modification for the production process (Mathews, 1992), CUTLETS contain bread crumbs. The cook-chill system includes a two phase cooking procedure, KAFTA is prone to drying if over cooked. This reinforces the importance of the next phase of the study where such issues can be trialed and appropriate solutions considered on site.
Steak was important to all participants. Preferably, it should be well grilled and served 'dry'. Gravies and sauces were not popular among these participants. Participants in all groups identified it as a strengthening food. The Lebanese women additionally noted that steak is considered to have a significant role in rejuvenating the blood loss during childbirth. They identified it as one of the five most important foods for this time.

Religious factors were evident again. Lamb and beef were consistently specified by Lebanese women as the preferred meats to use as Muslim dietary law prohibits pork consumption. These participants only mentioned the avoidance of pork when specifically asked about religious influences on eating in hospital. In this context they specified a preference for halal meat.

Assyrian participants did not generally distinguish a specific meat preferences, one lady in group 2 did note Veal Schnitzel as a preference. Religious influences on eating in hospital for people from Assyrian backgrounds relate to personal choices of not eating any meats on Wednesdays and Fridays. Unlike the Muslim religion, no specific meat was singled out. Many of the Assyrian participants referred to the prohibition of pork by followers of the Muslim religion.

Implications and recommendations as menu items

From this data I suggest that only a few pork based dishes comprise the Middle Eastern menus in SWSAHS. Moreover, in buying and preparing meats for soups and/or stews, pork products should be avoided. In this way the religious needs of all Muslim clients are assured and no compromise is made to any other group regarding their religious needs or preferences.
More importantly, it also indicates that serious consideration should be given to the adoption of Halal meats into the service, particularly in light of policies documenting the responsibility of hospital food services to make provisions for patients religious and ethnic needs. (NSW Department of Health, 1989; NSW Department of Health, 1987, cited in HSDU, SWSAHS, 1991).

Some hospitals buy small amounts of frozen halal dishes to accommodate their Muslim clients needs. It would be more feasible for SWSAHS to include these as standards on their menus, due to the significant size of the Muslim population in the area, and the evidence that this population at the local level want this need accommodated (The Torch, 1993). This also places the hospital food service in the position to market their products to the other institutions.

A cost analysis is indicated to assess the most appropriate and feasible way to provide Halal meats (and other products). Cost analysis should consider that the Muslim population is the largest minority group in Australia (The Torch, 1993) and the adoption of Halal products is likely to meet the religious needs of clients from Middle Eastern backgrounds and Muslim clients from other cultural backgrounds.

**Meats- Kidneys and Livers**

Fried Kidney and liver were additionally preferred by the Lebanese women. They considered that these meats also are essential, in rejuvenating the blood loss during child birth, and assist in regaining strength. These are simply eaten with Lebanese bread, lemon is an optional preference.

The women did not specify at which meal they would consume these foods. I would recommend that breakfast would be the most appropriate time because the women reported a preference for a light morning meal. Coote and Williams (1993) note that it is imperative that obstetric inpatients eat enough at breakfast to compensate for the long
overnight gap, which in conjunction with increased nutritional requirements, puts them at increased nutritional risk. They recommend that a hot option be availed to such clients as they provide a "...nutritionally significant and positive component of patient care" (p.102).

This would certainly be the case for women from Middle Eastern backgrounds as they expressed a great deal of concern about the times and size of hospital meals. In particular that the overnight gap between meals is too long, and that meal sizes are insufficient in satisfying both their hunger or meeting the belief that the lactating woman must eat "plenty" to rejuvenate her strength and produce good milk (chapter 5.1.3).

Implications and recommendations as menu items

Kidney and liver are inexpensive indicating the feasibility of offering it as a standard menu item for this group. Nutritionally Kidney is low in total fat products and is an excellent source of protein iron and vitamin B-12. Liver is higher in fat and is an additional good source of vitamin A and folate. Both are significant sources of dietary cholesterol. This validates the participants beliefs about these foods being significant in rejuvenating the blood loss and increase their strength.

These foods are recommended to comprise a significant role in a small part of a varied diet (Rogers, 1990). However, they are unlikely to be main menu choices in hospital as Arney and Tiddy (1992 a, b) and Williams (1988) identify that offal is very unpopular among Australian hospitalised patients. Due to the cultural and nutritional significance of these items it is worth offering them as standard Middle Eastern menu items. The challenge is for dietitians to develop the final menus in such a way that participants are offered such culturally appropriate choices yet can self select their meals within the nutritional standards easily. With the availability of a range of other culturally appropriate
choices available to them, it is likely that these clients would only incorporate these items as a small part of their diet.

5.2.2.5 Rice

The significance of RICE in the Middle Eastern diet was previewed in Chapter 3.4.3. of this report. My data were consistent with these reports. Participants identified it as a staple in their diet. However each cultural group have their own method of preparing rice and each additionally noted that when they refer to rice they are referring to:

"our rice, prepared our way"

The traditional way of preparing RICE as the staple dish used as an accompaniment to meals differed. In Lebanon egg noodles (shireeha) are sautéed in butter and salt first, the rice is then added with water and brought to the boil, and then left to simmer till the rice is well cooked. Only a small amount of water is added most of the cooking is done in the simmering.

Assyrian participants in this group identified that, Assyrian people from Iraq prefer fried rice, this does not resemble the fried rice common in Asian cuisine. Fried rice in the Iraqi context refers to melting butter in the pot before adding the rice and water to boil. Assyrians from Iran prefer boiling the rice first with salt, then adding butter on top.

Differences exist within nations depending on the meal being prepared. For example RED RICE is a specific dish prepared by Assyrian participants as an appropriate non meat option for Wednesdays and Fridays. It also was considered as a popular Assyrian dish for other days. Similarly the Assyrian woman noted that the traditional DOLMA stuffing can be modified to exclude meat to accommodate the religious preferences of clients. One of the Lebanese EHW noted that the rice for LABNEYA can be made with or without egg noodles, however it must be boiled with the addition of butter.
Plain boiled rice, as available in some NSW Hospitals, was unanimously identified as inappropriate. Only a small number of Lebanese participants in groups 1 and 3 identified that rice prepared in this way was essential for individuals with stomach upsets, particularly for children.

**Implications and recommendations as menu items**

The differences in the way to prepare rice as a staple provides logistic problems in developing an appropriate food service for this cultural group. However in light of the significance of rice in each nation's eating pattern a cultural suitable choice is indicated. The common outcome in the preparation method across all nations is the addition of fat. This may assist in developing an appropriate compromise acceptable across all cultural groups in the Middle East. These issues indicates the significance of the trialing and taste testing phase of SWSAHSs study.

RED RICE should be a standard menu option to accommodate their cultural and religious needs and preferences of Assyrian clients, particularly since few other culturally appropriate non-meat options were identified, limiting the choice for clients from this community particularly those who choose not to eat fish on Wednesdays and Fridays.

GERHDO also is appropriate and should be a standard for the same reason. The feasibility and versatility were discussed in chapter 5.2.2.4.

More research is indicated to determine additional culturally appropriate non-meat options for the Middle Eastern menus. Anthony et al (1993) support this as they indicate that many Lenten dishes were created as part of Lebanese cuisine for religious requirements to avoid meat, dairy foods and eggs. Further, the results of this research and other reports, indicate that the food related habits of Middle Easterners differ along religious lines (Grivetty, 1975).
Many participants in groups 1, 2, 3 and the pilot study reported that CREAMY RICE pudding was an important food in the healing process. It was thought to be soothing and light on the "tummy". It is particularly indicated for young children, but it was considered necessary for all age groups. People from Middle Eastern backgrounds add rose water or orange blossom water as an essential ingredient in the preparation of this food. Some Lebanese men in group 1 identified that the addition of these ingredients give the CREAMY RICE its therapeutic properties.

One Assyrian woman identified experiencing an overwhelming desire for CREAMY RICE during her last admission. The lack of availability upset her and she needed to have some brought in from home to relieve her distress.

Implications and recommendations as menu items

Williams and Brand (1989) refers to CREAMY RICE as an old fashioned and unpopular dessert, further it was rated relatively low as a preference by a sample of Sydney hospitalised inpatients (Williams, 1988). Yet it is a very nourishing dessert being high in complex carbohydrate and offering the benefits of calcium, riboflavin and other essential nutrients provided by milk and rice. It is simple and inexpensive to prepare, making it a very feasible option to offer these participants as a standard dessert. This is important as these participants noted very few dessert preferences.

The use of orange blossom or rose water in the preparation of CREAMY RICE by these participants is a substitute for vanilla essence commonly used as a flavour enhancer in the Anglo-Celtic preparation of the similar dish.

However the participants considered these ingredients to be more than simple flavour enhancers, they noted a therapeutic effect. There is no nutritional significance
documented for these ingredients, further the small amount used makes an insignificant dietary contribution of any sort. However the significance is in the participants perceptions.

The decision to substitute vanilla essence with either of these ingredients in the preparation of CREAMY RICE for the Middle Eastern menus is a choice left to the discretion of SWSAHS. My suggestion is to make the substitution as these ingredients have a distinctive flavour and clients will recognise the difference if it is not used. Moreover, both ingredients are relatively inexpensive and easily accessible through continental delicatessens and Middle Eastern food stores. With the small amount used in the preparation of the dessert it is a cost effective measure for the rewards of the satisfaction of clients. This small change in preparation may increase the acceptability of this old fashioned dessert among the broader inpatient population.

5.2.2.6. Bread

Bread is a staple in the Middle Eastern diet. It has a significant role in completing every meal. (Anthony et al, 1993; Kittler and Sucher, 1989; Barr-Stein, 1979). My data were consistent with this. The significance is demonstrated in the following exerts.

"Without bread we have not eaten." (GROUP 1 - 21/7/93
GROUP 4-28/7/93 )

It must be on the table at every meal, if you don’t eat with the meal then you will have it after with your cup of tea." (GROUP 2- 15/7/93)

"Without eating bread you are hungry half an hour after you have eaten, bread fills you up." (GROUP 2- 15/7/93)

"I was always hungry in hospital because they did not give me enough bread." (GROUP 2- 15/7/93)
Lebanese bread and bread rolls are most preferred by the majority of participants. Some of the young Assyrian men expressed less preference for Lebanese bread, reporting that it was too "elasticity" and not good for dissolving in soup. A number of participants specified Chinese rolls as a preference. This is likely to be a reflection of the large number of Asian bread shops in South Western Sydney Area.

The type of bread was less significant as the necessity to have it. Toast and rolls were most preferred at breakfast by a large number of participants. Some Assyrian men identified a preference for, and the health benefits of wholemeal varieties.

Beyond the role of completing the meal, bread is used as a utensil to eat many Middle Eastern Cuisine. That is, food scooped up into small hand held pieces of Lebanese bread and eaten. Participants in this research reported the role.

"Eighty percent of Arabs eat their food with their hands using Lebanese bread" (PILOT- 7/7/93)

"We must have Lebanese bread so we can eat our food properly. We need to be able to dip it in" (GROUP 3- 28/7/93)

Bread is always considered only as an accompaniment to other meals it was never considered as a complete meal, as in the case of sandwiches. Participants unanimously expressed this in a number of contexts through their sessions. Sandwiches were considered appropriate mid meal snacks or as accompaniments to other meals. This view was held very strongly by participants. A recommendation for sandwiches made with Lebanese bread and LABNEY or cheese fillings was made as an alternative preference.
Implications and recommendations as menu items

Due to the cultural significance of bread I recommend having it available as a standard option at each meal. Hospital Food Service Standard mandate that at least one slice of bread be offered at each meal (NSW Department of Health, 1989). Lebanese bread should be provided as a standard option on the Middle Eastern menus, this is feasible as it is relatively inexpensive and easily accessible. It can also be offered on the main menu as it is popular with many groups.

Making Lebanese bread sandwiches is not a necessary responsibility of the food service, and if participants are provided with the composite ingredients such as the Lebanese bread and LABNEY cheese and olives they are likely to compile the sandwiches themselves. However offering them as part of the food service may offer novel variety to other inpatients. They could also be sold in the hospital cafeteria, a common trend across many sandwich shops in Sydney. Further they offer variety to food service employees, which has been cited as an important strategy to increase their moral and resultant work efficiency (Arney and Tiddy, 1992, b)

I recommend that SWSAHS also adopt bread rolls as standard items on the Middle Eastern menus and the main menu, as they provide a novel attractive alternative to plain sliced bread. This may encourage consumption among all patients.

5.2.2.7. Olives and Olive oil

Lebanese participants reported a greater preference for olives. Again they were specifically identified as accompaniments to LABNEY or cheese at breakfast, or light mid meal options. Some also noted that customarily a few olives are eaten at the end of a meal to complete it. I know this to be a common practice among people from Middle Eastern backgrounds.
The following excerpt summarises this:

"Olives and LABNEY and bread is the most important thing to have". (PILOT- 7/7/93, GROUP 1- 21/7/93)

Assyrian participants reported a preference for olives only after they were prompted. The greater significance among the Lebanese participants particularly in this research may be influenced by religious factors. Olives are one of the foods specifically mentioned by the Quran as having special health value (Twaigery and Spillman, 1989).

**Implications and recommendations as menu items**

The type of olive preferred was not specified by participants. I cross checked with the EHWs to clarify what they perceived would be the most appropriate option for their communities, they reported conflicting preferences. Generally the preference is individual, but black or green olives are most common and acceptable. Ultimately, the most significant issue regarding olives as hospital menu items relates to their availability. The choice from a SWSAHS perspective can be based on resource parameters.

Nutritionally olives provide a good source of energy and mono-unsaturated fat. However, they also are high in sodium. This indicates that only a few olives should be served at any one meal. Participants made comments consistent with this, noting that only three to five olives are usually eaten, commonly at breakfast.

In the context of the preferred breakfast of these participants this is a feasible and recommended menu item for this target population. For example by providing low fat alternatives of LABNEY or cheese with bread, accompanied by a piece of fresh fruit or a serving of fruit juice, the inclusion of a few olives compose a small portion of an otherwise nutritionally balanced meal.
Participants in all groups identified olive oil as having significant therapeutic qualities and being healthy. Lebanese participants again expressed this belief more strongly. The Lebanese women specifically identified that olive oil must be consumed by women after childbirth as they believe it is essential in assisting lactation.

Muslim dietary law identifies that olive oil is recommend both as a food (Twaigery and Spillman, 1989; Sakr, 1971) and as a skin ointment (Sakr, 1971). This may explain the greater preference among Lebanese participants. Though the literature cites that olive oil is used extensively across all Lebanese (Anthony et al, 1993) and Middle East Nations (Kittler and Sucker, 1989; Barr-Stein, 1979). Indeed the Assyrian participants in both groups also noted this belief.

There appeared to be confusion and misconception in the participants reports and understanding about the health benefits of olive oil. On the one hand they reported that fat and oily food are too heavy for illness. On the other they considered olive oil as healthy. This may be explained by the fact that butter or Ghee (clarified butter) is commonly used in cooking, not olive oil. Olive oil is used to garnish foods or as a salad dressing. LABNEY must always be garnished with olive oil when served, or pickled in olive oil if it is moulded into balls.

There was some controversy between the Lebanese men in Group 1 regarding the perceived health benefits of olive oil. Some men were adamant that all fat was no good for people over 55 years. Others reported that olive oil was recommend by the doctors as healthy and that they should consume it.

Participants in other groups offered no reasons for their belief or understanding regarding the health qualities.
Implications and recommendations as menu items

The issue offers a good point for education. Dietitians can capitalise on this potential to assist this group in understanding more about fat and the 'health' benefits of olive oil. The fact that they recognise that dietary fat should be reduced in illness, and they perceive some health benefits in consuming olive oil over other sources of fat, can be clarified to assist in making long term dietary changes for health purposes.

There also are implications for SWSAHS, Chapter 5.1.4 discussed the recommendations that hospital food service departments adopt mono- and poly-unsaturated oils. Williams and Brand (1989) identify that "If hospitals are to be seen setting an example (of appropriate diet related habits) to the general public they should consider changing to a polyunsaturated frying medium" (p. 202).

