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SHORT RESEARCH ARTICLE

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Health promotion in emerging collectivist communities: A study of dietary acculturation in the South Sudanese community in Logan City, Australia

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Abstract

Issue addressed: Understanding dietary acculturation within collectivist communities is required to develop and tailor appropriate health promotion strategies to prevent diet-related chronic diseases. This research explores the journey of the South Sudanese community living in Logan City, Australia in establishing new norms around food choices and practices over time.

Methods: Three semi-structured group interviews and a final community forum of women (n = 20) from the South Sudanese community were conducted. These explored changes in and influences on dietary practices post-settlement. Sessions were recorded, transcribed and thematically analysed using inductive and deductive approaches. Feedback on findings from participants and community members was incorporated.

Results: Participants reported dietary acculturation phases, including assimilation, reflection and separation, with a return to traditional foods over time. Factors influencing the transition between phases included; the characteristics of the collectivist community such as shared knowledge, experiences and resources, increased accessibility to traditional foods, and increased food and health literacy as responses to emerging diet-related health issues.

Conclusions: The Logan City South Sudanese community has navigated a new and complex food environment with positive long-term dietary outcomes; however, the initial decline in health due to poor diet on arrival may have been prevented.

So what?: Early intervention and culturally appropriate health promotion strategies that are co-designed and tailored to the characteristics and strengths of newly settled collectivist communities are needed. These should promote the benefits of healthy traditional food habits, while assisting communities to successfully navigate a new food environment.

KEYWORDS
collectivist, cultural diversity, dietary acculturation, humanitarian, refugee, South Sudan, Sudan, dietary acculturation, collectivist, South Sudan, Sudan, refugee, humanitarian, cultural diversity

1 | INTRODUCTION

Refugees and migrants settling in Australia are generally at increased risk of diet-related conditions such as dental disease, hypertension, diabetes and obesity.[1-3] This is associated with post-settlement dietary changes thought to be part of the acculturation process.[4] Dietary acculturation is the process by which immigrants assimilate the dietary patterns of the host country.[5] It is understood that those settling in a new country experience various degrees of acculturation, involving the adaptation of the values, attitudes and behavioural patterns of the culture of origin to the host culture.[3] The acculturation process is described as taking four main forms; integration between both the minority and dominant cultures, assimilation towards the dominant culture, separation favouring the minority culture and marginalisation where neither the dominant or minority cultures are sustained.[6] The acculturation process is likely to differ between collectivist and individualistic communities due to differences in cultural values, social structures and networks.

When working with culturally diverse communities, it is important to know where they are located on the individualistic-collectivist scale,[7,8] and how this compares to the dominant culture into which communities are settled, in order to tailor health promotion strategies.[9] Collectivism values communal responsibility, interdependence, cooperation and collective survival.[10] Within collectivist cultures, the values and needs of the group take precedence over that of its individual members.[11] Key characteristics of both individualist and collectivist cultures are summarised in Table 1.

The level of collectivism has been used to distinguish nations from one another. Australia, along with the United States and the United Kingdom, rank highly as individualist cultures on the scale (90,91,89/100).[11] Many recently settled communities in Australia have low scores, meaning they are more collectivist in nature, for example, Sudan, Syria, Iraq and Ethiopia, rated 39, 35, 30 and 20 respectively.[7,12] Taking into consideration the level of collectivism is important in designing health promotion strategies for these communities.

This research explored changing dietary habits, the acculturation process, and how new community food norms were negotiated and entrenched within the South Sudanese, collectivist community living in Logan City, Queensland, Australia, in order to inform health promotion nutrition strategies.

2 | METHODS

2.1 | Setting

Logan City is located south of Brisbane and is one of the largest and fastest growing cities in Australia. Its vast geographical area (959 km2) consists of a culturally diverse population of 202,386 people, with 78% of people speaking a language other than English at home. In 2016, 8.9% people were reported unemployed compare to the Queensland state average (7.6%).[13]

2.2 | Study population

There are more than 24,000 South Sudanese living in Australia, with a majority arriving between 2001 and 2006 due to the civil war in Sudan.[14] The 2016 Census recorded 684 people of Sudanese ancestry living in Logan City.[15] This figure is likely an underestimate due to

TABLE 1 Key differences between collectivist and individualist societies

Collectivist	Individualist
Extended families/groups provide support and protection	Individual responsible for self and immediate family
Harmony in communication is valued and confrontation avoided	Speaking one's mind is seen as a characteristic of an honest person
High-context communication (ie use of stories and metaphors)	Low context communication (ie direct and task oriented)
Relationships prevail over tasks	Tasks prevail over relationships
Individual privacy is of little concern	Individual privacy is valued
Social network is the primary source of information	Media is the primary source of information
Resources are shared with the community	Individual ownership of resources

Note: Modified from Hofstede et al.[11]

language difficulties and lack of trust in governments resulting in low participation in the census.[16-19] On arrival, government-funded settlement support workers, church groups and local South Sudanese community members assist with orientation to accessing food and other services.

