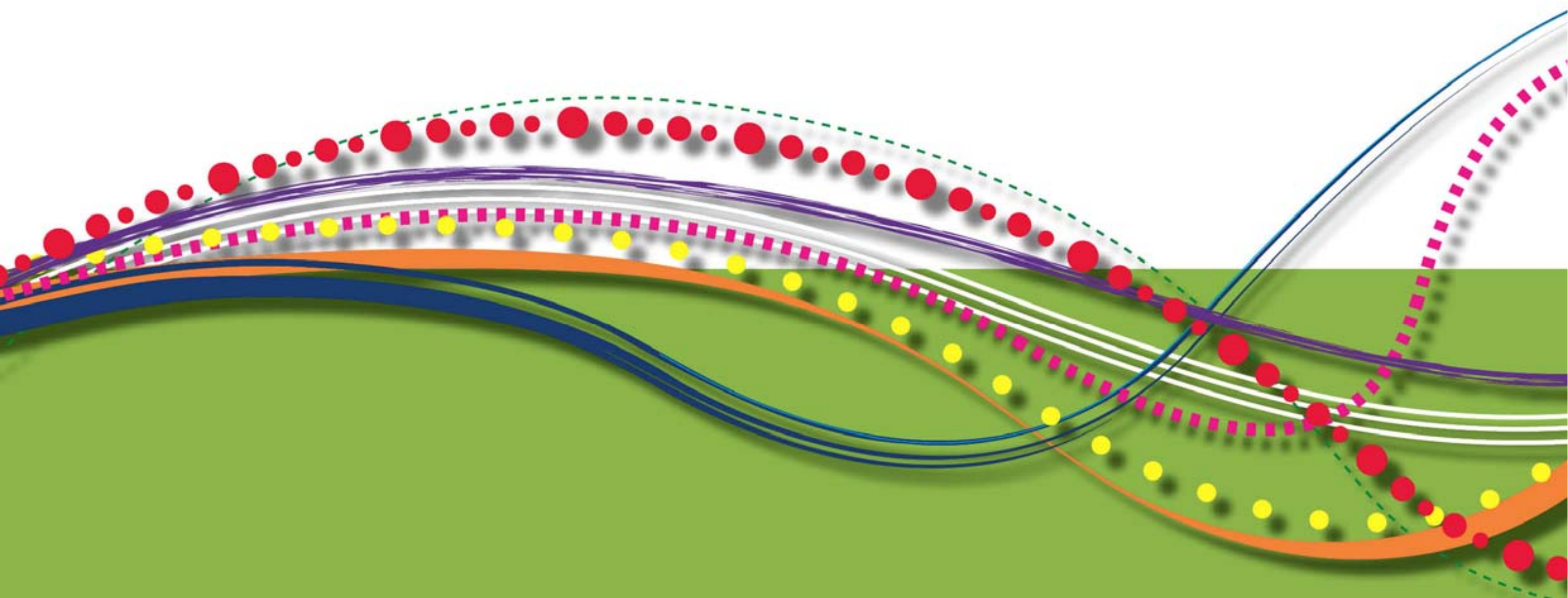
Queensland Health

The health of Queensland's Fijian population 2009



Queensland Government

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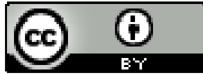

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An electronic version of this document is available at www.health.qld.gov.au/multicultural

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Executive Summary

This document profiles the health of Fijian Queenslanders. Where separate data are available, data on the indigenous Fijian and Fiji Indian communities are presented.

Data from a literature review, the Queensland Hospital Admitted Patient Data Collection, Australian Bureau of Statistics and focus groups with indigenous Fijian and Fiji Indian community members and leaders are presented. Quantitative data, particularly on the determinants of health and some health status indicators are not available. Improved data collection and analysis is required to enable the development of a complete synopsis of the health of Fijian Queenslanders.

At 2006 Census, there were 8931 Fiji-born Queensland residents. The top three ancestry responses that Fiji-born people in Queensland reported were Indian (60 per cent), indigenous Fijian (19 per cent) and English (9 per cent). The Fiji-born population grew by 17.9 per cent between the 2001 and 2006 Censuses. This is lower than that of the Australia-born and many other Pacific Islander countries. The population was predominantly distributed in Brisbane, Logan and Gold Coast – with 66 per cent of the population living in these three Local Government Areas.

The indigenous Fijian and Fiji Indian communities have distinct health beliefs and practices. Traditional indigenous Fijian spirituality, Christian religions, familiarity with Australian medical treatments, witchcraft and traditional healing practices can occur concurrently among indigenous Fijians living in Fiji and elsewhere. Fiji Indians, who are predominantly Hindu, are also familiar with Australian medical treatments and concurrently subscribe to *ayurveda*, evil eye, black magic and karma. Muslim, Sikh or Christian Fiji Indians would be less familiar with these beliefs and practices.