Williams (1990) later expands this to recommend that poly- or mono-unsaturated fats be used by caterers, citing that research has shown stability in frying oils with high P.S. ratio’s making them feasible for use. Further, that mono-unsaturated oils with high stability have been developed specifically for food service applications.

Olive oil is very expensive, therefore will need to be used sparingly. In the preparation and presentation of the cuisine recommended for the Middle Eastern menus, olive oil is an essential ingredient used as a dressing or preserver for LABNEY, and to make the salad dressing, therefore I recommend that olive oil be used for these dishes. Its distinct flavour will be recognised by these clients which will increase acceptability of the meal. I also recommend that the menus be designed to indicate the use of olive oil. In this way the hospitals will be setting a good example of appropriate eating habits. Other mono- and/or poly-unsaturated fats should be used in the preparation of fried foods and other dishes. This recommendation should be adopted as standard practice in the preparation of foods for all clients menus, in light of the documented health benefits of these fats over
saturated fats (Williams, 1990), and the recommendations for food service departments to do so (Williams, 1990; Williams and Brand, 1989).

5.2.2.8. **Vegetables**

"Every Arab that goes into hospital must have vegetables for healing. Fresh and cooked vegetables are the most important thing" (PILOT- 7/7/93, GROUP 1-21/7/93)

This sentiment was consistent across all groups. Indeed Anthony et al (1993), Kittler and Sucher (1989) and Barr-Stein (1979) state that vegetables prepared in a variety of ways are an integral part of Middle Eastern cuisine.

Vegetables are commonly prepared as stews and broths in Middle Eastern cuisine. These were consistent preferences by my participants. Though initially participants in all groups identified stews and broths as inappropriate meals for hospitalised patients as they were too heavy. However many of the women clarified that by reducing the fat and spices, and watering them down, these meals were considered very appropriate for illness and hospitalisation.

A range of dishes were identified by both the Lebanese and Assyrian. However, they noted the difficulty in preparing them. Additionally, they indicated that if other options of their cuisine, and the main menu are available to them then they would only require a few significant choices of these dishes. The most significant common dishes are BAMI (okra), SPANEEGH (spinach) and LOOBI (green beans) (all are served with RICE).

Stuffing vegetables is also a common cooking method across the nations of the Middle East (Assyrian people refer to these as DOLMA, Lebanese people refer to them as mihshi). While these were considered as healthy foods and highly preferred by participants in all groups, only Assyrian women considered that they were appropriate as
hospital menu items. Participants in all the other groups recognised these as too heavy, and labour intensive, and not necessary components as hospital menus.

The Assyrian women also recognised this however, they were adamant that DOLMA was significant. particularly since the recipes could be modified to make them lighter. However in light of the other participants responses I am not recommending DOLMA as a necessary Middle Eastern menu item. The Assyrian EHW supported this decision. Though more research needs to be undertaken to ascertain weather DOLMA is considered significant component of patient care to clients from other Middle Eastern nations.

Fresh vegetables are considered very important and must be consumed each day.

"Every thing from the ground is very important. We eat a range of greens like parsley these must be added to the cooking we also eat them fresh" (GROUP I- 21/7/93, GROUP 3,- 28/7/93, GROUP 4- 28/7/93)

Most commonly a fresh green salad comprising lettuce cucumber with a light dressing of olive oil and lemon juice is preferred. Traditional salads such as TABOULEH were considered too heavy.

"Tabouleh is traditionally enjoyed with alcohol. This is surely not appropriate in hospital" (GROUP 4- 28/7/93)

"Tabouleh is delicious and very healthy but a breast-feeding lady cannot have too much because it is too leamy and the baby will get diarrhoea" (GROUP 3-28/7/93)

All these traditional salads are too much for a sick person they don't even feel like having them when they're sick. All the want is something fresh and light the rest they can have when they're better" (PILOT - 7/7/93, GROUP 1- 21/7/93)
The Assyrian men expressed the greatest preference for fresh vegetables:

"Raw vegetables taste better than cooked they also have a better texture." (GROUP 4- 28/7/93)

"When you cook vegetables they lose their nutritional value so it is better to eat them raw, like salad." (GROUP 4- 28/7/93)

Yet another consistent theme regarding vegetables was that plain boiled vegetables were inappropriate for Middle Eastern clients:

"Sorry not many of us eat plain boiled vegetables we would rather have an alternative" (GROUP 4- 28/7/93)

"Not boiled in water! This is not tasty, no Arab would enjoy plain boiled vegetables. It must be prepared our way" (GROUP 1- 21/7/93)

**Boiled or not boiled**

There were some exceptions to this belief. All participants identified boiled potatoes as a preference. These are considered appropriate to feed young children and adults with stomach upsets and diarrhoea. Some Lebanese participants identified this as a favourite mid meal snack on their own or with bread, accompanied by tomatoes, olives and cucumbers.

Mashed potato also was noted as acceptable. Lebanese participants did not mind finely mashed potato. However most Assyrian woman preferred their potatoes to be chunky, dressed with fried onions and mushrooms. The Assyrian men did not specify a preferred cooking method but agreed that boiled potato was acceptable. Chips were identified by Assyrian woman as preferences for Assyrian children during illness, and as appropriate menu items for them.
Other exceptions were identified. Most commonly peas and carrots are considered acceptable to eat lightly boiled as accompaniment to light meals such as grilled meats. Boiled corn also was identified as an exception by some participants. These exceptions were commonly expressed by the Lebanese men. Lebanese women were less enthusiastic. Assyrian women were divided on this issue, some agreed that these vegetables are acceptable and appropriate for themselves, but they perceived that it is not likely to be common or popular among other Assyrian people.

There appeared to be agreement across all groups that vegetables such as spinach, green beans, and zucchini are not acceptable prepared and eaten plain boiled. This is likely to be because these vegetables are prepared in a variety of exotic tasty ways in Middle Eastern cuisine. The Assyrian men generally maintained their preference for fresh vegetables.

Participants in groups 1, 2 and 3 participants identified another exception to the acceptability of boiled vegetables. They believe that they had a significant role in feeding sick infants and children. In these situations the vegetables are prepared without salt or fat and pureed into a smooth paste. Small amounts of pureed meat may be added as the child tolerates it better.

**Implications and recommendations as hospital menu items**

The significance that vegetables play in the diet of Middle Eastern people necessitates the provision of culturally preferred meals. All the dishes identified by participants are feasible and should be provided as standard options on the Middle Eastern menus. I recommend that a tossed salad be offered as a standard at each meal, this is a mandate for hospital food services by the NSW Department of Health (1989).
The three vegetable stews/broths identified are also recommended as served with rice. They comprise an excellent nutritious meal. Okra is traditionally a relatively expensive item. However, in light of the cost effectiveness of the rest of the meals identified by these clients, I think it is still a feasible option. Seasonally okra is only available fresh in summer and autumn, however canned varieties are available and may provide a suitable substitute, though this was not assessed in this study. If the tinned varieties are to be used to prepare BAMI, recipes should be tested for acceptability in the next phase of the study to secure the acceptability and appropriateness.

The feasibility of offering these stews is supported by the fact that they store and re-heat well (Anthony et al, 1993). This indicates that they are likely to be successful in the cook-chill system. It is not likely that the okra stew could be adopted onto the main menu, as okra has consistently been identified as an unpopular or unfamiliar item by Anglo-Celtic inpatients (Arney and Tiddy, 1992, a, b; Williams, 1988). Similarly creamed spinach scored a low preference rating by a sample of Australian hospitalised patients (Williams, 1988), suggesting that the spinach stew may not be a popular item. The bean stew may be trialed for success as green beans have scored high preference ratings in the same study.

Participants indicated variations in preparation methods of these stews, both through the discussions and in there recipes, further they identified that they would require to be made lighter to be appropriate for hospitalisation. This indicates the importance of the next phase of the study in developing and trialing the recipes.

The boiled vegetables specified by the participants are those commonly served in hospitals. They are not considered a significant part of the diet for all participants but the provision as standards is feasible and recommended.
The issue of common foods is important to SWSAHS as the realities of practice preclude them from developing a food service that accommodates the hospital food preferences and perceived needs of each cultural group from the Middle East. In order to develop an efficient service which is culturally sensitive, yet efficient, SWSAHS have to know which foods are most acceptable across the majority of the Middle Eastern population sub-groups.

Caution must be exercised in considering the issue of common foods. Attempts of past service delivery to people from NES backgrounds have failed because of over generalising ethnic populations into homogeneous groups (Dollis, 1993; Donovan et al, 1992, Moussa, 1991). Webb and Manderson (1990) identify that in considering the food habits of migrant groups in Australia, attention beyond reliance on anecdotal accounts and cookbook summaries of characteristic foods needs to be given, particularly during times of illness.

My data support this, and provide an example of how easily such ignorance provides the potential for inappropriate service delivery. Many foods considered to be characteristic to the Middle East, such as: TABOULEH, HOMOS, stuffed vegetables, many legume dishes, and rich sweets, were not referred to as preferences during times of illness and hospitalisation by my participants. In fact they expressed the opinion that such foods were inappropriate during times of illness, as indicated by the following excerpt:

"Many of our food is very healthy but not all of it is good for illness" (GROUP 1- 21/7/93, GROUP 3- 28/7/93)

Considering the issue of common foods for this group is difficult due to the diversity of cultures and religions represented by the nations of the Middle East (Moussa, 1991; McCallum, 1990; Kittler and Sucher, 1989; Grivetty, 1975). The risks of emulating the mistakes of the past are likely if consideration is not given to these differences.
The discussions in chapter 5.2.2 collates the data into common food groupings. While this pools together the similarities in the cuisine of the two nations differences regarding the preferred way of preparing and servicing many of these common foods were evident. The differences were evident between the two represented nation groups and also both across representatives of the same nation and, within nation sub groups according to age, acculturation, and physiological condition.

For example, the Lebanese women reported the cultural practice of consuming CHICKEN SOUP for nine days post partum, the Assyrian women did not express the similar beliefs. The Assyrian women identified the importance of hot, traditional meals for hospitalised patients, where the young men identified the a preference for fresher foods. Some Lebanese men believed that olive oil was healthy, others ardently disagreed.

While some diversity is indicated by this discussions, it does not reliably reflect the true diversity among the groups. Further indication was evidenced in collecting recipes for the second phase of my study and, in participants perceptions of the issue when they were asked about common foods in there respective sessions.

5.2.3.1. Collecting the recipes

Collection of recipes from the session with the young men (Table 5.2.1.4) was not possible within the resource constraints of this research, therefore the proceeding information relates only to those in the pilot study groups 1,2 and 3.

In collecting the recipes I found some conflicting information regarding seemingly common foods and uncommon foods identified through the discussions. Foods which I thought were nation specific because they were named differently by representatives of the two nation groups, were actually similar, for example KAFTA (Lebanese)/CUTLETS (Assyrian), GERHDO (Assyrian)/LABNEYA (Lebanese).
Alternatively those foods with similar names had different ingredients and preparation methods, for example BAMI and LOOBI. In some cases this is evident not only between the two represented national groups but across them. For example the Lebanese women did not use tomato base sauce in preparing their LOOBI, but the Lebanese men did. I also prepare LOOBI with the tomato based sauce. Another example in regard to LABNEYA. The Lebanese men in the pilot session identified this dish as comprised of meat, yet in the second session with them we clarified that LABNEYA itself is made without meat, but a similar dish can be made using meat. The Lebanese women agreed, referring to the rice and yoghurt stew as LABNEYA. Yet, Anthony et al (1993) identify LABNEYA to be a stew of KIBI balls in yoghurt, further they make no reference to a simple rice and yoghurt stew.

These issues present a range of implications for SWSAHS in effective menu planning. Consideration must be given to how foods are going to be named on the menu, particularly since some participants identified that poorly described menu items negatively influenced their ability to eat in hospital (Chapter 5.3.3).

There also are ramifications for the food service staff and the Dietetics Department. They need to know which foods are being referred to. I suggest that the name most familiar to each cultural group be used on the respective translation and the description given be used as the referral name for the hospital. For example GERHDO for Assyrian LABNEYA for Lebanese and cooked yoghurt and rice stew for the hospital staff.

These data have implications for the importance of the next phase of the SWSAHSs study, the recipe development and trialing. Particularly since the product which will appear on the menu will be modified to make one common recipe, and to conform with nutritional standards.
5.2.3.2. Participants Perceptions

At the end of each session participants were informed that the menus were being developed for people from all Middle Eastern nations. They were asked to identify which foods they considered were common to all nations that would be appropriate as hospital items; both from the foods they had identified and others they may not have considered.

There were conflicting perceptions about the similarity of Lebanese and Assyrian food and that of other Middle Eastern nations. For example in the pilot study participants agreed that the majority of the foods and meals they had mentioned are common across all nations and would be acceptable to all Middle Eastern people. However when I asked the same question to the men in group 1 using prompts from the discussions with the Assyrian community as a bases for comparison, they indisputably claimed that there were no similarities between the two nations cuisine.

"It does not resemble our food at all, they have foods and present them in ways that we do not have or never have they may have similar ingredients and may even be called the same name but they prepare, serve and eat them differently" (GROUP 1-21/7/93)

The Assyrian women identified that many of the foods they had mentioned were specifically Assyrian. Though unlike the above participants they also were very quick to identify similarities with the cuisine of Lebanese and other nations and were very agreeable to compromise to include similar dishes and they mentioned many dishes consistent with those identified by the Lebanese participants.

However, some Assyrian participants in both groups stated foods such as TABOULEH and HOMOS, as appropriate common foods. These were specifically identified as inappropriate for illness and hospitalisation by the Lebanese participants.
The Lebanese women perceived that all the foods that they mentioned would be acceptable and appropriate to the majority of Middle Eastern people. One lady notes that:

*When I had my baby in hospital, I had an Egyptian lady next to me. Her family, also bought her chicken and rice likes ours.* (GROUP 3- 28/7/93)

5.2.4. IMPLICATIONS FOR MENU PLANNING

Clarification of the issues presented above required a great deal of investigation. I found my cultural affiliation with the group was a significant advantage in understanding this and deciphering which foods were most appropriate to recommend.

These recommendations include foods which were identified in the research as common to the majority of nations comprising the Middle East. It also includes some cultural specific and subgroup specific preferences. This is because, trying to generalise results so as to only provide those dishes which are seemingly similar across cultural groups, results in stereotypes, misconceptions, oversights and omissions of many significant culturally and religious specific choices for each groups being omitted from consideration.

For the Lebanese participants these include LABNEY, CHICKEN SOUP and associated dishes for lactating woman, olives and milk. Further, there is a need to use products for Muslim clients or to refrain from using pork or pork derivatives in the preparation of meals. For Assyrian clients it means not offering them culturally appropriate non-meat options for Wednesdays and Fridays or BOUSHALA, BORSH, and DAWEE. The significance of these foods to each national group was discussed in the respective sections of chapter 5.2.2.

There is support that accommodating differences is a more efficient and effective way to achieve cost containment and patient satisfaction. Arney and Tiddy (1992a) encourage
hospital food services to take into account the differences in food preferences of all their clientele in designing their menus as a way to decrease wastage and expense.

While I am confident of the validity of this study's results and my recommendations, the issues presented here collectively indicate the need for more research. Firstly, the research method itself precludes the generalisation of these results. Krueger (1988) recommends that only cautious generalisation be made with focus group results, and that multiple sets of research methods be used where the data required is to make really big decisions and where the consequence of error are major.

The results are only the personal opinions and perceptions of samples representing two national groups from the Middle East. In light of the diversity of the Middle Eastern community in Australia indicated in this and other research (Moussa, 1991; McCallum, 1990), the need to assess the preferences of representatives from other sub-groups from the Middle East is indicated.

This is further supported by Kittler and Sucher (1989) who state that the cuisine of the Middle East can be categorised into three to five distinct culinary areas, those of Greek/Turkish, Iranian, Arabic, with the addition of North African and Israel. At least representation from each culinary area should be included in the assessment. It is unrealistic to believe that the preferences of all can be accommodated, but by assessing the perceived needs and preferences of these groups, appropriate compromises may be negotiated. At least an equitable attempt can be made.