2.3 | Participants

To participate, community members had to meet the inclusion criteria below:

- A woman of South Sudanese ancestry
- Aged 25-65 years
- Involved in the Logan City South Sudanese community
- Currently living in Logan City
- Lived in Australia for greater than 5 years.

The Logan City South Sudanese community was chosen because of its size, extended settlement experience and the availability of cultural experts to inform the research design.

Women of this age range were selected because they are the main purchasers and preparers of food.[18] The age criterion ensured participants were old enough to remember the period from settlement to the present, while young enough to be active in current food purchasing and preparation.

2.4 | Recruitment

Recruitment methods were influenced by local knowledge and feedback from community members. Written flyers containing details of the study, eligibility criteria and contact information in English were distributed to key community leaders and South Sudanese community organisations by a member of the research team and a South Sudanese community member. Using a snowball sampling approach, community members were encouraged to distribute the flyer and its contents verbally to other community members. Interested community members then contacted the project team who provided eligible participants with a copy of the project information sheet.

2.5 | Focus group tools and processes

All group interviews followed the same semi-structured format. Focus group questions (provided in the supporting information below) were developed using a strengths-based approach, incorporating collectivist communication such as story-telling.

At the beginning of sessions, a consent form was provided in simple English, read to the group, interpreted into Juba Arabic and Ma'di languages for participants who required English language support and signed by all participants. This included written consent for audio recording of the focus groups. Confidentiality was also discussed, including the process of deidentifying transcribed audio recordings. All participants took part in the discussion and remained for the duration of the focus group.

2.6 | Data collection

The study used a qualitative approach comprising of focus group discussions and a follow-up community forum to cross-check the analysis. A qualitative approach was chosen to answer questions about experience, meaning and community perspectives,[20] relating to participants' food journey in Australia. There is evidence that people from collectivist communities feel more comfortable in speaking in focus group settings than people from individualistic cultures.[20] The community forum was part of a mixed methods approach to include a broarder range and number of community members. Community forums/meetings are common forms of community consultation within the Logan South Sudanese community.

Three focus groups and the community forum were conducted between February and June 2019 in central, easily accessed community centres. A female South Sudanese bicultural worker was paid to provide language support for group members.

Sessions were approximately 90 minutes in duration. The first focus group (FG1) included women who worked in health settings in order to explore how new health information entered the community. Two focus groups comprising of participants from non-health backgrounds were then conducted (FG2, FG3). After thematic analysis of the three focus groups, a summary of findings was developed. This was presented to the community forum, whose role was to validate findings and provide additional information.

Participant information on age, place of birth, length of settlement and migration history were not requested of participants, as key informants had indicated this was sensitive information and would impact on rapport and participation.

Audio recordings were externally transcribed verbatim and were reviewed independently by research team members, one of whom had Sudanese language skills and cultural knowledge. Transcription amendments were agreed to at a meeting of researchers. The research team identified that data saturation was reached after the third focus group when no new themes emerged from participants.[21]

At the community forum, the research findings were summarised and participants were given the opportunity to comment on interpretation. Two group facilitators made notes of the discussion, as audio-recording was not possible.

2.7 | Data analysis

As indicated by Braun and Clarke (2006) using both an inductive and deductive (with a collectivist lens) approach, the final transcriptions of focus groups and notes were manually coded

and grouped into preliminary categories by each individual research team member (AG, EL, BR).[22] Codes and categories were then shared between research team members and developed into themes, on which consensus was reached, thereby minimising potential bias.[22] Themes and representative codes were only included if they were confirmed by all research members as evident in the amended transcripts.

EL a member of the community, explained cultural norms, language and experiences to provide greater depth and understanding, without providing additional data. Due to the congruence of health worker themes, with other focus groups, all results were pooled.

Participants of FG1 were provided with the thematic analysis of their session. No changes were requested by members of this group. Feedback of the thematic analysis of other focus groups was not sought because cultural experts advised that it was an unrealistic expectation of participants and that the process of validation would confuse participants.