The Fiji-born community in Queensland was found to have higher standardised separation rates than the total Queensland population for total avoidable hospital admissions, coronary heart disease and diabetes complications and lower rates for chronic obstructive pulmonary disease, external causes and musculoskeletal conditions. Limited mental health data also indicate a higher representation of Fiji-born consumers of Queensland mental health services. Fiji-born women had lower exclusive breastfeeding rates than Australia-born women, indicating that additional support and information may be required.

The indigenous Fijian and Fiji Indian focus groups identified diabetes, coronary heart disease, mental illness, alcohol and kava abuse and cancer as the most prevalent conditions in their respective communities. This is consistent with Queensland Health data for diabetes, coronary heart disease and mental illness. Both communities also reported many shared experiences with the Queensland Health system including problems with the lack of Pacific Islander health workers, the lack of culturally tailored health promotion and economic barriers to health care. They also identified low health literacy in their respective communities and a strong cultural reluctance to seek help. Strategies to improve indigenous Fijian and Fiji Indian health were also shared across the two communities, with culturally tailored health promotion, culturally specific health workers, dedicated Pacific Islander health programs and services, and increasing the cultural competency in health services identified as some of the solutions.

Taking these findings together, the burden of chronic disease in the indigenous Fijian and Fiji Indian communities is high and the level of engagement with the health system, particularly preventive health, is low. The low level of health literacy across both communities presents an additional challenge to ensure these communities are engaged into chronic disease prevention and self management activities. Similar findings were made across other Pacific Islander communities in Queensland, highlighting what focus group participants themselves stated Pacific Islander people have more similarities than differences regarding health and cultural belief systems. Therefore, the strategies to improve Pacific Islander health in Queensland have been compiled into a separate document, *Queensland Health response to the Pacific Islander and Māori needs assessment*.

About the document

Background

In 2008/09 the Queensland Government identified Pacific Islander[1] communities as a priority population. In response to this, Queensland Health undertook a health needs assessment with the largest communities – Papua New Guinean, Māori, Samoan and Fijian (indigenous Fijian and Fiji Indian[2]).

Document structure

Section one, *Data sources*, describes the main data sources used in this document and the data limitations.

Section two, *A profile of Queensland's Fijian population*, includes the population size and growth, languages spoken at home, ancestry, year of arrival, participation in voluntary activities, and age, sex and geographic distribution of the population.

Section three, *Fijian health beliefs* outlines the key cultural issues and factors that relate to the indigenous Fijian and Fiji Indian construction and experience of health and illness.

Section four, *Wellness and illness, the health status of Fiji-born Queenslanders,* includes information on deaths (all causes and avoidable) and hospitalisations (all causes and avoidable).

Section five, *Determinants Fijian health and wellbeing*, includes health behaviours, psychosocial factors, socioeconomic characteristics, and knowledge, attitudes and beliefs.

Section six, *Health outcomes for Queenslanders born in Fiji,* principally documents on the national health priority areas including: cancer, cardiovascular disease, diabetes, respiratory disease and musculoskeletal disease.

Section seven, *The way forward to improve Fijian health,* provides information on the approach taken to develop strategies and recommendations to improve Pacific Islander health in Queensland.

[1] Pacific Islander people come from three main regions in the Pacific – Melanesia (including Papua New Guinea, the Indonesian provinces of Papua and West Irian Jaya, New Caledonia, Vanuatu, Fiji, and the Solomon Islands); Micronesia (the Marianas, Guam, Wake Island, Palau, the Marshall Islands, Kiribati, Nauru, and the Federated States of Micronesia); and Polynesia (New Zealand, Niue, the Hawaiian Islands, Rotuma, the Midway Islands, Samoa, American Samoa, Tokelau, Tonga, Tuvalu, the Cook Islands, French Polynesia, and Easter Island). Polynesia is the largest of the three zones.

[2] It should be noted that people from Fiji of Indian ancestry are known as Fiji Indians, Indo-Fijians and Indian Fijians. Consultation with Queensland community leaders showed a preference for the term 'Fiji Indians' as most in the community refer themselves to this name. The term 'Fiji Indian' is used in this report.

1 Data sources

This document draws on several quantitative and qualitative data sources. Data and methodology are further described in Attachment 1.

1.1 Literature review

A literature review was conducted for 1998 to 2010 using the following search terms:

- Health status Fijians
- Health priorities Fijians
- Morbidity Fijians
- Risk factors Fijians
- Pacific Islander health
- Fiji health
- Fiji epidemiology
- Fiji chronic disease
- Fiji mental health
- Social determinants of health
- Health inequity Fiji
- Health disparity Fiji
- Health inequality Fiji
- Fijian health models
- Fijian health beliefs
- Indian health models
- Indian health beliefs

Databases searched:

- Medline
- Meditext
- Austhealth

References in articles obtained were followed up. Internet searches were also conducted using these search terms.