The next phase of SWSAHSs study will be significant in directing further research as it will establish tangible results of appropriateness. The taste testing will be most significant in this regard. The HAHS, MHU (1988) reported that conducting extensive food trials in developing the Ethnic Food Kit, gave them an indication of the acceptability of their meals across a range of ethnic groups. Representatives from a large cross section
of Middle Eastern Nations should be included in the trialing of these suggestions to determine the level of acceptability.

Alternatively, the recipes could be trialed in one of the areas hospitals. In this way the success of the menu slips also can be tested and solutions to any potential problems worked through. Bankstown Hospital presents an ideal institution for the latter suggestions as it has the largest utilisation rate by residents from Middle Eastern backgrounds in SWSAHS (Chapter 2.6).

5.2.4.1. Implications for Menu Design

Support for the adoption of an a la carte menu for the Middle Eastern Menu is offered by many aspects of the above discussion.

Firstly it allows the incorporation of the diversity of the cultural group within resource constraints (HAHS, MHU, 1990). The recommendations to include the foods identified in tables 5.2.1.1-5.2.1.4. may appear extensive. In conjunction with the probability of additional items being availed from the results of further research, they may emerge as unfeasible or unrealistic. However, Williams (1990) notes that typically 10-20 hot items can be offered with a al carte menu design and cook-chill technology.

Many hospitals overseas are adopting such strategies and reporting increases in patient satisfaction, improved nutritional status of inpatients and, cost savings and profit increases (Parsons, 1992 a, c; Anon, 1985, Roberts, 1982, Hunwick, 1978, cited in Williams, 1990,p. 2). Australian authors support these findings and recommend that Australian hospitals adopt such strategies for effective and efficient menu planning (Arney and Tiddy, 1992 a, b; HAHS, MHU, 1991; Williams, 1990).

Secondly, my data suggest that a planned menu cycle is an inappropriate way to provide this client population with their food related needs as it does not accommodate their
religious or cultural requirements. The obstacles lie in the Standards For Food Services outlined by the NSW Department of Health (1989). On the one hand it is stipulated that dietary planning should;

ensure that inpatients are provided with meals, mid-meals and or feedings that meet their individual nutritional requirements as well as making provision for their religious; ethnic and vegetarian preferences (p. 3).

Yet other principles conflict with attaining this, particularly that pertaining to Varieties and Repetition (NSW Department of Health, 1989, p. 6-7). There are three observations related to this:

"a) Generally, the same food should not be served twice on the one meal or even twice on the same day. Where an exception is made, in case of a staple food such as potatoes, method of presentation or preparation is varied, e.g. use sliced boiled potatoes, jacket potatoes, sauteed potatoes or potato balls instead of repeating mashed potatoes.

b) Repetition of flavours in the same meals is to be avoided, e.g. tomato soup and grilled tomatos.

c) The same dish should not be served on successive days or on the same day of each week."

Such stipulation's preclude Assyrian Christians from having a fish meal available to them at each main meal on both Wednesdays and Fridays. Further, it is noted that few institution offer vegetarian options at every main meal (Kokkinakos, 1993-pers. comm.) indicating that these clients also are not likely to have culturally appropriate non meat option available to them on these days. Another example relates to the women in group 3 who report of the Lebanese cultural practice of consuming CHICKEN SOUP and associated chicken dishes for nine consecutive days post partum (Chapter 5.2.2.1)

Further, some participants identified that familiarity of foods was a significant aspect positively influencing their perceptions of the food service and eating in hospital, and further reports that they would order familiar dishes consistently if they were available. This is inconsistent with other data which suggest that patient familiarity with foods negatively influences their perception of the food service (Mailer et al, 1980). Planned
menu cycles are designed to avoid familiarity which provides further support for their lack of appropriateness for this group.

Finally, my data suggest that the adoption of an a la carte style menu's providing all the choices recommended from tables 5.2.1.1-5.2.2.4. will positively influence the healing process for many patients from Middle Eastern backgrounds, as it will give them the freedom of making food choice consistent with the "requests of their appetite", which participants identified as significant in the healing process (Chapter 5.1.2). Williams (1990) recommends that inpatients be given such control of their eating habits as one strategy of achieving an effective and efficient food service for the future.

The possibilities to provide these recommendations logistically have been implicated the challenge now lies with the dietitians and food service staff to work with the communities to develop the menus so that they are both nutritionally sound and culturally sensitive. The next phase of the study offers the ideal avenue for this and the first step to meeting the education needs of both groups as identified in chapter 5.1.6.
5.3. **ACCEPTABILITY OF CURRENT FOOD SERVICE AND SUGGESTED CHANGES**

Participants were divided in their views about this issue. Generally the Lebanese men in both sessions were resistant to admit otherwise and reported that it was very acceptable. While the women in both groups expressed more dissatisfaction. The young Assyrian men could only comment based on anecdotal accounts of current food services due to their lack of experience with the Australian health care system.

5.3.1. **REASONS FOR ACCEPTABILITY**

The initial responses of the majority of participants appeared to be influenced by their notions of health and illness and the belief that the doctor/hospital have authority and expertise to know what is best to eat when a person is sick (chapter 5.1.5) and hence the respect and acceptance of the food.

"I could not eat the foods while I was there- But I am not complaining about the hospital food" *(GROUP 2-15/7/93)*

"I can not say anything, they bring me here and treat me for free. I can not complain one word, of course I find their food acceptable" *(GROUP 1-21/7/93)*

"It is the responsibility of each person to accept whatever food is available to them in hospital. They can not reject the food and say NO I don't eat this food" *(PILOT-7/7/93)*

Some found it very acceptable:

"The food they bring is the best food they have and it is the best thing the hospital does. It comes to you morning, noon and night and in between. It is the best quality and the best type for illness" *(PILOT-7/7/93)*

"Bankstown hospital top food, the best" *(GROUP 1-21/7/93)*
"I liked the food while I was there it was a nice change for a short time" (GROUP 3- 28/7/93)

"I ate it and enjoyed most of it except the soup which was too spicy" (GROUP 2- 15/7/93)

"I told my wife to take the food back home" (GROUP 1- 21/7/93)

Mailer et al (1980) suggests that if an inpatient feels or knows that a food is better for them, as in special diets, they are more tolerant of it. In light of the notions expressed in chapter 5.1.5, regarding food as part of their treatment this may offer another explanations for these responses.

Another reason participants were reluctant to admit that the food was other than acceptable was the notion that they had choice. Participants perceived that the provision of a menu slip listing a range of foods, and the freedom to self select items indicated that they had choice. They cited that this is superior to practices in their country of birth where "you are offered what is available" (GROUP 1- 21/7/93, 4- 28/7/93). In the context of Middle Eastern culture to complain about such freedom is disrespectful (Lipson and Meleis, 1983; Meleis, 1981).

Participants could not see that the practices here are essentially the same as those at home. The issue of 'choice' goes beyond having the opportunity to select one item from a range of other unsuitable items. Williams (1990) identifies that menus of the future need to offer inpatients real choice and entitle them more control over the food they receive in hospital. Recommended strategies to achieve this include adoption of a la carte menus and keeping in touch with the needs and wants of clients. These strategies are being adopted in the development of SWSAHS culturally specific food service indicating a good starting point for the service.
Other participants expressed extreme dissatisfaction and unacceptability:

"We don't like it, we don't like it. It just does not taste good" (GROUP 2- 15/7/93)

"I have known other people in hospital and they also did not eat any of their food. They did not like it and they asked me to bring Assyrian foods in for them" (GROUP 2 -15/7/93)

"What was available did not satisfy my wife so she asked me to bring food in from home" (GROUP 1- 21/7/93, GROUP 4- 28/7/93)

"I was there three weeks and I did not eat one of their meals the whole time I was there" (GROUP 3- 28/7/93)

"I had no desire to eat their food in hospital" (GROUP 3- 28/7/93)

"I did not like the food" (GROUP 3- 28/7/93)

5.3.2. REASONS FOR UNACCEPTABILITY OF FOOD SERVICE

5.3.2.1. Food Issues

Those who identified the food service as unacceptable listed many influencing factors. Regarding the food they include: it is bland, there is no taste, the meat is undercooked, it smells bad, it is always cold, the serving size was not enough, there was not enough bread, I did not like the way it was prepared.

Many of these complaints are consistent with those cited in the literature as common patient complaints about hospital foods (Madhock et al, 1992; Samolsky et al, 1990; Inguanzo and Harju, 1985; Maller et al, 1980). Experts report that the implementation of a cook-chill system has the potential to overcome some of these problems such as the meal temperature (Mathews, 1992; HAHS, MHU, 1991; Fusco, 1987) and flavour
Retention with possible increases in flavour (Kokkinakos, 1993-pers. comm.). The other issues require consideration in the planning and development of the menus.

This issue of not enough bread appears to be culturally specific. The significance of bread in the diet of people from Middle Eastern backgrounds is reported in chapter 2 and chapter 5.2.2.6 of this research. The participants reported that one change they would make is to provide a bread roll or two slices of bread or half a piece of Lebanese bread at each meal to increase satisfaction.

The way food is prepared is common complaint among clients from NES backgrounds as much of it is unfamiliar (Madhock et al, 1992; Samolsky et al, 1990). Chapter 5.2 details how the preferred cuisine of participants in this research differs from that which may commonly be available in Australian hospitals. For example, the Lebanese women in group 3 recounted the importance in having boiled chicken for lactation and being disgusted and horrified by the red/brown roast chicken they were served. Fish is commonly baked or grilled. Participants reported being served steamed fish in hospital which was extremely inappropriate and looked unappealing. The implications for menu planning to increase patient satisfaction with the food service is to consider the culturally acceptable way to present and prepare these foods. The feasibility was discussed throughout chapter 5.2.

The women in both groups and the young Assyrian men specified the preference for larger serving sizes. Williams and Brand (1989) report that almost 25 per cent of all NSW hospitals do not offer patients a choice of serving size. They further note that allowing patients to nominate their own serving size is one strategy to assist menu planners wanting to improve the nutritional standards of their menus. I recommend that in designing all their menus, SWSAHS give patients the choice of serving size for each meal.
5.3.2.2. Service issues

Participants identified other aspects of the food service beyond the food which influenced its acceptability. They include: the meal patterns and times, the environment, their mood, gender, not being able to recognising food on the menu, limited choice in which religious factors play a significant part, and not knowing who made it and how it was made.

Gender influences are relate to cultural norms of this group. The women in this research were more likely to report other areas beyond the food. This is likely to be related to the fact that traditionally Middle Eastern women are responsible for all home and family related duties (McCallum, 1990). Therefore intuitively they are more aware of other aspects of the service.

Mood and environment are identified in the literature as common complaints effecting inpatients perceptions of their dining experience (Rosich and Garey, 1990; Maller et al, 1980). Limited choice is also reported as a common complaint among the general hospital population (Williams, 1990; Inganzo and Harju, 1985).

The influence of Religion

The specific role of religion influencing choice is noted as a problem for clients from NES backgrounds (Madhock et al, 1992; Samolsky et al, 1990; Webb and Manderson, 1990). Williams (1990) asserts that it is time that hospital catering departments offer their clients real choice including considering the cultural mix of the population.

Both the Assyrian and Lebanese participants identified that their respective religious beliefs did limit their choice in selecting foods in hospital.
The Assyrian participants stated that the current food service provides limited choices for many Assyrian people who choose not to eat meat Wednesdays and Fridays for religious purposes. They stated that the availability of fish meals, and culturally appropriate non-meat options on these days would assist in making the food service more appropriate and acceptable for many Assyrian people. The inappropriateness of current menu planning principles and practices in attaining this was discussed in chapter 5.2.4.1. It also reinforces my suggestion for further research to identify additional culturally appropriate non-meat options for the Middle Eastern menus.

The Muslim participants specified that they needed to avoid pork and any derivatives and that this influenced eating other foods in hospital because they were not aware of what was in the foods. Many additionally reported that, not knowing by whom, and how the food was made influenced their eating in hospital.

Twaigery and Spillman (1989) and Sakr (1971), assert that these are significant aspects of Muslim dietary law. Further they report that Muslim clients are consequently placed in distressing, situations when they are institutionalised and often go hungry as a result of this. My participants made comments consistent with this.

"When we are in hospital we avoid eating the meat and try to choose something else they provide, but it is very hard when you don't know how they cooked it " (GROUP 3-28/7/93)

"I told them that I would eat anything as long as it had no pork. Pork is absolutely prohibited." (GROUP 1-21/7/93, PILOT- 7/7/93)

"If one is not sure he can ask for Gods forgiveness before he eats it, but every attempt should be made to avoid it" (GROUP 1- 21/7/93)
Participants noted that the availability of Halal options, such as chicken and meat, on the menu is considered an appropriate strategy to increase acceptability. However, many expressed doubt about the validity of it.

"It may say Halal on the paper (menu) but how do we know that it has been killed and handled the right way or who did it" (GROUP 1- 21/7/93)

I tried to reassure them by explaining that hospitals are bound by laws, so if they stated that a product is Halal they could be confident that it was. While this eased some participants' conscience others obviously wanted to avoid further discussion on the issue. Others were surprised and excited by the potential that it would even be considered as an option for them.

Madhock et al (1992) notes the same responses with 'Asian' clients in a British hospital. Participants in their study reported increased positive opinion of the food service when they were informed of the availability of 'Asian' food on admission, and being reassured that it was consistent with their religious requirements. I recommend this strategy in the implementation of the menus for the target population represented in this research. This reinforces my recommendations to adopt Halal products as standard items on the Middle Eastern menus, a recommendation supported by Sakr (1971).

*By whom and how is the cooking done?*

While religious influences prompted this concern for Muslim participants, the same concern was indicated by participants in both Assyrian groups.

Many participants, particularly the women, identified that if they knew both how and by whom the meals are cooked; or in some way could be assured that the foods conformed with their religious beliefs they would feel more comfortable and they would find the food service more acceptable.
"If they had a Lebanese person doing the cooking we would be assured that we are getting the right meals. This would make the food and our stay more acceptable" (GROUP 3- 28/7/93)

"We would be more comfortable if we knew who made the food or if we knew that the person doing the cooking was shown by one of us how to do it properly" (GROUP 3- 28/7/93)

One reason for the participants reluctance to identify changes which pertained to the provision of culturally specific food, was because they thought it was too difficult for non-Lebanese or non-Assyrian people to do and that it would be too problematic for "the hospital" to include:

"It may be easy to talk about these dishes and to read a recipe but it is different to do it. They need to be shown how to do it" (GROUP 3- 28/7/93)

"It is very hard to make these foods, they will need to be shown" (PILOT- 7/7/93, GROUPS 1- 21/7/93, 2-15/7/93, 3- 28/7/93, 4- 28/7/93)

However Anthony et al (1993) identifies the contrary, they state that Lebanese cuisine is easily mastered by preparing and organising the menu. By having a small selection of raw foods and a large variety of substantial dishes can be made, with very little resultant wastage. Moreover most dishes store and reheat well. These characteristics are beneficial to fit into the hospital needs very well.

The literature cites that patients perceptions of the quality of the food they receive in hospital influences their acceptability of the food service (Rosich and Garey, 1990, Williams, 1988). The concern is evidently compounded by religious and cultural factors for people from NES backgrounds. The HAHS, MHU (1988, p. 1) justify this concern stating that "When preparing ethnic meals in order to maintain authenticity and taste, recipes must be followed precisely." It is likely that much of the concern expressed by
participants can be related to the cultural significance and the associated pride and emotion tied to food habits of Middle Eastern people (Kittler and Sucher, 1989; Barr-Stein, 1979).

These issues support the significance of the training phase of SWSAHSs' study. Involving members of the community in this will reinforce the appropriateness of the food service for their religious and cultural needs. Indeed all were enthusiastic to be involved and many expressed that this would reassure them of the quality and value of the food. They also stated that it would increase the acceptability of the food service and make their stay more comfortable, consequently aiding in the healing process.

**Meal patterns and times**

Meal patterns and times were a significant issues effecting the perception of the food service for all participants. Meal times were considered too early, where the times of dinner caused the most dissatisfaction. The preferred pattern by all groups resembled that of traditional eating practices (Anthony et al, 1993; Kittler and Sucher, 1989; Barr-Stein, 1979).