Participants of the community forum discussed a summary of the findings of all groups.

3 | RESULTS

Key findings included insights into the research process, changes in dietary intake after settlement initially and then over time, and the multiple factors influencing dietary acculturation.

3.1 | Participant characteristics

A total of 20 participants were grouped into three subgroups:

- Participants working in the health sector (n = 5)
- Non-health worker, community members (n = 10 (5, 5))
- Community forum (n = 5).

3.2 | Research process

All participants engaged in lively conversations, often taking turns and sometimes prompted by others from the group. Opinions were illustrated by sharing of stories. This provided rich information but made time-keeping challenging. Many people talked simultaneously making the audio transcription process difficult for some conversations.

As supported by other researchers,[23-25] this research identified the concepts of confidentiality and anonymity to be culturally problematic for this collectivist community. This research also identified a need for language and cultural support for participants, regardless of the length of stay.[26] Support was also required by researchers who were part of the studied community in order to understand traditional terms, context, assist with research design, and check assumptions and conclusions.[25]

3.3 | Dietary intake from settlement over time

Participants described that, upon settlement in Australia, they were required to navigate an unfamiliar food environment. Community members made dietary choices on arrival based on convenience, familiarity, taste, availability and accessibility. This tended to result in a diet rich in items such as soft drinks, cordial, fruit juice, pizza, takeaway, sausages, white bread and fried chicken. These foods were consumed both in homes and at community gatherings. Participants often referred to their initial lack of knowledge about the health consequences of overconsuming these items.

> Australia is a land of abundance. You're coming from refugee camp; it is very hard to get those luxury [items]—Coke and so forth. So, we [were] really eating everything this country can offer. [FG1]

> They put [cordial] into the bottle for babies. And then the kids would just be sucking it all the time. It is not good, but I think in a way, I will not blame anyone, because maybe from where people are coming from, [the knowledge] was not there.[FG1]

Participants reported that the lack of access to traditional foods, especially traditional green vegetables such as molokhia, pumpkin and sweet potato leaves, as well as grains such as millet and maize flour, made the early settlement phase very difficult.

> The first time I arrive here, it was really very hard. What can you eat? Where can you go. It's really very hard. [FG3]

Over time, participants reported that the community grew in size and changes in dietary practices occurred. More traditional foods or close substitutions were being eaten, including okra, molokhia, spinach, peanut butter, millet, maize and various meats, chicken and fish. There was a significant decrease in soft drink and cordial consumption, which were replaced with tea, coffee, milk and fruit juice.

> We cut off the soft drinks. Maybe in case visitors, so we have to then buy those things. But if no visitors, we have to deal with apple juice and orange juice. So, more water in the house. [FG3]

At community gatherings and events, sausages, fried chicken, soft drinks, white bread and salad remained shared items; however,

traditional foods were added in the form of big pots of meat stew with vegetables.

3.4 | Key factors influencing dietary acculturation

3.4.1 | Support for new arrivals

For families who were among the first to arrive, much of the navigation of the food environment was done on their own, with information on the location of local supermarkets provided by non-South Sudanese settlement workers. Participants did not report receiving any nutrition information or assistance to access traditional food. As a small community was established, often female community members took on the role of orienting newly arrived families, taking women to supermarkets and weekend markets and introducing them to new community food practices and household items. New arrivals were also quick to mirror the behaviour of others in their new community.

> She [a community member] said; "OK I will take you to go shopping—so, she start taking me to the shopping centre where she know". [FG3]

3.4.2 | Value of community gardens and access to traditional foods

Access to land for community gardening was reported to have made a major difference to food eaten and the mental and social wellbeing of community members. Traditional vegetables were cultivated using land provided by a local university, and the produce shared and sold at community markets.

> Most of us, we used to be farmers, so we grow up with the farm, we grow up using our own farm food. The gardening thing is socialisation for us. You get together. You share pieces [produce]. You share joy. [FG2]

As the community grew, greater demand and influence over local shops led to increased availability of traditional foods.

3.4.3 | Changes in health status

Participants reported changes in health status after settlement. Links between dietary intake, sedentary behaviour and weight gain were made, as well as the resultant increased risk of chronic disease through intra-community communication networks and from external health professionals. Some community members were diagnosed with type two diabetes, dental diseases, hypertension and risk factors such as high cholesterol, which catalysed dietary change for both the diagnosed individuals and other community members.