Articles were prioritised to include studies on immigrant indigenous Fijian and Fiji Indian populations including those in Australia and New Zealand.

1.2 Quantitative data sources

1.2.1 Hospital separation data

Hospital separation data were derived from the Queensland Hospital Admitted Patient Data Collection, including private and public hospitals. All disease specific hospital separations were derived using the principal diagnosis of inpatient episodes of care. All separations were coded using the International Classification of Diseases version 10 Clinical Modification (ICD-10-CM) using standard code sets. Death and hospitalisation rates for all diseases and conditions are reported as age standardised rates. Standardisation minimises the distorting effects of age on the indicators and facilitates comparisons among populations.

With the method of direct standardisation, the proportional distribution of the standard population by age group is applied to the rates to obtain age standardised rates, which minimise or remove the distorting effects of age. Indirect standardisation uses the age distribution of the standard population to obtain

expected counts, total number of expected counts and subsequently, standardised ratios (standardised mortality ratio or standardised separation ratio etc). The end product of direct standardisation is age adjusted rates, while the end products of indirect standardisation are expected counts and standardised ratios.

It should be noted that hospital separation only includes those born in Fiji – not members of the indigenous Fijian or Fiji Indian communities born in other countries, including Australia.

1.2.2 Australian Bureau of Statistics

Several data were obtained from the Australian Bureau of Statistics - National Health Survey 2007-08[1], Health Literacy[2], Australian Social Trends[3] and 2006 Census of Population and Housing.[4] All sources are cited and information about specific surveys including sample size can be obtained from the appropriate data custodian.

1.3 Focus groups with Fijian community members and leaders

As the Fijian community comprises two ethnically distinct communities – indigenous Fijians and Fiji Indians - separate focus groups were held with these communities.

In the indigenous Fijian community, three focus groups involving 28 people were held– four indigenous Fijian leaders participated in the leaders' focus group in Brisbane, eight community members attended the first community focus group and 16 attended the second community focus group. The first community focus group took place at a Fijian church in Annerley and involved four women and four men. The second focus group took place in Carina at a private residence and involved eight women and eight men.

In the Fiji Indian community, three focus groups involving 28 people were also held– four Fiji Indian leaders participated in the leaders' focus group in Brisbane, 11 community members attended the first community focus group and 13 attended the second community focus group. The first community focus group took place at a community hall in Bald Hills and involved three women and eight men who were predominantly of the Muslim, Hindu and Christian faiths. The second focus group took place in a community hall in Murarrie and involved 13 people predominantly from the Hindu faith.

The focus groups were co-facilitated by an indigenous Fijian or Fiji Indian facilitator and the Project Officer. Focus groups were conducted predominantly in English and also in Fijian and Fiji Hindi. A standard list of prompting points was used (Attachment 2 for community and Attachment 3 for leaders' focus groups). The focus group data was analysed by the Project Manager and Project Officer and then checked for cultural accuracy by the co-facilitators.

1.4 Health service provider survey

A potential sample of health services was developed. Health services in locations where the indigenous Fijian and Fiji Indian populations reside comprised the sample. Participants were randomly selected and contacted for a telephone interview. However, as most potential respondents were either not available or not able to participate due to time constraints, additional participants were selected from the sample or from referrals from the services contacted who could not participate. In total, sixteen participants completed the questionnaire. However of these sixteen participants, eight had not worked with people from an indigenous Fijian or Fiji Indian background, or did not know if they had. Therefore only eight health service providers were able to participate in the survey and the results have not been included as 50 per cent of the sample could not participate.

1.5 Data quality

Data are not available for several sections of this document. Health status data are limited as firstly the two communities cannot be separately identified and secondly, the data only includes country of birth as the sole indicator of membership of these communities. This excludes members of the indigenous Fijian and Fiji Indian communities born in countries other than Fiji.

Quantitative data on the determinants of health relies on overseas studies and aggregated Australian data that place all Pacific Islander people into the category 'Oceania'. Queensland data on vaccination, mental health, alcohol, tobacco and other drugs, and communicable diseases are not available for Fiji born Queenslanders, or those with indigenous Fijian/Fiji Indian ethnicity.

2 A profile of Queensland's Fijian population

Fijians have lived in Australia since the late 19th century but migration was in small numbers and predominantly by those of European ancestry until the 1960s. By 1966, more than 60 per cent of Fijians living in Australia had settled in Sydney and this pattern of settlement in Sydney has continued.[5] In 2006, Sydney had 55.9 per cent of the total Fiji-born population in Australia.[6]

Following the military coups and political unrest in Fiji in 1987, Australia received an influx of Fiji Indians seeking asylum. In 1987-88 the number of settler arrivals reached a peak of 2980 and by 2001 the Fiji-born population in Australia had increased to 44 040, making up 1.1 per cent of the overseas-born population and 0.2 per cent of the total Australian population. Most Fiji-born people in Australia are of Indian origin.