The breakfast meal elicited the least level of dissatisfaction among all participants. Generally they preferred a continental style breakfast with an egg option. Coote and Williams (1993) cite this to be a consistent preference among most hospital patients.

They inclusion of a few culturally specific staples will ensure the appropriateness. Specifically, breakfast options need to include LABNEY, olives, and cheese. LABNEY is more important for the Lebanese participants. The Assyrian participants identified a preference for corn flakes and other breakfast cereals that the Lebanese participants did not.
The participant identified that any cheese would suffice. The Assyrian woman specified Ricotta. The Lebanese EHWs stated that Haloumi and Fetta cheese are most commonly used by Middle Easterners. Though all EHWs agreed that the prepacked serves of tasty cheese would suffice. The options of yoghurt and cheese are consistent with the NSW Department of Health's (1989) recommendations for additional choices to hospital continental breakfast menus (cited in, Coote and Williams, 1993).

Initially participants in all groups considered lunch to be the main meal and dinner a light meal or snack. However they were responding in the context of their usual practices. Once it became apparent that in the majority of NSW hospitals dinner is served between 5:00 and 6:00 pm (William and Brand, 1988), they quickly declared that a light dinner meal would not be acceptable. The women in both groups were immediately identified this. The young men in group 4 eluded to it much later.

"The dinner time is too early, no one eats dinner at 6:00 pm." (GROUP 2 - 15/7/93, GROUP 3 - 28/7/93, GROUP 4 - 28/7/93)

"If one eats dinner at 6:00 pm then he will be hungry again at 9:00 pm he will need to eat something again then" (GROUP 4 - 28/7/93)

"At home we have lunch (our main meal ) at about 3:00 pm and then we have a light meal at about 9:00 pm" (GROUP 2 - 15/7/93)

(GROUP 3 - 28/7/93):

"Dinner at 6:00 is too early, especially for a lactating woman, and their meals are so small. No, dinner must be a heavy complete meal in hospital to get you through the night."

"Yes and something light like a sandwich or LABNEY and cheese before one sleeps."
The men in the pilot study did not directly state this but they implied it in their responses. For example;

"A light dinner of steak and potatoes and vegetables, with some bread and tea is nice and then at about 9:00 pm a sandwich or LABNEY or cheese." (PILOT- 7/793)

Lunch and dinner were areas perceived participants as requiring most change. Participants identified they would like to have culturally specific food at these the meals (as presented in Tables 5.2.1-5.2.4).

"It would be good to have our food available at these meals because we are not eating the food they are providing us we are bringing it from home. "(GROUP 3- 28/7/93)

Participants cited that they would most likely prefer one of the 'heavier' meals such as stew and RICE at lunch time. For dinner they reported that they would chose either a smaller serving of the same meal or a lighter meal of grilled meat and salad, or soup and sandwiches. This reinforces the recommendation to include options for serving sizes on the menu. Some of the Lebanese men indicated that they would like to have the option of these foods and those on the main menu.

Participants also identified that they would prefer the meal times, particularly dinner, to be later. Failing this they suggested that the serving sizes be increased at each meal and more substantial mid meals be offered. Supper was considered the most essential mid meal to have to compensate for the long overnight gap

The Lebanese women identified this as a particular matter of concern for obstetric patients. One of the Assyrian men supported this concern as he recounted having to bring food in for his wife after she gave birth in an Australian hospital.

"They bought my wife those tiny triangles. I had to bring her food from home as this is not enough to satisfy anybody, especially since she had not eaten anything since dinner the night before" (GROUP 4 -28/7/93)
Coote and Williams (1993) suggest that obstetric patients are put at nutritional risk due to the large (often 15 hour) overnight gap and the trend of the hospitals to move towards adapting continental style breakfast, similar to that preferred by my participants. Chapter 5.2.2.4. discusses practical recommendations to overcome this with these participants.

Based on this discussion participants reported that they found mid meals essential to compensate for the long wait between meal times. Supper is identified as the most significant meal to ensure one does not get hungry. Commonly, sandwiches or light continental snacks resembling breakfast are considered appropriate for supper. It was identified that all sandwiches preferred included meats, or cheese to make them substantial. Fresh fruit is preferred by all as other mid meal snacks.

Williams and Brand (1989) support the need to revise the traditional meal patterns in NSW hospitals. They assert that such practices are inconsistent with the times that most people eat at home. Further, that patients in our hospitals run the risk of being undernourished as a result of some these practices being inappropriate for them.

My data show that the meal patterns and times in hospital are inconsistent with Middle Eastern practices. In conjunction with the cultural influences of eating in hospital for this group the suggestion of nutritional compromise is heightened.

Additionally a review of patient menus in NSW hospitals made no indication that fresh fruit or sandwiches are offered as mid meal options (Williams and Brand, 1989). Indeed that only three per cent and seven per cent offer afternoon tea and supper respectively (Williams and Brand, 1989). Most commonly hospitals serve sweet biscuits with tea or coffee. While participants agreed that this was nice they noted it was not substantial enough. Further it is nutritionally inferior to the fruit preference identified by my participants.
Success in increasing both patient satisfaction and profits has been cited overseas by experimenting with a number of smaller meals scattered throughout the day (cited in Williams, 1990). Such practices are more consistent with traditional eating patterns noted by my participants and resemble the style of eating now recommended by nutritionists.

Changing meal patterns and times are realistic and feasible with a cook-chill food production system (HAHS, MHU, 1991), and have been recognised as a simple strategy to improve the nutritional care of clients in NSW hospitals (Williams and Brand, 1988). I recommend that SWSAHS consider this alternative in implementing the new food service to all their clients.

What's on the menu?

Finally, the issue of acceptability of the current food service being influenced by the inability to understand the menu is also very significant and has implications for successful menu planning and increased satisfaction for this group. Some identified lack of proficiency in language as one barrier to this but on the whole it was lack of familiarity with the foods. That is, they could not understand what many of the dishes meant.

This is common among people from NES backgrounds (Madhock et al, 1992). Williams (1990) identified that many of the menu's in NSW hospitals are unimaginative, difficult to read, poorly produced and are not easy to complete. He suggests that a more descriptive naming of menu items is one effective strategy to assist in nutrition education of inpatients. Maller et al (1980) also suggests that descriptive menus are important in increasing patient satisfaction.

Arney and Tiddy (1992 b) found the importance of using both ethnically and locally acceptable names for inpatients to understand the food on the menus. Moreover they
suggest that recognition of composite meals is assisted by listing some ingredients of the dish (using HOMOS as an example)

Participant in this study made comments consistent with this. The Lebanese women in group 3 stated that descriptive menus would be an effective strategy to help understand what the menu items were, consequently increase that acceptability of the current food service, and decrease the distress and embarrassment caused by not understanding.

some women identified that;

"Once you know what you are ordering you can at least pick the food." (GROUP 3- 28/7/93)

"Once I was familiar with what it was I could try it and decide if I liked it" (GROUP 2- 15/7/93, GROUP 3-28/7/93)

They recommended that such a strategy should also be employed in the development of the Middle Eastern menu as many nations have different names for the same dish. I support this recommendation in the development of the Middle Eastern menus for SWSAHS residents. It also reinforces the previous recommendation for more research to assess the culturally appropriate names, spelling and descriptions for the menu items for the major groups in the area.

5.3.3. ACCEPTABLE BUT INAPPROPRIATE.

As the discussion unfolded it became clearer that all participants believed that the hospital food service was acceptable and they did not want to speak against it. Yet they did believe that it was inappropriate for people from Middle Eastern Backgrounds. This change in consistency occurred through a great deal of negotiation. I found that the use of the word acceptability implied a value judgment to participants, once we found
acceptable ways of expressing the lack of appropriateness participants were more willing to discuss other preferences.

Similarly, participants were initially hesitant to comment on suggested changes. The way I phrased the question and, the participants cultural perceptions of encounters with the health care system (chapter 5.1.5.) are likely to explain this.

The women in both groups were more uninhibited as they relaxed and opened up. The Lebanese women were the most uninhibited. The Lebanese men in both the pilot study and group 1 reported conflicting comments and appeared indecisive. Many reported their views through the third person the following excerpts explicate this. The young Assyrian men could not comment based on actual experience, but from our explanation of current practice they agreed that some would not be appropriate for all Assyrian people.

"It might be acceptable to us, but for others it might not be, to offer them our food would be good as this would make them happy "(GROUP 1- 21/7/93)

"The food they have is very acceptable but if they increase variety to include Arabic food it will be even more acceptable" (PILOT- 7/7/93)

"We agree that the current food service is not appropriate for the Assyrian community but by making some small changes as we have discussed it will be more acceptable" (GROUP 2- 15/7/93)

"At home we must prepare what they [the sick person] request. In hospital it would be nice if they can have some BÖRSH, BOUSHALA and other foods we have mentioned "(GROUP 2- 15/7/93)

The Assyrian participants in both groups identified that the current practices are likely to be most inappropriate for older Assyrian patients. While the women in group 2 identified
that current practices would be very acceptable for Assyrian children who have been bought up in Australia;

"Our kids do not eat much Assyrian food. Even when they are sick they ask for Australian food. We give it to them because that is what they want." (GROUP 2- 15/7/93)

"The food they have in the hospital will be O.K. for the kids bought up here." (GROUP 2- 15/7/93)

An older, more traditional lady among the group who has been in Australia less than four years, expressed shock and disbelief at such responses.

"Not when they are sick!" (GROUP 2 - 15/7/93)

The Lebanese women believed that current practices are most inappropriate for obstetric clients. Unlike the Assyrian woman, these women noted that the culturally specific meals they had identified (Table 5.2.1.3) are appropriate for Lebanese children, though they would require modification to be lighter. They made no indication whether the current service would be appropriate for their children.

Assessment of the demographic profile of participants may explain this difference in perception and practice. All but one of the women in group 2 have been in Australia longer than four years. Most reported an average of 18 years. While those in group three who signed the consent forms are all relatively new migrants (length of residence <4 years).

The literature provides the need to provide the elderly (HAHS, MHU, 1990) and obstetric inpatients (Duke, 1988), particularly those from NES backgrounds, with their food related needs. This is particularly pertinent to SWSAHS in light of the increasing proportion of aged and the large number of obstetric clients among the Areas Middle Eastern community (chapter 2.5.2).
Additionally the above discussion suggests that more recent arrivals retain their traditional eating habits. In light of the current population trends indicating an increase in the proportion of new Middle Eastern migrants in the area (Brittain, 1993-pers. comm.) the provision of culturally appropriate food also is indicated to meet their food preferences.

**Reflections of the inappropriateness**

The degree of unacceptability and inappropriateness was evident through many of the participants reports. For example a large number of participants admitted that they had friends and family bring culturally appropriate foods in for them, or alternatively that they did the same for family or friends who were hospitalised.

Visitors will often bring food to hospitalised friends and relatives as an expression of care, or for patients who wish to supplement their diet. However, inpatients should not *have* to bring food in from home principally to compensate for the food available in hospital.

Particularly in light of the role of food services, and the existence of polices which define actions to ensure that the food related needs of clients from NES backgrounds are accommodated (HSDU, SWSAHS, 1993; Government’s Mainstreaming Policy, cited in HSDU, SWSAHS, 1991; HSDU, SWSAHS, 1991; NSW Department of Health, 1989; NSW Department of Health, 1987).

Maller et al (1980) state that patients supplementing there meals is indication of the practical importance for hospital food service departments to provide highly acceptable food and to continue efforts to improve the acceptability to clients.

My data reflect the importance of this for clients from Middle Eastern backgrounds as there is an indication that they are not eating. Additionally, the conflict they experience in
doing so should not be allowed to prevail in our Multicultural society, which allegedly is committed to a universal policy of Health for All. Moussa (1991) agrees in describing the agonising choices that Arab-Australians experience in the health system and add that in today's society no community should experience such conflict.

Participants stated that the provision and endorsement of culturally appropriate food would reduce stress and conflict and increase acceptability of the food service, which ultimately influences their healing as identified in chapter 5.1.2.

"Getting better in hospital is helped if you can have the food you want" (GROUP 3- 28/7/93)

"If our food was available I would order it because I know it would be OK. But if it is not available how can I order it" (GROUP 1- 21/7/93)

A comparative reflection

Table 5.3.3.1, Appendix 8 provides a comparative example of the degree of inappropriateness and unacceptability of the current food service in NSW hospitals for people from Middle Eastern backgrounds. The food preferences for people from Middle Eastern backgrounds and those of a sample of Australian hospitalised inpatients are tabulated.

The data for the former group have been collated using the finding of this research in conjunction with literature on the traditional eating habits of the group (Anthony et al, 1993; Kittler and Sucher, 1989; Barr-Stein, 1979; Grivetty, 1975). The data for the latter group have been adopted from Williams (1988) study on the food preferences of a sample of Australian inpatients, which was designed to assist hospital caterers develop more appropriate menus for Australian inpatients (people from NES backgrounds were under represented in the study population). Amey and Tiddy (1992 a) collected similar results
to Williams (1988) in their study of Food preferences of older inpatients at a repatriation general hospital.

Summarising this information, many of the foods reported as least preferred by William's (1988) participants have been reported as most preferred and significant to participants in this study and in the traditional food habits literature for the target group (Anthony et al, 1993; Kittler and Sucher, 1989; Barr-Stein, 1979). For example okra, plain yoghurt, olives and fried liver and kidney. These are foods which I have recommended for SWSAHS Middle Eastern menus. Others not recommended as menu items but have been reported as preferences for Middle Easterners include radish, blue vein cheese and brains.

Similarly least familiar foods reported by William’s (1988) participants include foods which are staple in the Middle Eastern diet e.g.; okra, lentils, chickpeas and eggplant. Ricotta cheese and artichokes are also very popular among my study population.

CREAMY RICE was stated as a very popular and therapeutic dessert among my participants, yet Williams and Brand (1989) report this to be an old fashioned and unpopular dessert.

The remaining foods reported by the Australian clients as either unpopular or unfamiliar are likely to also be identified as such by the Middle Eastern group. Though much of the data can be misleading this relates again to the issues of meal preparation and presentation. This discussion reinforces the perception that the eating habits of this group is significantly different from that of the Anglo-Celtic population as conceded at the outset of this report. It indicates that if such data is being used as the basis for menu planning then we are consistently going to have inappropriate menus for ethnic clients particularly those from Middle Eastern backgrounds.

The issues regarding the inappropriateness of menu planning principles (chapter 5.2.4.1.) for this population also reflect the inappropriateness of the current services to this group.
5.3.4. IMPLICATIONS

The discussion presented above denotes that many areas of concern and dissatisfaction with the current practices of hospital food services for my participants equate with those stated for the majority of hospitalised clients. The situation becomes inequitable because these factors are compounded by the lack of consideration of menu planners, Australian institutions and government agencies in recognising the specific cultural issues which influence health and illness for all people from NES backgrounds.

Inguanzo and Harju (1985) state that once research has found that negative impressions exist regarding any non-clinical aspect of patients care there should be no reason to allow such impressions to prevail. Madhock et al (1992) confirms this specifically for food services to ethnic groups, and Parsons, (1992 b) cites this for food services in general. All authors confirm that there is no room for complacency, which is a significant issue in the competitive health care environment of the 1990s (FM staff, 1992; Madhock et al, 1992; Parsons, 1992, b). They also contend that patient satisfaction should be consistently monitored to appropriately direct service provision. Most commonly patient satisfaction surveys are used in hospitals. The unreliability of these measures have been well documented (Rosich and Garey, 1990; Kernish et al, 1988; Carvey and Pasovac, 1982).

My data indicate that these methods would be inappropriate and yield invalid results with these participants due to the language barriers, and the cultural perceptions regarding the authority of the health system and their role in it (chapter 5.1.5). Yet the need for more research and monitoring of satisfaction of the new service has been well recognised in this research and others (Meleis, 1981).

Successful strategies to monitor satisfaction of clients from Middle Eastern backgrounds should emulate that adopted in this research. Williams (1990) supports this as a
successful strategy for the majority population. Such strategies are required because current practices are inappropriate, yet it was challenging to get the participants to disclose this. The strength of the focus group method in attaining this data also has been supported throughout this research process.