> Some people develop type two diabetes, and all those things. ..... and their specialist also advise them on healthy eating, so that they can reduce their risks. [FG1]

3.4.4 | Sharing of food, knowledge, experiences, values and attitudes

The willingness to share enabled the community to navigate and create rapid dietary change. As community members discovered sources of traditional foods or alternative vegetables, these were shared with visiting community members.

> Your wealth is the wealth of the community.

> If one person get it, you will buy for at least five mothers. That is how we share. [FG1]

Communication within the community occurred predominantly face-to-face at community events or within homes. Events were frequent, with gatherings at least weekly for birthdays, funerals, weddings, baby showers and community barbeques. Participants reported that these times provided the greatest opportunity to share knowledge and experiences, often through storytelling. There was also a growing use of social media within the South Sudanese refugee population.

> ... but as a community, we always share information, without any cost. So everywhere we go, we share information. [FG1]

> If we don't communicate, we will have no survive. [FG2]

> ... there's a few ladies who were really this big. They shrink. Then they put it on Facebook, okay? Because we are all interconnected. "Oh, look at that! What is your trick? [FG1]

The community members reported sharing values and attitudes, even when these were shifting. For example, the community collectively shifted their cultural perceptions to value slenderness over larger body sizes.

> But when someone say, "Oh, you're gaining weight." [We now think] Oh my God! That is the most disgusting thing ever to have in your ears. Because in Africa, if someone say that, "Oh, you are getting weight." You are so happy! [FG3]

4 | DISCUSSION

4.1 | Collectivism and acculturation

Focus group discussions provided evidence that the South Sudanese community in Logan City has continued to be a collectivist community post-settlement, demonstrating the collectivist traits outlined in Table 1. These included group support and protection, high-context communication, less concern for individual privacy, resource sharing and the use of the social network as the primary source of information.[11]

Participants shared the same food and nutrition issues reported on arrival by other researchers for Sub-Saharan communities settled in developed countries.[27-31] However, this paper documents how, over the 17 years of settlement, as a collectivist community, the Logan South Sudanese community successfully navigated issues such as lack of knowledge, poor access to traditional foods, differences in socially acceptable body image perceptions and social norms around food at events and household visits. The return to traditional food was consistent with previous research findings that cultural foods are tightly held as a means of preserving traditions and maintaining the group.[32]

The community navigated the dietary acculturation phases as outlined in Table 2. Initially, due to limited knowledge of local food environments and limited availability of traditional foods, there was dietary "assimilation" with the adoption of the predominant culture's food practices evidenced by an increase in energy-dense, micronutrient-poor foods and beverages and a reduced intake of vegetables.[6,33] Changes in health status and increased knowledge on the impact of diet on health were drivers to reflect on the value of traditional dietary practices ("reflection" phase). This resulted in increased consumption of traditional foods and vegetables ("separation" phase).

4.2 | Early education and support

A focus on providing nutrition support and information on arrival may have reduced the incidence of rapid weight gain, dental disease (including bottle caries) and the emergence of chronic diseases suffered by community members.[1-3] Recruiting community navigators may have been effective given the established communication networks and other collectivist traits. Early investment in small businesses to supply traditional foods and the set up local community and commercial gardens to supply traditional fruit and vegetables could have created a more welcoming and healthier food environment for those settling in Logan City.[34,35]

4.3 | Culturally appropriate health promotion strategies and teams

The use of theories and frameworks that promote community capacity-building are likely to be more effective in health promotion, while those based on individual behaviour change are unlikely to be persuasive in collectivist communities.[8] For example, a community development approach where community members are supported to identify and take collective action on issues that are important to them, may be appropriate.[36] A strengths-based approach, which identifies and acknowledges the current assets, such as highly developed intra-community networks, within the community could also be more effective. This would be complemented by co-design methods and culturally tailored communication methods (eg story telling). The inclusion of cultural consultants on project teams and the employment of bicultural workers and community champions to implement community-led strategies is also recommended. It is also important that those involved in health promotion, especially those with an individualistic cultural background, understand their own cultural values and how these may influence their practise when working with collectivist communities.[9,37]

On a practical level, community gardens for this group are a culturally attractive approach to increasing vegetable and fruit consumption, improving physical activity and supporting social and mental wellbeing.

4.4 | Culturally appropriate research methods

To reduce suspicion around confidentiality and anonymity, researchers and ethics committees need to consider negotiating the contexts in which confidentiality and anonymity should be guaranteed.[38] It is recommended that bilingual staff identify these contexts and assist in explaining these concepts to research participants.