Queensland has Australia's second largest population of Fiji-born people, with 18.6 per cent of the national total, following New South Wales, with 59.4 per cent of the total Fiji-born population in Australia.

2.1 Population size and growth

The minimum core set indicators defining cultural and linguistic diversity (CALD) are country of birth, main language other than English spoken at home, and proficiency in English. Refer to Attachment 5 for the full list of indicators.

The size of the Queensland Fijian population can be estimated from 2006 Census data on country of birth. According to this data, there were 8931 Queenslanders who were born in Fiji. Fiji was ranked 16th of all overseas birthplace groups in Queensland. People born in Fiji comprise 0.2 per cent of the total Queensland population.[7]

However, country of birth data does not indicate the size of the indigenous Fijian and Fiji Indian communities. Ancestry data provides further information. There were 4064 Queenslanders with indigenous Fijian ancestry and 26,042 with Indian ancestry. Of those with Indian ancestry, 5329 were born in Fiji.

At the 2006 Census, 843 people spoke Fijian at home while 4,491 Fiji-born people spoke Hindi at home.

Table 1 Queensland Fijian population by three CALD indicators, 2006

Queenslanders born in Fiji	8,931[3]
Queenslanders who speak Fijian at home	843
Queenslanders born in Fiji who speak Hindi at home	4,491
Queenslanders with indigenous Fijian ancestry (all birthplaces)	4,056
Queenslanders with Indian ancestry (born in Fiji)	5,329

The Fiji-born population (based on country of birth) grew by 17.9 per cent between the 2001 and 2006 Censuses, while the Australia-born population grew by 27.4 per cent.

[3] For some demographic and health determinants indicators (such as ancestry or weekly individual income by birthplace) the total population number may differ by a few, depending on which source was used. This is due to the application of randomisation formulas by ABS.

2.2 Languages spoken at home

At the 2006 Census, there were 843 Queenslanders who spoke Fijian at home. This was a 15.5 per cent increase from the 2001 Census. Of these people, 690 were born in Fiji while 118 were born in Australia. Fijian was ranked 30th of all overseas languages spoken at home in Queensland.[8]

Other languages spoken by Queenslanders who were born in Fiji were Hindi (4491 people), Cantonese (51) and Tongan (10). Queenslanders who were born in Fiji spoke a diversity of languages at home.

2.3 Ancestry

At the 2006 Census, 4056 Queenslanders identified indigenous Fijian ancestry. Of those who identified Indian ancestry, 5,336 were born in Fiji. Fiji Indians comprised 20.4 per cent of all Queenslanders with Indian ancestry– the third largest birthplace group after India (31 per cent) and Australia (27.1 per cent).

In the 2006 Census, the top three ancestry responses that Fiji-born people in Queensland reported were, Indian 60 per cent (5,336), indigenous Fijian 19 per cent (1,662) and English 9 per cent (769).

2.4 Religious affiliation

At the 2006 Census, those Queenslanders born in Fiji identified with the following religious affiliations:

Table 2 Fiji born Queenslanders by religious affiliation, 2006

Religion	Number
Hindu	3912
Islam	1090
Uniting Church	699
Assemblies of God	178
Seventh-Day Adventist	98
Sikhism	43
Brethren	15
Born again Christian	13

2.5 Year of arrival

Table 3 shows that the majority of Fiji-born people arrived in Australia between 1991 and 2000.

Table 3 Fiji-born Queenslanders by year of arrival, 2006

Before 1971	1971-1980	1981-1990	1991-2000	2001-2005	2006	Not stated	Total
550	767	2706	2771	1,571	256	366	8987[4]

[4] For some demographic and health determinants indicators (such as ancestry or weekly individual income by birthplace) the total population size may differ by a few, depending on which source was used. This is due to the application of randomisation formulas by ABS.

2.6 Participation in voluntary activities

At the time of the 2006 Census, 17.6 per cent of the Fiji-born population in Queensland had participated in voluntary activities in the preceding 12 months, ranking Fiji-born Queenslanders 18th among country of birth groups. Australia-born people were ranked 5th with 20.3 per cent of people participating in voluntary activities in the preceding 12 months. Participation in voluntary activities is considered an important indication of social inclusion.[9,10]

2.7 Age and sex distribution

Among the total population of Fiji-born in Queensland, there were 4905 females (54.45 per cent) and 4103 males (45.55 per cent) in 2006. The sex ratio was 83.7 males per 100 females for Queensland and 86.3 males per 100 females for Australia.