All the suggestions are within the responsibilities of Hospital Food Services (NSW Department of Health, 1889), and are feasible with the adoption of a cook-chill system and a la carte menus (HAHS, MHU, 1991; Williams, 1990; Williams and Brand, 1989; Williams and Brand, 1988).

My data indicate that ensuring satisfaction with the food service goes beyond the provision of culturally acceptable food choices alone. The most significant concern expressed by participants in all groups was that pertaining to the preparation of the food. This concern indicated the need for training of the cooks. However, training of the cooking staff is not indicated specifically to ensure that the meals for the Middle Eastern community are prepared authentically. All the relevant literature state this as a crucial component for success in the implementation of a cook-chill system (Mathews, 1992; HAHS, MHU, 1991, Fusco, 1987)

The training session can be used as an education strategy for both staff and the community. As the seemingly common recipes will require modification to comprise one 'common' recipe and, all will require modification to conform to nutritional standards, and it is not known how Middle Eastern Cuisine will fit in the cook-chill system. Together compromises can be negotiated and increased awareness and sensitivity of each other's needs can be cultivated.

All the relevant literature cites the importance of hospitals incorporating patients' preferences into its food service program (Arney and Tiddy, 1992 a, b; FM Staff, 1992; Madhock et al 1992; Williams, 1990; Samolsky et al, 1990; Lutz, 1989; Maller et al,
Considering this strategy in menu development is now being recognised as one which indirectly effects cost control and profit. Increasing patient satisfaction reduces food wastage and enhances the image of the institution.

The importance of image enhancement was indicated in this research. Many participants held Bankstown Hospital in high regard, as they recounted their experiences there. Others reported extreme dissatisfaction with the services and experiences they received in a hospital in another health area, and recommended to other participants not to go there.

Williams (1990) identifies that one outcome that hospital administrators are looking for in food service diversification efforts is to enhance the image of the institution. Simple strategies are indicated to attain and maintain a positive image among the Middle Eastern community. They include:

* The adoption of Halal meats on the menu, and the reassurance to clients of this.

* More descriptive menus, which are also translated into Arabic and Assyrian.

* Involving the community in all deliberations regarding the development of the food service.

* Later, marketing the meals out to other institutions which do not have the facilities to provide their Middle Eastern clients with culturally appropriate meals, and to other organisations such as MOW.
CHAPTER 6

RECOMMENDATIONS

The results of this research can be applied into the development of SWSAHS menus in the following ways. These recommendations summarise the discussions presented in the preceding chapters.

6.1. MENU PLANNING

6.1.1. Food Issues

- Tables 5.2.2.1 - 5.2.2.4 outline the foods I recommend to be adopted as menu items on the Middle Eastern menus.

- **Standard beverages** for all meals and mid meals should include water, DAWEE, orange juice, tea, coffee and a choice of full cream, reduced fat or low fat milk.

- Fresh fruit should be available as an option at each main meal and midmeals.

- **Standard mid meals should include:**
  - Lebanese bread sandwiches, filled with LABNEY, cheese, egg. Alternatively patients could be provide with the composite ingredients to the Lebanese sandwiches and they could make the sandwiches themselves.
  - Sliced bread sandwiches filled with: roast chicken and salad, roast lamb and salad, cheese and salad, egg.
- Continental snack comprising, LABNEY or cheese, and Lebanese bread and olives.

- Tub or natural yoghurt. Halal products should be adopted.

- A choice of standard beverages

6.1.2. Service Issues

- Provide three mid meals a day, offering a choice from the standard mid meal list above. It is particularly significant to offer a supper option in light of the long overnight gap between meals. This should be a standard service to all clients.

- All recommended foods should go on the Middle Eastern menus for cultural, religious and logistic purposes.

- Halal products to be used where there is a choice of such products, for example yoghurt, meats. This also will be appropriate for Muslim clients from other ethnocultural groups.

- Clear indication on both the Middle Eastern and the main menus of Halal products and products free from pork or pork derivatives.

- Develop all menus so that they are more descriptive, using culturally appropriate naming and descriptions of the foods for each respective group.

- Offer a choice of small, medium and large serving sizes on all menus.
• Provide facilities for obstetric clients from Middle Eastern backgrounds to make their herbal teas. Either, microwaves for women to heat home made preparations, or a small heating element so that the women can bring in a jug and the herbs to prepare the tea themselves.

• All Middle Eastern clients should be informed of the availability of the Middle Eastern food service and informed about the process on admission. This includes informing obstetric clients of the availability of the tea service and reassuring Muslim clients of the validity of the Halal products and other non pork containing products.

6.2. CONSIDERATIONS

• Adopt an a la carte menu system for Middle Eastern menus.

• On site kitchens to have a constant stock of yoghurt, olives, cheese, bread and fruit as these are staples in the diet of people from Middle Eastern backgrounds. These basic ingredients can be used to prepare a variety of snacks or meals to satisfy a large proportion of people from this community.

• Prepare yoghurt (LABEN), LABNEY and DAWEE at each respective receiving kitchen for efficiency purposes this also ensures that products are made to the Muslim clients religious specifications. Alternatively, commercial products could be bought ensuring that Halal options are chosen.

• Contract with Halal butchers to supply the meat for the Middle Eastern menus. A cost analysis needs to be undertaken to assess the most feasible way of allowing this. In considering costs, it is worth noting that the Muslim population is the largest minority religious group in Australia, therefore Halal meats are likely to be appropriate to a larger portion of SWSAHS clients.
• Buy the basic KAFTA and KIBI mixtures pre-prepared from the butchers, again contracting from Halal butchers for this meat.

• Consider ways of promoting the use of Halal products to reinforce the validity of the claims to the clients.

• Prepare all fish dishes in the receiving kitchens. Due to the cultural significance of fish in the diet of these clients it is important to ensure the best quality product is served to them. Fish has been reported as not responding well to the cook-chill food production process.

• Sell natural almonds and walnuts in the kiosk and on the patients shop trolley. Specify the availability of these to obstetric clients.

• Promote the use of olive oil on the menu. Clearly label or describe products which incorporate olive oil.

• Due to the cost, I recommend that olive oil be used in these foods in which it is an essential ingredient in the authenticity of the food, such as LABNEY and in the preparation of salad dressing, alternative mono- and poly-unsaturated oils can be used in the preparation of other dishes.

• Trial the following items on the main menu to increase variety for other clients.
  
  • KAFTA mishwee - with salad accompaniments
  • KIBI baked - with salad accompaniment
  • Fish dishes, with salad or vegetable accompaniments
  • Soups
  • LOOBI and rice (green bean stew)
  • Lebanese bread sandwiches
• Trial the following items and variation on the cafeteria menu:

  • KAFTA/CUTLETS in Lebanese bread sandwiches, or with salad
  • KIBI with salad accompaniment or prepared in yoghurt or tomato sauces
  • Lebanese bread sandwiches
  • RED RICE
  • -Soups

• Market Middle Eastern menus to other hospitals with large Middle Eastern or Muslim client bases but who do not have the facilities to cater for their perceived needs and preferences. Other agencies such as MOW, also can be approached. This strategy will assist in enhancing the image of the Area Health Service and raise revenue to continue to improve the services to its clients. It also extends equitable service to Middle Eastern and Muslim clients outside the Area, and increases choice for all other clients in these respective institutions.

• Piloting the new menus in one of SWSAHS hospitals with a large Middle Eastern client base will assist in testing the acceptability of the menu items, menu designs, and the food service process.

• Possibility of employing a Middle Eastern cook or kitchen hand at the CPU. This was identified by participants as a significant strategy to assist in increasing the acceptability of the food service to members of the Middle Eastern community. In this way Middle Eastern clients would feel assured that the food was being prepared authentically to meet their cultural and religious needs. The literature supports having community representation at such levels as an effective strategy in the development of appropriate services for respective ethno-cultural groups.
6.3. FUTURE RESEARCH

- This study only set out to determine the views of a sample of the Middle Eastern community in SWSAHS regarding their hospital food preferences, feasibility and cost analysis for these proposed changes need to follow.

In doing these analyses, it should be considered that the foods in Table 5.2.1.1 - 5.2.1.4 represent those which participants identified as essential to have, they were very selective in naming these foods as they were very conscious of labour and cost issues.

- Notions of health and illness were identified here but there is a need to ascertain those specifically relating to special diets. These discussions yielded some indication that participants have a great deal of misconception regarding these areas, but it was not within the scope of this research to pursue these. Determining these perceptions will assist in developing and targeting diet and health information and education in culturally appropriate ways.

- Due to the diversity of the Middle Eastern community in Australia there is a strong need to assess the preferences and needs of representatives from a broader range of Middle Eastern backgrounds to identify additional menu items. The data indicate that there are differences between the preferences and perceived needs of obstetric, elderly and younger clients. Representatives from each of these subgroups should be included in future research initiatives.

- Future research needs to assess more culturally appropriate non-meat options to increase the choice available to clients who choose not to eat meat for religious purposes.
• There is a need to determine culturally appropriate ways to name and describe dishes for representatives of all Middle Eastern nations, additionally, there is a need to develop a code system, or naming standard for the Middle Eastern food items for food service, dietetic, and other staff.

• Give thorough consideration and deliberation in the development and implementation of the next phase of the larger study. The results of this will be instrumental in determining the effectiveness and efficiency of the proposed service.

  • Community representation at the recipe development session for the proposed menu items will assist in ensuring that the modified products will maintain their authenticity, and hence appropriateness. It also provides the perfect avenue for negotiating culturally acceptable compromises for seemingly common dishes.

  • The taste testing session will ensure the acceptability of these products to a wider sample of the Middle Eastern community before incorporating them into the system and finding that they are unpopular.

• Continue monitoring acceptability and perceptions of service to base improvements on. Patient satisfaction surveys are inappropriate.

• Encourage ethno-specific research among health professionals, particularly those with a cultural affiliation or awareness with the Middle Eastern population.

• Channel funding and support for more research regarding health care issues for the Middle Eastern and other ethno-cultural communities in the Area. Seek support from such organisations as the Australian Arabic Welfare Council.
6.4. TRAINING

There is a lot to learn about this cultural group. Training will assist employees' awareness of the community's needs which will ultimately result in better service provision. It also will increase the morale of employees and assist in fostering a multicultural environment.

- Facilitators to be more thoroughly trained in the focus group process, particularly in inviting participants, to make them aware of what to expect at the session to reduce the intimidation of the research process for them.

- All hospital staff having any involvement with patients should be included in training programs regarding the development and implementation of the new food service. Training should provide information and skills so that employees are able to answer any client queries regarding the service, for example, whether it conforms to their religious dietary requirements.

- Food service staff to be trained how to serve meals appropriately.

- Cooks to be trained how to prepare dishes appropriately. They also need to be trained regarding the appropriate way to cook for cook-chill production. The challenge is experimenting with the Middle Eastern cuisine to determine compatible products with the system that are still acceptable to the community. Negotiations with community representatives will assist this process.

6.5. EDUCATION

- Address the misconceptions participants expressed about the nutritional value of Middle Eastern cuisine and hospital food.
• Educate the Middle Eastern community in the Area about healthful aspects of the Middle Eastern cuisine and how to modify eating habits in culturally appropriate and nutritionally sound ways.

• Inform the Middle Eastern community in the Area about the health system and their rights within it.

• More education of health professionals regarding Middle Eastern culture and the health care needs of this community so that health care can be delivered in a culturally sensitive way. Specific training of dietitians regarding Middle Eastern cuisine and diet related habits of the people from Middle Eastern backgrounds so as to be able to provide culturally sensitive advice.

• These topics could be part of professional continuing education programs. In this context, the training and education should be extended to include the health care related needs of other ethno-cultural groups.

• Use the food training trialing session of the larger study as an education session for both the Middle Eastern community and SWSAHS staff members. In this way members of the Middle Eastern community can increase their awareness of the policies and practices of the food service, including hygiene standards, and which will be significant in reassuring them of the appropriateness of the service to this religious and cultural requirements.

6.6 **METHODOLOGY**

• Do not offer money as an incentive or as a gesture of appreciation for participation in the research process. The provision of culturally familiar foods is a more powerful gesture of appreciation and it is more culturally appropriate.
• Future focus groups with members of the Middle Eastern community should use community ethnic health care workers and individuals with an understanding of the Middle Eastern culture or a cultural affiliation with the group as this has significant positive impact on attaining valid and reliable data. This strategy is recommended for further research with the Middle Eastern community.

• Allow more time between sessions to analyse the tapes, make notes, make duplicates of the session tapes, and to assist in better planning for proceeding sessions.

• Increase funding proposal to allow for professional transcript analysis.

• Add 10 per cent to final funding estimate for incidentals.

• More thorough training of facilitators in the focus group method. This would be most useful as a consistent strategy throughout the entire research process. That is, a few pre-session briefings in the setting up of the groups, another after the pilot study and subsequent groups, to provide practical insight arising from conducting each session.
CHAPTER 7

LIMITATIONS / CONCLUSION

7.1. LIMITATIONS

The results of this study cannot be, and should not be generalised for all Middle Eastern clients due to the nature of the research process and the fact that such stereotyping has resulted in the poor service delivery response and stereotyping in past attempts of ethno-specific research.

Only two nations and two religious sub-groups have been represented here due to the diversity of the Middle Eastern population in Australia and the fact that food preferences and needs differ along religious lines for this target group. Additional research is indicated and should include representation of people from a broader range of Middle Eastern backgrounds to secure the efficiency and effectiveness of the Middle Eastern menus to SWSAHS clients.

The focus group process in this research was modified from that described in the literature in the following ways: the selectivity and recruiting of participants; the number of participants in each group; recommendations for anonymity, and the sequence and style of the questioning route.

Contrary to the literature concerns about such modifications to the method, I found that they actually enhanced the process and significantly influenced attaining the results and the validity of the results, Krueger (1988) supports this.

However these modifications in practice did influence the process in the following ways:
(1) The sessions with more than 12 participants each, were difficult to control, participants spoke over each other and to each other. Whether this influenced the data negatively I can not be sure as we still attained a rich information base. However the audiotapes of each session were very chaotic.

(2) The chaotic recordings of each session made it difficult to transcribe. Consequently the transcript analysis were not done word for word. The resultant summaries were thus a reflection of the transcribers perceptions of the data. I had to work through and transcribe the data from each session to reduce the bias of the initial transcripts.

(3) The young Assyrian men had no personal experience with the Health Care system in Australia. Their responses were based on anecdotal accounts of the current food service.

Analysis for this group also was influenced by the fact that half of the audio tape from their session was unintentionally erased in the transcript process. So the data was collated partly from the initial transcript, and the remainder from my transcripts. In conjunction with the inability to collect recipes from this group the inclusion of representatives from this target group in the recipe trialing phase of the project is indicated.

(4) Payment of participants was inequitable. Only those who signed the consent form were eligible for payment. This meant that many participants in the larger session did not get paid. It would have been more appropriate not to have offered any monetary payment than to pay only a few. Hawe et al (1990) recommend not to pre-empt paying participants in advance, as many people are then willing to participate, particularly if they perceive benefits in doing so.
This was the case with many participants in this research. The majority were honoured to take part and many were embarrassed at the mention of payment while others were surprised and confused. Apparently not all the EHW had informed all participants of any payment. It certainly was not a culturally appropriate or equitably strategy.

Due to the paucity of (Australian) Literature on the health care needs and food related habits of Middle Easterners, the majority of the information regarding cultural issues was taken from American literature, thus it carries the biases of the American culture. Further, much of the literature is out dated, and culture is such a dynamic phenomenon, the use of such information is unreliable.

7.2. **CONCLUSIONS**

A hospital food service is a critical component of patient care, it also has a significant role in influencing clients perceptions of their hospital stay. Historically hospital food services have been slow to respond to the food related needs of patients from NES backgrounds. In a Multicultural society which is committed to equality of health care, such responses need to be redressed. South Western Sydney Area Health Services initiative to develop culturally appropriate hospital food services for the major ethno-cultural groups in its Area is the first comprehensive strategy in this regard.