TABLE 2 Dietary acculturation phases for South Sudanese settling in Logan City, Australia

Acculturation phase	Diet-related impacts
1. Assimilation	Adoption of fatty meats, fast and junk foods High intake of soft drinks
2. Reflection	Diagnoses of nutrition-related health conditions Rapid weight gain and its link to poorer health Education from external health professionals
3. Separation	Community and home gardens producing traditional vegetables Increase in availability of traditional foods Reduced intake of fatty meats, fast and junk foods

Incorporating story telling within focus group questioning is recommended as a culturally effective method of communication.

4.5 | Study limitations

The focus on a single cultural group limits the generalisability of this study's results to other communities. In addition, the use of established networks may have created sample bias. Characteristics of the collectivist community may have also led to early saturation. It was unclear whether early consensus was reached due to shared experiences and beliefs or in order to maintain harmony and united messaging within the community. This was addressed by validating the themes using a community forum. There is also potential for a lack of trust in non-Sudanese researchers influencing results. This was addressed by researchers familiarising themselves with South Sudanese culture and cuisine, and being recruited and introduced by a trusted community member.

5 | CONCLUSION

To prevent the adoption of less healthy dietary patterns of the host culture and an associated decline in health status, the early implementation of health promotion strategies that increase the capacity of collectivist communities to access to traditional foods and navigate a new food system are recommended. Community gardens are recommended to increase the consumption of traditional and new vegetables, while providing venues for social interaction and physical activity.

During the planning process, health promotion practitioners and researchers should explore where their own culture sits on the individualist/collectivist scale and develop an awareness of how this might influence their work with collectivist communities. Health promotion strategies will also benefit from recruiting bicultural workers and community champions who can utilise collectivist community strengths, such as sharing and strong communication networks.

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CONFLICT OF INTEREST

Danielle Gallegos is currently supported by the Children's Hospital Foundation (CHF) via a philanthropic donation from Woolworths. Neither the CHF or Woolworths were involved in this study.

ETHICAL APPROVAL

Ethical approval was granted by the Metro South Human Research Ethics Committee and the Queensland University of Technology Human Research Ethics Committee (HREC/18/QMS/46909-SSA/18/QMS/46909).

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REFERENCES

1. Australian Government. Community information summary - sudan-born 2011 [cited 2018 October 6]. Available from: https://www.dss.gov.au/sites/default/files/documents/02_2014/sudan.pdf
2. Commonwealth of Australia. Sudanese community profile 2007 [cited 2018 October 6]. Available from: https://www.dss.gov.au/sites/default/files/documents/11_2013/community-profile-sudan.pdf.
3. Delavari M, Sonderlund AL, Swinburn B, Mellor D, Renzaho A. Acculturation and obesity among migrant populations in high income countries–a systematic review. BMC Public Health. 2013;13:458.
4. Gallegos D, Nasim S. Exploring weight status, dietary intake and acculturation in South Asian women living in Brisbane, Queensland. Nutr Dietetics. 2011;68(4):285–90.
5. Garnweidner L, Terragni L, Pettersen K, Mosdøl A. Perceptions of the host country's food culture among female immigrants from Africa and Asia: Aspects relevant for cultural sensitivity in nutrition communication. J Nutr Educ Behav. 2012;44(4):335–42.
6. Rudmin F. Critical history of the acculturation psychology of assimilation, separation, integration, and marginalization. Rev General Psychol. 2003;7(1):3–37.
7. Hofstede G. Country comparison 2019 [cited 2019 29 September]. Available from: https://www.hofstede-insights.com/country-comparison/australia,the-uk,the-usa/.
8. Wang-Schweig M, Kviz FJ, Altfeld SJ, Miller AM, Miller BA. Building a conceptual framework to culturally adapt health promotion and prevention programs at the deep structural level. Health Promot Pract. 2014;15(4):575–84.
9. Triandis HC, Singelis TM. Training to recognize individual differences in collectivism and individualism within culture. Int J Intercult Relat. 1998;22(1):35–47.
10. Parker A, Grinter R. Collectivistic health promotion tools: Accounting for the relationship between culture, food and nutrition. Int J Hum Comput Stud. 2014;72:185–206.
11. Hofstede G. Cultures and Organizations. 3rd ed. Hofstede GJ, Minkov M, editors. New York, USA: McGraw-Hill Professional Publishing; 2010.
12. Pirju LS. Four Sudan's cultural values - an international benchmarking analysis. Jurnalul de Studii Juridice. 2018;12(3–4):12.
13. Australian Bureau of Statistics. 2016 census quickstats Logan 2017 [cited 2020 3 October]. Available from: https://quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/SED30046?opendocument.
14. Refugee Council of Australia. Key facts on the conflict in south Sudan 2016 [cited 2019 6 October]. Available from: https://www.refugeecouncil.org.au/south-sudan/.
15. Logan City Council. Logan city 2016 [cited 2019 21 October]. Available from: https://profile.id.com.au/logan/ancestry.
16. Losoncz I. Absence of respect: South Sudanese experiences of Australian Government and Social Institutions 2014. PhD Thesis,