In 2006, the median age for the Fiji-born population in Queensland was slightly higher than that of Australia-born population - the median age of the Fiji-born in 2006 was 39.5 years compared with 46.8 years for all overseas-born and 37.1 years for the total Australian population. The age distribution showed 5.5 per cent were aged 0-14 years, 12.8 per cent were 15-24 years, 45.0 per cent were 25-44 years, 29.7 per cent were 45-64 years and 7.0 per cent were 65 and over.[5]

2.8 Geographic distribution

In 2006, the three Health Service Districts with the largest populations of Fiji-born Queenslanders were Metro South (4261), Metro North (2324) and Darling Downs West Moreton (622). The top three Local Government Areas (LGA) were Brisbane, Logan and Gold Coast.

Table 4 Fiji-born by top 10 Queensland LGAs, 2006

Local government area	Responses (2006)	Percentage
Brisbane (C)	4275	47.82
Logan (C)	1012	11.32
Gold Coast (C)	648	7.25
Pine Rivers (S)	491	5.49
Ipswich (C)	354	3.96
Caboolture (S)	238	2.66
Redland (S)	229	2.56
Cairns (C)	149	1.67
Townsville (C)	143	1.60
Redcliffe (C)	139	1.55
Other	1262	14.12
Total	**8940**	**100.0**

2.9 Summary of the Fijian population profile

The size of the Fijian population in Queensland can be measured from 206 census country of birth data. The population of Fiji-born people in Queensland in 2006 was 8931. The Fijian population was culturally and religiously diverse, with 60 per cent identifying Indian ancestry, 19 per cent indigenous Fijian ancestry and 9 per cent English ancestry. The religion with the largest affiliation for Fiji-born Queenslanders was Hinduism.

The majority of Fiji-born people arrived in Australia between 1991 and 2000. This has implications for the 'healthy migrant effect' which is a temporary phenomenon whereby healthy migrants start losing their relatively good health after the first five years of settlement.[11-14] The Fiji-born population grew by 17.9 per cent between the 2001 and 2006 Censuses, which was lower than most other Pacific Island countries of birth groups.

The median age for the Fiji-born population was slightly older than that of the Australia-born population and the sex ratio was 83.7 males per 100 females. The population was geographically distributed in Brisbane, Logan and Gold Coast – with 66.39 per cent of the population living in these three Local Government Areas.

The Fiji-born population had a lower participation rate in voluntary activities, than the Australia-born which has implications for social inclusion.

3 Fijian health beliefs

Health and illness are constructs that differ across cultures. Culture significantly shapes perceptions of health and health-related behaviour. The failure to adequately take into account a population's cultural and social constructs can result in barriers to effective health care.[15] This section will briefly outline the fundamental concepts that are integral to the indigenous Fijian and Fiji Indian constructions of health and illness.

The concepts presented in this chapter are generalisations, and health beliefs will vary according to level of acculturation, level of education, religious beliefs and other particulars. Individuals may not fit in a predetermined cultural box and will be in different stages of acculturation.

3.1 Indigenous Fijian community

Health beliefs

The World Health Organisation defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, and this approach is widely used in Western countries. However this approach to health and wellbeing does not encompass the indigenous Fijian understanding of health. Like other Pacific Islander beliefs, the indigenous Fijian approach has a greater emphasis on the social, family and spiritual dimensions of health and wellbeing.

indigenous Fijian values and beliefs are reflected in the *fonofale* model of Samoan health and the *Te Whare Tapa Wha* model of Māori health. The *fonofale* model of health is represented by a house – the roof represents cultural values and beliefs that constitute shelter for life; the floor or foundation represents the family; and the four pillars connect the culture and the family, and represent physical wellbeing, spiritual wellbeing, mental wellbeing and 'other'. The house is encapsulated in time, context and environment. Similarly, the *Te Whare Tapa Whā* Māori model of health expresses the equal importance of the physical, spiritual, family/social and mental dimensions of health.

Spiritual beliefs

Spirituality is a key component in Pacific Islander health belief systems and models of care, and exists alongside the physical, mental and social aspects of a person's wellbeing.[16] Traditional indigenous Fijian spirituality, Christian religions, and traditional healing practices can occur concurrently in Fijian communities. Nearly all indigenous Fijians living in Fiji are Christian and more than three-quarters are Methodist. As European contact and Christianity occurred only two centuries ago, indigenous Fijians have a spiritually related explanation for almost everything that occurs.[17]

The indigenous Fijian worldview encompasses three dimensions: *lagi* (the heavens), *vuravura* (the earth) and *bulu* (the underworld or spirit world).[17] With the introduction of Christianity, the Christian God was integrated into the heaven dimension.[17] The three dimensions are closely interconnected and are part of daily Fijian life.

indigenous Fijians often attribute sickness to spiritual causes. The power that makes a person sick can come from God, demons, a curse, or *mana* (spiritual power) of a living person.[17] Illnesses that are ascribed to natural causes are treated with Western medicine and medical practices, but illnesses that are thought to result from spiritual causes are treated by traditional healers, including seers, diviners, massage masters, and herbalists. When Western medicine fails, traditional cures are sought as the cause is then considered to be witch-craft.[18] The spiritual understanding of illness can encompass both Christian and ancient cosmological concepts, which coexist, each within its own sphere[16].