This research was undertaken with Lebanese and Assyrian representatives of the Middle Eastern community in the Area to assist SWSAHS in developing its hospital menus for this ethno-cultural groups. Five focus group discussions were under taken to assess the food preferences and perceived needs for hospital food as they relate to health and illness, within a cultural context.
The results of this research indicate that people from Middle Eastern backgrounds express common notions of health and illness and encounter similar experiences and reactions in the health care system. The same degree of similarity for the food preferences is not evident. Cultural and religious factors, the length of time in Australia, and the patients' physiological state significantly influence the perceived food needs and preferences for people from Middle Eastern backgrounds. The line between cultural diversity and stereotyping is a fine one. In order to meet its objectives for both effective and efficient food services, and to fulfil the philosophies and directives of the many government policies regarding the responsibilities of food service to all Australians, these differences must be considered in the development of the SWSAHS Middle Eastern Menus.

The significance for meeting these needs and the implications and possible feasibility were identified in the discussion, the recommendations were developed from these. The results strongly indicate the significance of the next phase of SWSAHS study in effecting the success of implementing the recommendations.

All the food related recommendations are feasible within the resources and responsibilities of the Areas food service, particularly with a cook-chill food production system and the adoption of a la cart menus. The next phase of the study is crucial in directing the success of the proposals and should be capitalised on.

The discussions also identify that food services to people from NES backgrounds have been under valued, and that in order to develop truly culturally sensitive food services requires organisational, political and social change. Total satisfaction with food services is an ideal but we can be more aware of the preferences and the needs of our clients and make our best attempts at meeting them. Part of the challenge has been the lack of information regarding these needs and preferences. Positive experiences in health care result in positive health outcomes and more satisfied clients who are more willing to seek
further care when and if necessary. In today's competitive healthcare environment and multicultural society it is essential that positive experiences are fostered.

Though these results cannot be generalised, they have uncovered unmatched value able information about the preferences of the experiences of members of the Middle eastern community in the Area regarding eating in hospital. The results have the potential to significantly influence the process of change regarding food services to Australians from NES backgrounds. The challenge now lies in pursuing the recommendations of this research to bridge the food service gap between "their food" and "our food" for members of the Middle Eastern community in SWSAHS, and set the precedence for other institutions to follow and meet the needs of all Australians.
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OUR OPERATING ENVIRONMENT – FEATURES AND TRENDS

FIGURE 2.1: MAP OF SWSAHS
The geographic boundaries of SWSAHS are shown in the map below:

(Adopted from HSDU, SWSAHS, 1993, p.3)
The goals of the SWSAHS Ethnic Health Services Plan are (HSDU, SWSAHS, 1991, p.3).

1. To establish a multicultural organisational environment in SWSAHS.

2. To improve the health status of people of non-English-speaking background.

3. To improve the accessibility and appropriateness of mainstream health services.

There are five major objectives of the SWSAHS Multicultural Health Strategy.

1. To incorporate multicultural issues into all levels of the SWSAHS corporation.

2. To develop and review ethnic-specific health services and referral points.

3. To improve the accessibility, appropriateness and availability of mainstream health services to people of non-English speaking background.

4. To meet the primary health care needs of immigrants and ethnic communities.

5. To promote, maintain and protect the health of immigrants and ethnic communities.
TABLE 2.1: SOUTH WESTERN SYDNEY AREA HEALTH SERVICE HOSPITAL UTILISATION RATES BY MAIN CAUSES OF MORBIDITY* IN 1990/91 FOR MIDDLE EASTERN RESIDENTS OF SOUTH WESTERN SYDNEY

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Program</th>
<th>OBST</th>
<th>GSURG</th>
<th>DIAL</th>
<th>GYNO</th>
<th>ORTHO</th>
<th>CARDI</th>
<th>UROL</th>
<th>GSTRO</th>
<th>ENT</th>
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<th>NEURO</th>
<th>RESP</th>
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<tbody>
<tr>
<td>Bankstown</td>
<td>19.5%</td>
<td>13.3%</td>
<td>9.77%</td>
<td>9.2%</td>
<td>7.7%</td>
<td>6%</td>
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<tr>
<td>N=840 (14%)</td>
<td>326</td>
<td>104</td>
<td>0</td>
<td>85</td>
<td>42</td>
<td>66</td>
<td>25</td>
<td>36</td>
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<td>32</td>
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<td>1</td>
<td>22</td>
<td>21</td>
<td>9</td>
<td>22</td>
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<tr>
<td>Fairfield</td>
<td>168</td>
<td>90</td>
<td>0</td>
<td>72</td>
<td>40</td>
<td>67</td>
<td>24</td>
<td>43</td>
<td>15</td>
<td>25</td>
<td>4</td>
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<td>14</td>
<td>17</td>
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<td>N=684 (11.7%)</td>
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<tr>
<td>Liverpool</td>
<td>168</td>
<td>99</td>
<td>0</td>
<td>33</td>
<td>32</td>
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<td>N=604 (10.3%)</td>
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<tr>
<td>Campbelltown</td>
<td>96</td>
<td>53</td>
<td>0</td>
<td>38</td>
<td>7</td>
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<tr>
<td>N=314 (6.6%)</td>
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<tr>
<td>Camden</td>
<td>1</td>
<td>3</td>
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<td>2</td>
<td>1</td>
<td>2</td>
<td>6</td>
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<td>3</td>
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<td>2</td>
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<tr>
<td>N=28 (0.5%)</td>
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* This data only reflects the top 15 (defined as incidences of greater than one percent of subgroup) causes of morbidity this group recorded in 1990/91. Separation are based on country of birth.
Let us start by asking

**Q1** What is the importance of eating?

(prompt) to survive, to enjoy, stop from getting sick, keep strong.

**Q1(a)** Why do we eat when we are sick?

(prompt) is it to get better, keep strong

**Q1(b)** Are there any special foods that help you get better when you are sick?

(prompt) hot foods/cold foods, certain meals, more/less food
(probe). If (yes) what are they?

**Q1(c)** What are the foods needed if you were sick/very sick to make you better/strong?

Who has been in hospital over the past 2 years or known anyone from Middle Eastern backgrounds who have been in hospital over the past two years?

**Q2** What did you/they think of the food in the hospital?

(prompt) was it acceptable/unacceptable

(probe) what made it acceptable/unacceptable
(prompt) did it taste good/bad? Was it the kind of food you need/did not need to make you better?

**Q2(a)** What would you change?

**Q2(b)** How acceptable/unacceptable were the meal patterns?

(prompt) breakfast/lunch/dinner, too small/large, too many/few meals per day, hot vs cold meals.

- What are preferred breakfast foods
(prompt) hot vs cold

- What are preferred lunch foods?
- What are preferred dinner foods?
- Are mid meal snacks important?
(probe if so) - what are preferred snacks
Q2(c)  What would you list as the five most important changes you would like to have made about the type of food and the way it's served in hospital.

(prompt) more strengthening food, more/less meals, bigger/smaller meals, hotter meals.

We have talked about food preferences. Now I would like to get a better idea of Middle Eastern food practices and customs. It is important for us to know about these things to make sure that we provide a suitable food service.

Q3  What foods do/do not go together?

(prompt) hot and cold, fresh and cooked, fish and yoghurt

Q3(a)  Do certain drinks go with certain meals

(probe) if so which ones
(probe) which beverages are preferred?

Q3(b)  How is food eaten?

(prompt) with hands, with knife and fork, with bread
(probe) are certain meals eaten with certain utensils? eggs with knife and fork; boiled eggs with spoon

Q3(c)  What are the utensils used in meal preparation?

Q3(d)  What are the utensils used to serve meals?

(prompt) separate/same plates for hot/cold, fresh/cooked, sweet/salty

Q3(e)  What is the role of bread in eating and meal preparation?

There are many nations that make up the Middle East, each one has its own culture, food practices and preference. But there are some similarities across all cultures.

The hospital cannot provide every person from each country in the Middle East with their food preferences. What they can do is provide a range of food which is common within the cultures. So I would like to ask you:

Q4  What are the common foods across Middle Eastern cultures?

(To Assyrian group: for example what foods would you agree to have that would be acceptable also to Lebanese people - similar for Lebanese groups using Assyrian example)

What are the similarities?
What are the differences?
What is the role of religion?
APPENDIX 5

REVISED FOCUS GROUP PROTOCOL - THE MAJOR STUDY

I would like you all to think back to a time when you were sick or in hospital.

Q1. What were the kinds of food you ate to make you get better/strong again?

(prompt) - hot/cold, cooked/fresh, rice, soup, vegetables, cheese (what type)
(prompt) - what foods did you feel like

Q1(a) Are these foods considered as special foods needed by sick people to help them get better?

(prompt) are they traditional foods?

Q1(b) Are these foods the same for all sicknesses?

For example: Does somebody in hospital recovering from:

(i) broken bones need the same foods as somebody recovering from
(ii) a serious operation

(probe) If not what are the differences?
what are the similarities?

To group 2 and 3 participants (Q1c, d)

Q1(c) Are there special foods for a woman after she has just had a baby?

(probe) If so what are they?
(probe) Are they the same food for all women?
(probe) If similar/different what are similarities/differences
Q1(d)  Are there special foods that a woman who is breastfeeding needs to keep her strong/the baby strong?

(probe) If so what are they?
(probe) Are they same as foods for just after pregnancy?

Q1(e)  Are there special foods for different age groups to make them better/strong when they are sick?

(prompt) for infants
for toddlers
for youth/young adults
for elderly?

(probe) If so: What are the similarities?
What are the differences?

Q2  Do certain foods go together/not go together?

(prompt) rice and beans, fish and yoghurt

Q2(a)  What is the role of bread?

(prompt) makes meal, to eat with, therapeutic, strengthening
(probe) What type of bread is preferred?

Q2(b)  What are the preferred beverages?

(probe) Are there certain beverages which go with certain:
(1) meals
(2) sicknesses/life stages?

To group 3: You have all just been in hospital recently

To others: Who has themselves, or known anybody from Middle Eastern backgrounds, who has been in hospital in Australia over the past two years......

I would like to get an idea of:
Q3 What did you/they think of the food they got in hospital?

(prompt) was it acceptable/unacceptable?

(probe) What made it acceptable/unacceptable? (taste, colour, temperature, type of food inappropriate, familiar/unfamiliar)

(probe) were there any foods that you/they missed/felt like?

(prompt) for example "strengthening foods" mentioned earlier

(probe) did you/they ask for friends or family to bring any food in?

(probe) what was it? did you eat it instead of hospital food or in addition to it?

(probe) What was the reason they brought the food in for you?

(prompt) Did not like food available
The food available was not appropriate to help recovery
There was not enough food
They were gifts/gestures of good will
Q3(b)  How acceptable/unacceptable were the meal patterns?
(prompt) Breakfast/Lunch/Dinner too small/large, too many meals, too few meals, too early/late, hot vs cold?

Q3(c)  What are preferred breakfast foods?
(prompt) hot/cold, cheese (what type), jam, bread, yoghurt, bread, eggs, vs cereal and milk vs bacon and eggs, baked beans on toast?

* What are preferred lunch foods?
(prompt) (hot vs cold meal), heavy vs light, main vs light

* What are preferred dinner foods?

* Are mid meal snacks important?
(probe) If so - what are preferred snacks
(prompt) biscuits, sandwiches, fruit, tea

Given what we have just talked about, I would like you to imagine that you could make any changes you liked to the type of food served in hospital and the way it was served.

Q3(d)  What changes would you make to the type of food?
(prompt) would you add rice, Lebanese bread, soup, no change?
(prompt) what food would you prefer?

What changes would you make to the way the food is served? (i.e. meal patterns)
(prompt) light continental style breakfast, light/heavy main meals
Q3(e)  What are the three most important changes?

There are many nations that make up the Middle East. Each one has its own culture, food practices and preferences. But there are some similarities across the cultures.

The hospital cannot provide each person from each country with their food preferences - what they can do is provide a range of food which is common across all cultures.

So I would like to ask:

Q4  What are the common foods across Middle Eastern cultures?

What are the similarities?
What are the differences?
What is the role of religion?
INTRODUCTION

It is well documented that when people from Non-English Speaking Backgrounds (NESB) are institutionalised they are commonly faced with foods and cooking methods that are not only unfamiliar to them but also culturally inappropriate. Research by food service implementation steering committee developed to review the current food service system provided by South Western Sydney Area Health Service (SWSAHS) has indicated a need to tailor the food service available in SWSAHS hospitals, to provide a more equitable service to their NESB population. The re-development of the Area’s facilities and services provide SWSAHS with the unique opportunity to attain these.

AIM

To provide people from NESB’s a culturally appropriate food service, knowledge about their food habits needs to be attained.

PROPOSAL

The working party has proposed a project which will take the following format.

1. Acquire knowledge of eating habits, cooking methods, beliefs about food and health of the ethnic group in question.

2. Collect traditional recipes suitable for use in hospital for various patient sub-groups, e.g. weaning foods, foods for convalescing, pregnancy, lactation, etc.

3. Training of Central Production Unit Staff by Community members in preparing ethno-specific food.

4. Analyse recipes to determine if they meet nutritional standards.

5. Test recipes. This will involve the preparation of recipes and taste testing by members of the ethnic community involved to determine acceptability.

6. Adapt recipes for modified diets. This will include food preparation and taste testing.

7. Foods adopted into ethnic food bank and available in the hospitals.

8. Provision of menus in different languages available in the hospitals.
The main aim is to develop a food bank of menu items that will cater for the majority of the NESB population utilising the SWSAHS.

The investigation will be undertaken culture by culture. The following four issues were used as the basis to determine which ethnic group to concentrate on first:

1. the number of people going to hospital (based on 1990-91 hospital separation statistics) for people living in South Western Sydney.

2. acculturation of the group.

3. present menu items.

4. gaps in our knowledge regarding suitability of certain foods in a cook-chill system.

Based on this analysis it was determined that a need exists to work with Middle Eastern* and Vietnamese groups.

An opportunity exists to pilot this project utilising the assistance of a Student Dietitian from the University of Wollongong (Lily Hamdan) as part of the research component of her Masters Degree.

It is proposed that Lily implement the first two points for the Middle Eastern community. The mode of enquiry is through focus groups. These will be co-ordinated in conjunction with Health Care workers who have contact with the target audience and share a common cultural background.

**SUPERVISORS:** Clair Matthews (Ethnic Services Co-ordinator, Liverpool)
Heather Yeatman (Senior Lecturer - University of Wollongong)

**c.c:**
Peter McKay - General Manager
Jackie Krassie - Food Service Consultant, South Western Sydney Area Health Service
Clair Matthews - Ethnic Services Co-ordinator Liverpool
Louise Spencer - Dietitian-in-Charge Fairfield Hospital
Hoda - Arabic Obstetric Liaison Officer Fairfield Hospital
Anise - Assyrian Health Care Worker Fairfield Community Health Centre
Ahmed - Arabic Health Care Worker Bankstown Community Health Centre
George Totidis - Interpreter Service Co-ordinator Fairfield Hospital
THE FOCUS GROUP PROCESS

The process of running a Focus Group has three phases.

I) Conceptualising the Study - this step is critical for success of the research. It includes consideration of:
   * a) The purpose of the study
   * b) Who the information will be used by, and
   * c) Developing a plan to guide the remainder of the research project

II) Conducting the interviews - this step involves completing three important tasks before the first interview. They are:
   # a) Developing the questions
   # b) Learning Interviewer skills
   # c) Selecting Group participants

III) Analysing and reporting data - this is the final step to be completed by the interviewer

Notes:

* Refer to brief outline of purpose titled: "Middle Eastern Food Service Project - May 1993" (Appendix 6.1 in this research)

# To be developed with your assistance. Pages 2-5 (overleaf) detail the procedures to be undertaken.
DEVELOPING THE FOCUS GROUP QUESTIONNAIRE

Questions are the heart of the Focus Group interview. They provide the stimulus for participant responses.

Quality Answers are directly related to quality questions.

Usually five-six key questions are used. Additional probes and prompts are used to guide the discussion through smoothly.