ANU. [cited 2019 Oct 06] Available from https://openresearch-repository.anu.edu.au/handle/1885/151579.
17. Australian Human Rights Commission. Justice: African Australians: Human rights and social inclusion issues project [Compendium]. Internet 2010 [cited 2020]. Available from: https://humanrights.gov.au/our-work/justice-african-australians-compendium-2010.
18. Abbato S. Community profiles for health care providers. Division of the Chief Health Officer, Queensland Health; 2011.
19. Australian Institute of Health and Welfare. Australia's health 2018. Canberra: AIHW; 2018.
20. Hammarberg K, Kirkman M, de Lacey S. Qualitative research methods: When to use them and how to judge them. Hum Reprod. 2016;31(3):498–501.
21. Liamputtong P. Qualitative Research Methods, 4th edn. South Melbourne: Oxford University Press; 2013.
22. Braun V, Clarke V. Using thematic analysis in psychology. Qualit Res Psychol. 2006;3(2):77–101.
23. Durham J. Ethical challenges in cross-cultural research: a student researcher's perspective. Aust N Z J Public Health. 2014;38(6):509–12.
24. Crow G, Wiles R. Managing anonymity and confidentiality in social research: the case of visual data in community research. 2008.
25. Roberts LR, Jadalla A, Jones-Oyefeso V, Winslow B, Taylor EJ. Researching in collectivist cultures: reflections and recommendations. J Transcult Nurs. 2015;28(2):137–43.
26. Abdelkerim AA, Grace M. Challenges to employment in newly emerging African communities in Australia: a review of the literature. Australian Social Work. 2012;65(1):104–19.
27. Wilson A, Renzaho A, McCabe M, Swinburn B. Towards understanding the new food environment for refugees from the horn of Africa in Australia. Health Place. 2010;16(5):969–76.
28. Renzaho A, McCabe M, Swinburn B. Intergenerational differences in food, physical activity, and body size perceptions among African migrants. Qual Health Res. 2012;22(6):740–54.
29. Legault A, Marquis M. Nutrition information-seeking behaviour of low-income pregnant maghrebian women. Canadian J Dietetic Pract Res. 2014;75(1):22–8.
30. Dweba T, Oguttu W, Mbajiorgu C. Factors influencing dietary choices of immigrants upon resettlement in host countries - a scoping review. Appl Ecol Env Res. 2018;16(2):1329–51.
31. Regev-Tobias H, Reifen R, Endevelt R, Havkin O, Cohen E, Stern G, et al. Dietary acculturation and increasing rates of obesity in Ethiopian women living in Israel. Nutrition. 2012;28(1):30–4.
32. [32]Kittler PG, Sucher KP, Nahikian-Nelms M, Nelms M. Nahikian-Nelms M, Nelms M. Food and culture: Cengage Learning. 2017.
33. Australian Bureau of Statistics. Australian health survey: Nutrition first results - foods and nutrients, 2011-12 Internet 2014. Available from: https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4364.0.55.007Main+Features12011-12?OpenDocument.
34. Hartwig KA, Mason M. Community gardens for refugee and immigrant communities as a means of health promotion. J Community Health. 2016;41(6):1153–9.
35. Harris N, Minniss FR, Somerset S. Refugees connecting with a new country through community food gardening. Int J Environ Res Public Health. 2014;11(9):9202–16.
36. Australian Institute of Family Studies. What is community development? Internet 2017 [cited October 2019]. Available from: https://aifs.gov.au/cfca/publications/what-community-development.
37. Kaihlanen AM, Hietapakka L, Heponiemi T. Increasing cultural awareness: Qualitative study of nurses' perceptions about cultural competence training. BMC Nurs. 2019;18:38.
38. Svalastog AL, Eriksson S. You can use my name; you don't have to steal my story–a critique of anonymity in indigenous studies. Dev World Bioeth. 2010;10(2):104–10.

SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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