Mental health beliefs

It is believed that the breakdown of the holistic self can result in mental illness. Breach of *tapu* (sacred, a restriction or prohibition) may also contribute to mental illness. Some indigenous Fijians generally believe that mental illness is the manifestation of a curse. By and large this belief remains prevalent today.[19] Curses could be placed due to jealousy, rivalry or punishment. Curses that have specifically arisen as a result of an offence that has been committed by a person against an elder, the village or province, are referred to as the *'Kudru ni vanua'*.[19]

The indigenous Fijian relational self

The indigenous Fijian creation story explains life by reference to the relationships between people and God, and how humans were born out of these relationships. These interconnected relationships are the basis of life in traditional indigenous Fijian society. Relationships are formed around tribal structures. These structures are based on three main elements: land, kinship and spirituality. In Fiji these three elements underpin a person's birthright. It is believed that within these three elements many sacred relational bonds exist. When one of these bonds is broken, vulnerability and illness can occur.[19]

Collectivity is evident in all aspects of life, including social life, food preparation and consumption and identity. Health and illness of the individual is perceived as being closely related to the overall sense of interpersonal harmony in the community.[15]

Eating and body size

As in any society, food types are accorded different status. In Fiji root crops and protein are highly valued. However, the most highly valued can reflect its availability, such as pork (rather than fish) among coastal people. In many indigenous Fijian families living in Fiji, males receive more high-status food and greater quantities compared to females.[20]

Food is fundamental to establishing and sustaining social relationships and Fijians are expected to prepare more food than required in order to accommodate guests, both expected and unexpected. The giving and receiving of hospitality is important to expressing Fijian values such as respect and humility. Feasts are important to social and religious occasions.

Rank and status are also reflected in body size, with a more robust body size being a sign of wealth and social status for both males and females in some areas of Fiji. However, urbanisation and the influence of Western images of beauty and body sizes via the television and internet is changing these perceptions in Fiji. Over the last 100 years, demographic, lifestyle and food supply changes influenced by European contact and domination in trade and development, together with the forces of globalisation, have changed eating and physical activity patterns resulting in a decline in population health and a marked increased in obesity.[20,21]

3.2 Fiji Indian community

Fiji Indians trace their ancestry largely to indentured labourers who were taken to Fiji by the British between 1879 and 1916 to work on Fiji's sugar cane plantations, and to the later arrivals of Gujurati and Punjabi immigrants. Although they adapted to the new environment with changes to dress, language and diet, they maintained a distinct culture. They particularly maintained their religious and spiritual beliefs and practices. Some of the Indian health beliefs and traditions such as *ayurveda* are helpful to understanding Fiji Indian health beliefs and behaviours. There is no recently published literature on the health beliefs and practices of Fiji Indians.

Health beliefs

Dependence on traditional medicines has declined among Fiji Indians in favour of Western medicine.[22] There is general acceptance of Australian medical treatments, medicines and procedures. Those Indians who are vegetarians (many Hindus) may not want medications that are derived from animals. As the health system in Fiji is based on the western system of health, Fiji Indians are familiar with western medicine.

However, alongside their familiarity with western medicine they may also believe in *ayurveda*, evil eye, black magic and karma.

Ayurveda

The most common Indian system of medicine is known as *ayurveda*, which means "knowledge" or "science of life" (ayur – longevity; veda – science). Unlike modern medicine, which is primarily concerned with the treatment of disease, *ayurveda* is focused on prevention, encompasses a philosophy for living, as well as a holistic system of medicine. Diet and daily exercise are integral to maintaining good health. According to *ayurveda*, good health requires that there is a balance of three humours or "doshas": bile (fire), phlegm (water) and wind (vatta). Diagnosis according to a*yurveda* is based on investigating the root cause of a disease, which may be outside the body, and will be informed by an assessment of the humours and achieving equilibrium through diet, herbal remedies, meditation or yoga. Much of *ayurvedic* treatment is based on over 1,400 plants extraction and herbal remedies.

Although *ayurveda* is the national system of medicine in India it is not officially available in Fiji. However its use of home remedies, herbal remedies, massage and spiritual belief system has been maintained by Fiji Indians. The most common manifestation of home remedies is the use of certain spices and plants for the treatment of conditions. Beliefs about restorative powers and medicinal powers are based on *ayurvedic* practices. Some commonly used foods are bitter melon for lowering blood sugar levels and asafoetida for gastric ailments.