The questions should be simple and easy to answer. They should appear to be spontaneous. Considerable forethought is required to design questions which elicit the maximum amount of information in the time.

The sequencing should generally be designed to achieve a funneling effect. The first question should be broad providing a general overview to set the context for discussion. Subsequent questions become more specific and sensitive

   e.g. What is your favourite food?

   What food is important when:
   a) convalescing from serious illness
   b) having a baby

As participants answer questions - their answers should spark new ideas or connections from other participants.

ACTIVITY:

This activity is designed to get an idea of some appropriate questions to ask the groups.

* Establish your views of issue i.e. foods, food practices related to health and illness
* Brainstorm question ideas
SELECTING GROUP PARTICIPANTS

People are essential for the Focus Group

The importance of careful recruitment of participants cannot be overlooked or underestimated.

Unlike recruiting for other meetings or group programmes the Focus Group Interview requires recruiting of participants according to deliberate features that ensure that exactly the correct number of, and the right type of people will attend.

1) **Homogeneity is the key.** The purpose of the study dictates this. For the current study we require the opinions of representatives from the Middle Eastern Community in South Western Sydney with the following characteristics.

   - **Group 1:** Adult males from Middle Eastern backgrounds aged over 55 years (Ahmed)
   - **Group 2:** Adult females from Assyrian backgrounds aged over 55 years (Anise)
   - **Group 3:** Women from the target group who have recently been hospitalised for obstetric or gynaecological purposes (Hoda)
   - **Group 4:** Young adult males 15-24 years. They can be people who have recently been hospitalised.

2) People should be invited to "discuss" or "share" their opinion or ideas on the topic. It is important to avoid the use of the word "FOCUS GROUP" as this has little meaning.

   Invitations to participants should be personalised. Each participant should feel like they are personally needed and wanted at the interview.

   It should stress that the potential participants have special insights or experiences that would be of value to the study.

   e.g. The group of ladies who have recently been hospitalised for obstetric purposes can each offer valuable information on the experience. Specifically, since they have had recent experience with the existing food service they are in a position to comment on their satisfaction of it and the appropriateness to their cultural beliefs. Further since childbirth marks a "special" time - they may be able to provide valuable insight on any food traditions that maybe associated with that physiological condition.

3) Inform each participant about the purpose of the study and how their contribution assists. Avoid giving too much information - or getting in a discussion about the purpose or process of the research. This may give participants the opportunity to develop perceived ideas and responses.

   It will suffice to inform them of the purpose by outlining or summarising the 8 stage proposal outlined on "Middle Eastern Food Service Project - May 1993".
* * * (Please refer Attachment 1 as an example of what to include in the verbal invitation/discussion with participants).

4) Following up on the initial invitation is essential for success. The following is a systematic outline of the follow up activities:

a) Contact participants (by phone) approximately 10-14 days before the meeting.

b) Send personalised invitation one week before the meeting. This will provide additional information about the session, location, time and topic of discussion. (See Attachment 2 for example).

c) Phone each person the day before the Focus Group reminding them of the session and asking about their intention to attend.

By conveying a sense of importance to the study people are more likely to attend.

Remember that the group is important. The results yielded have the potential to provide our community with a food service which is appropriate for their needs. They deserve such an equitable service. Describing this to them will help convey this sense of importance.

Another way to convey the sense of importance is to mention that they will each be paid $10 to cover any cost which may be incurred in attending the interview.

A further way to convey the importance of study to participants is to inform them that light refreshments will be available. this is as a gesture of appreciation for their time, effort, and provision of valuable experience.
ATTACHMENT 1

WHAT TO TELL PARTICIPANTS

PURPOSE: give enough information to fill them in and establish importance.

IMPORTANCE: This should be stressed by personalizing invitations, informing them of their payment and the availability of refreshments showing them how their participation will benefit them. This helps to increase moral value of the participants opinions of the study.

ESSENTIAL INFORMATION: Tell participants about the process including explaining the purpose of the Consent and Demographic forms.

CONSENT FORM: inform them of * confidentiality
(Appendix 3 - Arabic)
(Appendix 4 - English)
* voluntary
* agree to be taped
* aware that can contact ethics committee at University for more information

DEMOGRAPHIC QUESTIONNAIRE:
(Appendix 5): to give us information to help group results
- unidentifiable personally (i.e. confidential)

FOLLOW UP:
* As per four (4) steps

Be uniform, succinct and consistent in the information you provide to each participant remembering that too much information may result in the development of "expert opinion" and pre-conceived ideas about the research topic

Too little information could develop ideas of suspicion, i.e. silent understanding, ulterior motives.
Dear ____________________________

This letter is to remind you of the discussion about food and health that you agreed to attend.

The details of the discussion are below:
Place: __________________________________________

Time: ___________________________________________

Date: ___________________________________________

The discussion is part of a research that aims to provide people from Middle Eastern Backgrounds with foods which they would prefer to eat when they are in hospital. To do this properly we would like your ideas about this.

The discussion group you will be attending will include a small number of __________________________________________

__________________________ will also be there to help run the session.

To make the research project successful we need to speak with enough people. We thank you that you have agreed to join us. If for some reason you cannot make it, please contact ____________________________ on ____________________________ and let us know as soon as possible. If we do not hear from you we are expecting that you are coming and look forward to seeing you on ____________________________.
رسالة على القبول

هذه الرسالة هي لتؤكد بأن الأهداف من أجل هذه الدراسة قد شرحت لي بوضوح وأنها
أنبها وأقبلها. لذلك إنني أوافق على هذا الأساس بأن أشارك في هذا البحث.

لقد شرح لي بوضوح بأن انشراك هو تطوعي بالكلية. إنني أفهم ذلك بأنه يعني بأن
انطع انشراكي كما أختار بدون أية أسئلة أو أية تعليقات دون إبداء الأسباب.

أنا أفهم أيضاً بأن ذلك يعني بان لي الحق لأسأل أية أسئلة حول أي من خصائص هذه
الدراسة.

ولقد أوضح لي بان المعلومات التي أعطهما ستعمل بكل سرية. أنا أفهم بأن ذلك يعني
بأن لا أعرف من خلال انشراكي في هذه الدراسة. ولقد شرح لي بأنه خلال هذه
اللغات سيمكن تسجيلات على الشريط. ولقد وافقت على التسجيل وبأن المعلومات
التي سأعطهما ستسكون من ضمن تقرير.

"أية أسئلة حول إجراء هذا البحث ستمكن أن تقدم إلى سكرتارية جامعة ولنجنجر -
لجنة البادي العلمية الإنسانية تلفون 9213079 (2042).“

اشكرك على تعاونك بهذه الدراسة.

المخلّفة

ليلى حداد.

الاسم:
التاريخ:
الإسماء:
LETTER OF CONSENT

This letter is to verify that the purposes of this study have been clearly explained to me and that I understand and accept them. On this basis I consent to participate in the research.

It has been made clear to me that my participation is entirely voluntary. I understand this to mean that I can discontinue my participation as I elect, without any questions or judgements of the reasons why. I also understand this to mean that I am entitled to ask questions about any aspect of the study.

It has also been made clear to me that any information that I give will be treated with strict confidentiality. I understand this to mean that I will not be able to be identified through my participation in the study. It has been explained to me that the sessions will be audiotaped. I have consented to being recorded and having the information I provide be compiled to write a report.

"Any enquiries regarding the conduct of the research may be forward to the Secretary of the University of Wollongong Human Experimentation Ethics Committee – phone (042) 213 079".

Thank you for your cooperation in this study.

Yours sincerely

LILY HAMDAN

NAME:
DATE:
SIGNATURE:
Demographic Questionnaire

This questionnaire is to help us group information together. You do not need to give your name - you will not be identified through your answers on this questionnaire.

Age: (in years)

- □ 15-24,
- □ 25-34,
- □ 35-44,
- □ 45-54,
- □ 54+

Occupation: ____________________________

Country of Origin: ____________________

Language spoken at home:

- □ Arabic
- □ Assyrian
- □ Other __________

Length of residence in Australia

- □ 0-4 years
- □ more than 4 years

Have you been in hospital in the past 2 years?

- □ YES
- □ NO

If yes, what was the reason? ____________________________
### PROPOSED SESSION OUTLINE

<table>
<thead>
<tr>
<th>TIME ALLOCATED</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 minutes</td>
<td>Arrival</td>
</tr>
<tr>
<td></td>
<td>- greet name tags</td>
</tr>
<tr>
<td></td>
<td>- fill in questionnaire</td>
</tr>
<tr>
<td></td>
<td>- sign consent forms</td>
</tr>
<tr>
<td></td>
<td>- refreshments</td>
</tr>
<tr>
<td>5 minutes</td>
<td>Intro</td>
</tr>
<tr>
<td></td>
<td>- thank for attending</td>
</tr>
<tr>
<td></td>
<td>- review purpose of Attendance</td>
</tr>
<tr>
<td></td>
<td>- re study - practical sol'n for HS</td>
</tr>
<tr>
<td></td>
<td>- review purpose for filling in forms &gt; remind anonymity/confidentiality</td>
</tr>
<tr>
<td></td>
<td>- outline NOT to get idea of FAVOURITE RECIPES, OR FOODS FOR SPECIAL DIETS/TO MAKE YOU HEALTHY. BUT ideas about kind of food which is important if in hospital, for different reasons, to get through that condition.</td>
</tr>
<tr>
<td></td>
<td>- OUTLINE RULES ie. .one at a time .keep to time frame</td>
</tr>
<tr>
<td></td>
<td>- anonymous</td>
</tr>
<tr>
<td></td>
<td>- encourage open disclosure</td>
</tr>
<tr>
<td>75 minutes</td>
<td>Questions/Discussion</td>
</tr>
<tr>
<td>Question 1</td>
<td>(5 min)</td>
</tr>
<tr>
<td>Question 2</td>
<td>(40 min)</td>
</tr>
<tr>
<td>Question 3</td>
<td>(20 min)</td>
</tr>
<tr>
<td>Question 4</td>
<td>(10 min)</td>
</tr>
<tr>
<td>5 minutes</td>
<td>Close Session - Thank for coming - describe process of collecting cash.</td>
</tr>
<tr>
<td>1 hr 55</td>
<td>* Inform re: Collection of recipes - to provide to Health Workers</td>
</tr>
</tbody>
</table>
APPENDIX 7.6

SAMPLE TIME TABLE FOR MIDDLE EASTERN PROJECT

TO: AHMED ABDEL RAZEK

FOCUS GROUP:
DATE: Wednesday 21st July 1993
PLACE: 78 Restwell Street
        BANKSTOWN 2200
TIME: 10.30a.m. – 12.30p.m.

TRAINING:
DATE: Tuesday 6th July 1993
TIME: 9.30 – 11.30a.m.
PLACE: Hoxton Park Community Health Centre
        Hoxton Park Road
        HOXTON PARK 2171
        PH: 827 2222

PARTICIPANT NOTIFICATION:

1st Contact - Invitation
Make sure all eligible and potential participants have been invited to attend at least two weeks prior to the date of the meeting.
That is by - Wednesday 7th July 1993

2nd Contact - Follow Up
Post out invitation letter one week prior to date of meeting.
That is - Monday 12th July 1993

3rd Contact - Confirmation
One day before the meeting, phone all participants and remind them of the time and place, and confirm their attendance.
That is - Tuesday 20th July 1993

CHECKLIST:
- All material translated
- Enough copies for each
SUBSEQUENT CONTACTS - RECIPE COLLECTION

Collect recipes which participants identified as foods they would prefer to have while in hospitals.
Collect by - Monday 6th September 1993

Please contact me on 314 2286 (or Clair 827 2203) at any time to discuss any aspect of the study.

Thank you.

Regards

Lily Hamdan
I, ..................................................... participated in the focus group on the 
......th July, 1993 for the Food Services’ Project on Middle Eastern food 
customs.
I have received the cheque for $10 from the South Western Sydney Area 
Health Service to cover expenses incurred from this participation.

Signed......................................

Date......................................
### APPENDIX 9

#### TABLE 5.3.3.1: COMPARISON OF REPORTED MIDDLE EASTERN FOOD PREFERENCES FROM A SAMPLE OF THE COMMUNITY IN SOUTH WESTERN SYDNEY AREA HEALTH SERVICE WITH THOSE OF A SAMPLE OF AUSTRALIAN HOSPITALISED PATIENTS IN SYDNEY

<table>
<thead>
<tr>
<th>Food</th>
<th>Middle Eastern (ME)</th>
<th>Anglo (AA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fresh Fruit</td>
<td>Report to love: significant component of diet</td>
<td>Reported high hedonic scores</td>
</tr>
<tr>
<td>Poultry</td>
<td>Very important particularly in Lebanese diet. Boiled was preferred as it is used in stews/soups. Alternative baked or grilled chicken preferred. • It is also stuffed with rice</td>
<td>A variety of poultry dishes rated quite highly. Most popular is fried, this is inconsistent with reports of ME, i.e. frying is 'heavy'. No mention of boiled chicken or grilled chicken</td>
</tr>
<tr>
<td>Red Meat</td>
<td>• Determined by religion • No pork for Muslim people • Halal preferred • Lamb preferred ( roast or or beef steaks) grilled • CUTLETS identified as popular • Extensive use of shanks/bones to add flavour to cooking. Also therapeutic, nutrition quality identified in such practices • KIBI • KAFTA • Meatballs (made with eggs etc. and served with yoghurt)</td>
<td>• Consistent high ratings for lamb roast and cutlets • Inconsistent, high ratings for pork • Snitzel identified not common to traditional ME diet • NO KIBI, KAFTA • Meatballs lower score but not likely to be the same as ME</td>
</tr>
<tr>
<td>Eggs</td>
<td>Poached or boiled are preferred with ME or omelette usually eaten with bread. Vegetables also accompany them</td>
<td>Consistent but probably not eaten the same way</td>
</tr>
</tbody>
</table>

212
Table 5.3.3.1: (Continued)

<table>
<thead>
<tr>
<th>Food</th>
<th>Middle Eastern (ME)</th>
<th>Anglo (AA)</th>
</tr>
</thead>
</table>
| **Beverages** ♦ Note this was amended from Williams to include other drinks identified by ME | • Fresh fruit juices liked, particular reference to orange juice and lemon juice  
• DAWEE - quite significant among Assyrian  
• YINSOUN/MUGLUE - particularly for obstetric patients  
• Arabic style coffees preferred  
• Tea or coffee acceptable | • Orange juice rated high no mention of lemon  
• Pear and apple also liked no assessment for ME  
• No DAWEE  
• No mention of fresh boiled herbal tea  
• No Arabic style coffee  
• No results available for tea or coffee but suspect high scores |
| **Potato and Substitutes** | • Report boiled potato as preference or chunky mashed potato. Indeed often just like to eat a boiled potato as snack with bread  
• Otherwise potato used in soups or casserole type dishes  
• Chips not preferred by adults, reports of younger generation preferring them  
• RICE is most significant part of ME diet. Used as basis of many dishes. Prepared in a variety of ways depending on recipe/meal and nation. It is one of the staples and is eaten at every main meal. It is rarely plain boiled. Bread can be included. Not a substitute in the diet but some nutritional value. Bread significant and eaten with every meal | • Boiled potato and hot chips scored highest with mashed and boiled scoring lower. Boiled rice was popular, inconsistent with ME. Fried rice was popular. This is consistent with some Assyrian dishes.  
• No information on bread available. |
<p>| <strong>Canned, Stewed Fruit</strong> | Not assessed. Traditionally make a variety of preserves and pickles with fruit or dry it out. Otherwise enjoyed fresh | Generally scored quite high with the exception of canned plums |</p>
<table>
<thead>
<tr>
<th>Food</th>
<th>Middle Eastern (ME)</th>
<th>Anglo (AA)</th>
</tr>
</thead>
</table>
| Desserts           | Not necessarily served as dessert at end of meal. But always with coffee to visitors or snacked on biscuits with meals.  
• Usually fresh fruit or preserves eaten with bread  
• Halawa  
Range of intricate pastries, cakes, biscuits and desserts. They are usually made to celebrate religious or family occasions  
Hospital preferences  
• CREAMY RICE (made with rosewater)  
• CUSTARD (made with biscuits)  
• Fresh fruit  
• Jelly (not all Muslims)  
• Plain biscuits  
• Ice cream  
• Fruit salad highest rating  
• Other high scores consistent with ME preferences are ice cream jelly. Custard and sweet creamed rice rated well but do not appear to be as popular as for ME. Indeed some literature cites these desserts as 'old fashioned'. Further not likely to be prepared same way as ME.  
Other high scorers:  
Pavlova, steamed puddings, trifle, apple pie, cheesecake are not familiar to diet of ME.  
Low scores of blamange  
Spanish cream and junket also not familiar to ME and likely to score low.                                                                                                                                                     |                                                                                                                                                                                                                                   |
| Seafood            | Consistently refer to fish. Very important especially for Christians as this can be eaten on Wednesday and Friday. Baked and grilled fish very popular.  
• Fried liked but not considered appropriate for illness. No mention of other seafoods such as tuna, prawns, crab, etc.  
Traditionally served whole and prepared in a variety of elaborate spicy ways  
• Fish never to be served with dairy products. Steamed fish unacceptable.  
• Prawns and lobster rated highest inconsistent.  
• Baked and grilled next highest.  
• Fried fish in batter also acceptable.  
• Steamed fish rated acceptable inconsistent with Lebanese and Assyrian                                                                                                                                                                             |                                                                                                                                                                                                                                   |
| Savoury Dishes     | Spaghetti is agreeable but prepared differently  
• Pizza - Lebanese style very popular.  
• Italian style noted popular by younger generations.  
• Chicken curry very popular.  
• KAFTA b'sianeeya served with RICE  
• Stews, broths, casseroles served with rice  
Many of the dishes rated highly not familiar to ME.  
e.g.  
Only consistency is curries where chicken only one familiar to ME.                                                                                                                                                                                                                       |                                                                                                                                                                                                                                   |
Table 5.3.3.1: (Continued)