In a US study on the prevalence of *ayurveda* use among Indians living in California, 57.8 per cent of respondents were born in Fiji and 93.8 per cent of total respondents had heard of *ayurveda*. The majority (59.4 per cent) had used or were currently using *ayurvedic* products or therapies.[23]

"The Evil Eye" (*Nazar*)

As in many other cultures, the concept of the 'evil eye', or the malevolent gaze, is a belief that may be strongly held by Indians and is considered a determinant of poor health. Envy or jealousy are thought to prompt the evil eye which can then result in illness or catastrophe.[24] As a result, persons who might induce envy (good-looking children, healthy families, brides and grooms) are considered to be most susceptible to receiving the evil eye. A number of rituals or practices may be employed to ward off the evil eye. Waving salt or salt water over the head of the affected person and throwing it in fire or water is one of the most common ways of removing the effects of the evil eye. Protective measures are applied particularly to infants and small children who may be made to wear special protective charms, amulets and lockets, with each serving a different purpose. One of the most popular charms against the evil eye is the application of eyeliner to children's eyes and a small black dot (kala tika) to their forehead. This mark is believed to mar their beauty and make them unappealing to the evil eye.

Hinduism and health

Hinduism is the most widespread religion among Fiji Indians in Fiji and also in Queensland. Aspects of Hinduism that commonly affect health decisions and communications between patient, family, and provider include:

- Karma – a law of behaviour and consequences in which actions in past live(s) affects the circumstances in which one is born and lives in this life. Thus a patient may feel that his or her illness is caused by karma (even though there may be complete understanding of biological causes of illness). In addition,

pain is attributed to God's will, the wrath of God, or a punishment from God and is to be endured with courage [25,26]
- Meditation and prayer are used by many Hindus
- Vegetarianism is common among devout Hindus. Vegetarianism among Hindus is based on belief in reincarnation and non-violence, the idea that the soul of a person enters back into creation as a living being. Hindus may pray a specific prayer before eating, in which one asks forgiveness for eating a plant or vegetable in which a soul could dwell
- Astrology - the movement of the planets is considered to have a major influence on human life. Illness may be attributed to supernatural causes and misalignment of planets.[27]

It must be noted that these religious beliefs are not universal among all Hindu Indians.

Islam, Sikhism and Christianity

A minority of Fiji Indians are Muslim, Sikh or Christian. Adherence to *ayurvedic* understanding of health would be lower among Muslims and Christians. As *ayurveda* was first recorded in ancient Hindu spiritual texts, its use is more widespread among Hindus.

Health beliefs and acculturative stress

The preceding summary of health beliefs should be considered in the context of a population in the process of acculturation. As for any immigrant population, the indigenous Fijian and Fiji Indian populations are adjusting to a host culture and a range of experiences referred to as acculturative stressors. These include[28] :

- Physical stressors – changes in weather, housing, new settings, safety
- Social stressors – loneliness, homesickness, missing family and friends, difficulty relating to others, making new friends
- Cultural stressors – differences in cultural values and attitudes, racial discrimination
- Functional stressors – change in mode of transportation, languages used daily, work and study conditions, financial situations
- Biological stressors – different foods, illnesses or disease.

Both traditional health beliefs and the process of acculturation play an integral role in the health and wellbeing of Fijian Queenslanders.

4 Wellness and illness, the health status of Fiji-born Queenslanders

As this chapter is based on Queensland Fiji-born data, it is not possible to distinguish between indigenous Fijian and Fiji Indian health status. The data presented is based on country of birth, not ethnicity.

4.1 Self-reported health and quality of life

The 2007 National Health Survey presented data relating to self-reported health status and quality of life at a national level. Data are not routinely available by country of birth as analysis is limited by small numbers of overseas born participants.

4.2 Life expectancy

The life expectancy of the Queensland population 2004-06 (including Australian and overseas-born) was 78.5 years for males and 83.4 years for females [3]. The relatively small number of Fiji-born Queenslanders prevents meaningful country of birth specific life expectancy calculations from being made.

4.3 Infant mortality and health

The most recent available Queensland data reporting infant health and infant mortality are for the period 2006-07. During this period, there were 386 infants born to women who recorded Fiji as their country of birth. The number of perinatal deaths (stillbirths and deaths to infants in the first 28 days of life) was six [29]. There was no difference in the perinatal mortality rate for infants born to Fiji–born mothers (15.5 per 1,000 total births) compared to all Queensland mothers (10.5).

For the same period, of the 386 births recorded to Fiji-born mothers, 39 occurred before 37 weeks gestation and were therefore classified as pre-term births. There was no difference in the rate of pre-term birth for Fiji-born mothers (101 per 1000 births) compared to all Queensland mothers (88.7 per 1000 births).[29]

4.4 Deaths – avoidable and all causes

Under nationally agreed criteria, almost two-thirds of all deaths of Queenslanders aged less than 75 years in 2004 were considered to have been potentially avoidable.[30] Of the 9598 deaths of people aged less than 75 years in 2004, 6805 (64 per cent) were considered avoidable and 3092 or 36 per cent were considered non avoidable.