<table>
<thead>
<tr>
<th>Food</th>
<th>Middle Eastern (ME)</th>
<th>Anglo (AA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vegetables</td>
<td><strong>Staple in the diet.</strong> Eaten a wide variety</td>
<td>Many eaten boiled. Not likely to be prepared in variety of ways ME do.</td>
</tr>
<tr>
<td></td>
<td>- raw</td>
<td>Many low scoring or never tried options comprise diet staples of ME e.g.</td>
</tr>
<tr>
<td></td>
<td>- in salad</td>
<td>okra, olives, radish, broad beans. Cucumber not specified to be</td>
</tr>
<tr>
<td></td>
<td>- stews</td>
<td>continental type</td>
</tr>
<tr>
<td></td>
<td>- stuffed</td>
<td>• Crossiferous vegetables rated very high</td>
</tr>
<tr>
<td></td>
<td>- pickles</td>
<td>contrary to popular belief that such vegetables old fashioned and unpopular</td>
</tr>
<tr>
<td></td>
<td>- fried, barbecued</td>
<td>• Gherkins rated low.</td>
</tr>
<tr>
<td></td>
<td>Not very popular - boiled/steamed vegetables,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>* crossiferous vegetables are thought to cause wind and to be avoided in times of</td>
<td></td>
</tr>
<tr>
<td></td>
<td>illness or lactation.</td>
<td></td>
</tr>
<tr>
<td>Soups</td>
<td>• Generally very substantial and can be eaten as meal.</td>
<td>• High scores for vegetable soup which is only consistent with ME.</td>
</tr>
<tr>
<td></td>
<td>• RICE SOUP with bones or chicken most popular.</td>
<td>However not likely to be prepared the same</td>
</tr>
<tr>
<td></td>
<td>• Vegetable made on bones.</td>
<td>• Other high scorers are not familiar to ME.</td>
</tr>
<tr>
<td></td>
<td>• CHICKEN very popular.</td>
<td>• No mention of RICE SOUP or CHICKEN SOUP or lentil soup.</td>
</tr>
<tr>
<td></td>
<td>• Lentil very popular.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Such soups as pumpkin, creamed vegetable type or tomato not eaten</td>
<td></td>
</tr>
<tr>
<td></td>
<td>similarly pea and ham and consommé not familiar to ME.</td>
<td></td>
</tr>
<tr>
<td>Small Goods</td>
<td>• Not traditionally eaten by ME.</td>
<td>Relatively lower rating as a food class. But generally high scores for</td>
</tr>
<tr>
<td></td>
<td>• No data available on preferences.</td>
<td>bacon, ham, sausages and frankfurts.</td>
</tr>
<tr>
<td></td>
<td>However pork bases not appropriate for Muslims.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Sausages and frankfurts not likely to be eaten except for younger generation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>specific Lebanese sausages would be chosen (eaten at breakfast with lemon)</td>
<td></td>
</tr>
</tbody>
</table>
Table 5.3.3.1: (Continued)

<table>
<thead>
<tr>
<th>Food</th>
<th>Middle Eastern (ME)</th>
<th>Anglo (AA)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dairy Products</strong></td>
<td>Many ME are lactose intolerant therefore dairy foods are usually fermented type. Also keeps longer. Yoghurt is nationally enjoyed. Plain natural yoghurt either dried to make a thick dip (resembling cheese), cooked and used as sauce or dressing, diluted and drunk usually eaten with bread; olives, tomatoes. Sweetened tub style yoghurt not traditionally familiar may be enjoyed by younger generation. Cheese is also significant in the diet of ME. Many home made Fetta, Kaseri, Halumi, Ricotta are some favourites.</td>
<td>Generally dairy products not excessively popular with these clients. Cream milk and cheddar cheese scored highest. These are inconsistent with ME. Plain yoghurt rated very low and fruit yoghurt is preferred (although also low). Cheeses such as Ricotta, and Blue Vein scored very low and high reports of never tried. These are popular among ME. No mention of other continental style cheeses.</td>
</tr>
<tr>
<td><strong>Pulses</strong></td>
<td>These are an integral part of ME diet. One of the staples used in many dishes eaten at any meal. However baked beans not familiar foods. Our target group avoided using them in times of illness and lactation so as not to produce wind.</td>
<td>These foods rated quite low overall with Anglo community. Baked beans most popular. Only ones mentioned that are consistent with ME choices and preferences are lentils and chick peas but these had high 'never tried' ratings.</td>
</tr>
<tr>
<td><strong>Offal</strong></td>
<td>Generally many ME would not rate these as low. These are enjoyed by ME. Not as common dishes but there are many elaborate ways to prepare them. Liver and kidney appear to play a significant role in post partum.</td>
<td>People from Anglo Saxon background rated offal very low. Kidney and liver were most popular and brains least. Further, all but kidney scored very high 'never tried' rating.</td>
</tr>
<tr>
<td><strong>Breakfast Dishes</strong></td>
<td>Right across Middle East breakfast is generally light meal where • LABNEY, cheese, bread must be consumed. • Eggs are also popular. • Some soups and dips are eaten. • Fried continental sausages with lemon. • Lebanese pizza may be eaten. • In Australia breakfast cereal may be adopted as breakfast</td>
<td>Very different, high scores given to potato cakes, fried mushroom and savoury mince. These are completely unfamiliar to ME's.</td>
</tr>
</tbody>
</table>

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### Glossary

The spelling of the terms presented here have been adopted from Anthony et al (1993) or from participants recipes and suggestions of how best to spell each.

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAMI</td>
<td>OKRA stew. Made by sauteing onions and okra with meat and adding a tomatoe based sauce, served with rice. Variations across nation regarding thickness of stew exist. Assyrian clients report a preference for a wetter stew than Lebanese.</td>
</tr>
<tr>
<td>BORSH</td>
<td>Assyrian dish. Ingredients include carrots, beetroot, potatoes, cabbage, parsley and meat. Served with rice as a heavy meal.</td>
</tr>
<tr>
<td>BOUSHALA</td>
<td>An Assyrian dish made from watery yoghurt, green vegetables, herbs and rice or barley. Traditionally eaten as heavy main meal but modified to make a soup for hospitalisation. It is considered imperative in the healing process, particularly for the elderly.</td>
</tr>
<tr>
<td>CHICKEN and RICE</td>
<td>Basic chicken soup is made and served with RICE in the same dish.</td>
</tr>
<tr>
<td>CHICKEN SOUP</td>
<td>Made with chicken breast fillet boiled in water and pinch of spices, salt and cinnamon barks. Noted to be essential for Lebanese women in immediate post partum period. All other groups identified the healthy benefits of chicken soup. One piece of chicken is served with the boiling water in bowl, the remainder of the boiling water can be used to make other chicken dishes noted for their significance in lactation.</td>
</tr>
<tr>
<td>CREAMY RICE</td>
<td>A nourishing dessert made by stewing rice with milk and sugar. In Middle Eastern nations, orange blossom or rose water are essential ingredients, thought to have therapeutic qualities</td>
</tr>
<tr>
<td>CUSTARD</td>
<td>Nourishing dessert because of milk base. Preferred custard powder, set with biscuits.</td>
</tr>
<tr>
<td>CUTLETS</td>
<td>Assyrian name for KAFTA. Basic KAFTA mixture is used, bread crumbs are added to the mixture to help it bind so that it can be moulded into patties and pan fried. Two cutlets per serving accompanied by salad and rice complete the meal.</td>
</tr>
</tbody>
</table>
DAWEE  Diluted yoghurt. Refreshing, nourishing drink, consumed by Assyrian people. One cup of yoghurt to three parts water are whipped together. It is served chilled or with ice. Adding salt is optional.

DOLMA  Assyrian people refer to all stuffed vegetables as DOLMA. In Lebanon stuffed vegetables are referred to as MIHSHI. The same basic mixture is used to stuff a variety of vegetables. Some variation is evident across nations, for religious purposes, and depending on the vegetable being stuffed. Usually eaten as complete meals on their own, or served with salad and bread and/or yoghurt.

GERHDO  Rice and Yoghurt dish. Assyrian equivalent to LABNEYA identified by Lebanese participants.

HOMOS  Directly translated this refers to chick peas. HOMOS is the abbreviated name for HOMOS b'TAHINI which is the chick-pea and tahini dip characteristic to Middle Eastern cuisine.

KAFTA  Basic meat mixture used in a variety of dishes. The basic mixture is made from; finely ground meat with finely chopped onion, parsley and mixed spices. Lamb or Beef is preferable, lean hamburger meat is suitable.

Alternatively the basic mixture can be bought prepared from Middle Eastern butchers. Particularly halal butchers. Very versatile meat used in a variety of dishes and much appreciated for its versatility. Very popular across all nations.

KAFTA Mishweey  The basic KAFTA mixture is moulded into long thin finger shape, usually on skewers and grilled. KAFTA dries out very easily and should not be over cooked. Salad is an appropriate option to comprise an appropriate light meal in hospital. Alternately it is enjoyed served in Lebanese bread with HOMOS to make sandwich. This may be an appropriate cafeteria item.

KAFTA b'saineeyeh  KAFTA and potatoe casserole. KAFTA is moulded into short fingers and baked with sliced potatoes and tomatoe paste sauce. Served with rice or LABNEYA as an optional extra.

KIBI  Ground meat and Burghul (crushed wheat). Mutton leg is the ideal meat. Young meat not suitable as it does not blend well. A suitable alternative is ground lean topside beef. Approximately one and a half cups burghul to 500g meat. Other ingredients included ground spices and onion. Can be bought prepared from butcher. As grinding meat is a long tedious process as it is imperative to be grounded extremely fine. KIBI can be prepared in a variety of ways but usually very elaborate. There we have identified the most basic way, that is to bake it, but it needs to be modified as KIBI is high in fat. Assyrian identified boiled, not eaten in Lebanon. Assyrian also identified baked.
LABEN  Natural yoghurt. Used across Middle East in a variety of way and usually home prepared because it is more economical and can be made to individual preferences regarding consistency. In making it temperature must be exactly right and culture must not be disturbed while it is working. Made from full cream powered milk, unhomoginsed whole milk, small amount of yoghurt is used for starter. Skim milk varieties can be made.

LABNEY  This is a thick creamy yoghurt. It is a favourite Lebanese breakfast or continental snack when dressed with olive oil served with Lebanese bread and olives. Natural yoghurt, LABEN (home made or commercially bought) is simply placed in a cheese cloth or similar material and left to hang on the sink or a bowl, till all water is drained. This takes approximately 8 hours. It can be served in a small dish dressed with olive oil or moulded into small balls, for individual serves. These are pickled in olive oil and can be refrigerated for a very long time. LABNEY is a versatile food as it can be used to satisfy most Lebanese at any time.

LABNEYA  Yoghurt and rice stew equivalent to Assyrian dish GERHDO.

LOOBI  Green string bean stew. Most commonly made with stewed meat and tomatoe based sauce and served with rice.

MUSCLE SOUP  Nourishing, inexpensive soup made from boiling shanks (no pork products) with parsley and lemon.

MUGLEE  A fresh herbal tea made of a combination of variety of fresh herbs and spices such as cinnamon sticks, cloves, nutmeg, caraway seed, mint, cumin, aniseed and basil. The tea is indicated for use during lactation for its role in assisting milk production.

RED RICE  Assyrian non-meat main meal option for Wednesday and Friday. Rice boiled with tomatoe, fried onion an mushrooms. Served with salad and DAWEE.

RICE  is an integral food in the Middle Eastern diet as it comprises many meals and is served as a meal itself. Yet each nation has its own preferred preparation method for the staple form.

Lebanese-  Saute egg noodles in butter and salt before adding white rice and a small amount of water to boil. Most of the cooking is done in the simmering phase.

They also consider plain boiled rice is appropriate for diarrhoea.
| Assyrian | White rice is boiled with salt and butter is added to the top when it is complete.

| Iranian | Fried rice is preferred. Fried refers to melting butter in the boiling pot before adding white rice and water to biol. Salt is added for taste.

| Iraqi |  

RICE SOUP

This is usually made with chicken or meat which is stewed until tender. The rice is then added with parsley and salt and boiled together. This was considered the most essential common soup identified for illness by all groups.

SPANEEGH

Spinach stew served with rice.

TABOULEH

Parsley salad, made with burghul, tomatoe, spring onions, mint, pepper, spices, and dressed with a tangy mixture of lemon juice and olive oil.

YINSOUN

Herbal tea prepared by boiling anise seed in a large pot. Lebanese women noted that it has a significant role in lactation and reported the need to consume it in this time. Blanched almonds and walnuts may additionally be boiled with this. Other Lebanese participants also note the significance it has in healing, considering it necessary for ill people.
## APPENDIX 11

### GLOSSARY OF TERMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>AMES</td>
<td>Australian Migrant Education Service</td>
</tr>
<tr>
<td>COB</td>
<td>Country of Birth</td>
</tr>
<tr>
<td>CPU</td>
<td>Central Production Unit</td>
</tr>
<tr>
<td>EAPS</td>
<td>Ethnic Affairs Policy Statement</td>
</tr>
<tr>
<td>EFB</td>
<td>Ethnic Food Bank</td>
</tr>
<tr>
<td>EHW</td>
<td>Ethnic Health Worker</td>
</tr>
<tr>
<td>FM Staff</td>
<td>Food Management Staff</td>
</tr>
<tr>
<td>HAHS, MHU</td>
<td>Hunter Area Health Service, Migrant Health Unit</td>
</tr>
<tr>
<td>HSDU, SWSAHS</td>
<td>Health Service Development Unit, South Western Sydney Area Health Service</td>
</tr>
<tr>
<td>LGA</td>
<td>Local Government Area</td>
</tr>
<tr>
<td>MCMN</td>
<td>Multicultural Marketing News</td>
</tr>
<tr>
<td>MOW</td>
<td>Meals On Wheels</td>
</tr>
<tr>
<td>NES backgrounds</td>
<td>Non English Speaking Backgrounds</td>
</tr>
<tr>
<td>NFNPh</td>
<td>National Food and Nutrition Policy</td>
</tr>
<tr>
<td>NSW</td>
<td>New South Wales</td>
</tr>
<tr>
<td>SWSAHS</td>
<td>South Western Sydney Area Health Service</td>
</tr>
</tbody>
</table>