Avoidable deaths include those caused by preventable conditions (for example lung cancer, hepatitis or chronic obstructive pulmonary disease), treatable or health care amenable conditions (for example most cancers) and preventable and treatable conditions (for example diabetes).

There was no difference in the standardised mortality rate for all causes of death for Fiji-born Queenslanders (110.6) compared to the total Queensland population (100). There was also no difference in the standardised mortality rate for total avoidable conditions for Fiji-born Queenslanders (95.3) compared to the total Queensland population.

4.5 Hospital separations – all causes and avoidable

Hospital separations are a measure of hospital activity, representing episodes of hospital care from admission to discharge, transfer or death. In this document, hospital separations are presented as comparative ratios between the total Queensland population and Fiji-born Queenslanders. In each case, hospital separation ratios have been age standardised using the 2006 Queensland population as standard. 'All Queensland' is the reference group for this comparison and therefore in each instance has a standardised hospital separation ratio of 100. The source for these hospital separation data is the Queensland Hospital Admitted Patient Data Collection.

Hospital separation rates and ratios, adjusted for the age of the population, are often used to compare levels of illness in communities. However, they need to be interpreted with caution. Hospital separations also reflect access to hospitals, the need for repeated admission, and current medical practice of treating an illness or injury in hospital, all of which can vary over time and in some cases between geographic areas.[31]

Between July 2006 and June 2008, there was no difference in the standardised separation ratio for all causes for Fiji-born Queenslanders (103) compared to the total Queensland population (100).

The standardised separation ratio for total avoidable hospitalisations was 116.5 for Fiji-born Queenslanders, which was higher than the ratio for the total Queensland population.

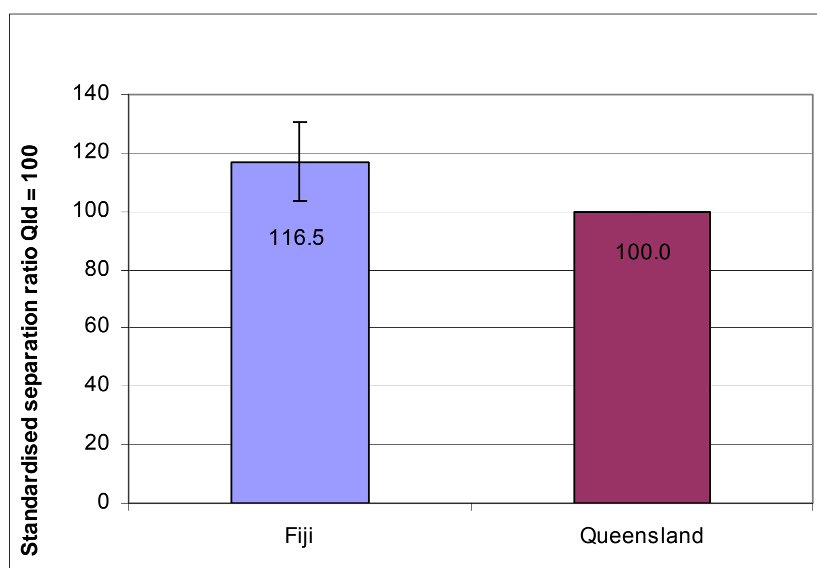

Figure 1 Total avoidable admissions standardised hospital separation ratio all Queensland and Fiji-born persons July 2006 to June 2008

5 Determinants of Fijian health and wellbeing

5.1 About this chapter's data sources

This chapter presents the key determinants of Fijian population health. The chapter presents findings of a literature review and focus groups with the indigenous Fijian and Fiji Indian communities.

Each section is documented in the following format:

1. Background information about the health factor summarised from *The Health of Queenslanders* report[32] (where available)
2. Literature review findings about each health factor in relation to the PNG population
3. National and Queensland data on the prevalence of each health factor among the PNG-born population
4. Focus group findings on each health factor
5. Health service provider survey findings on each health factor.

A summary of findings from focus groups with the indigenous Fijian and Fiji Indian communities is presented in Attachment 4. The major points of discussion will be documented in this chapter.

5.2 Determinants of health

Determinants of health refers to the factors that influence the health status of populations and individuals.[33] These factors act in various combinations; that is, health is multi-causal.[34] These determinants or factors include societal factors such as culture, resources and systems; socioeconomic factors such as education, employment and income; health behaviours such as tobacco use, physical activity and alcohol consumptions; and biomedical factors such as blood pressure, blood cholesterol and body weight. These factors are often categorised as either risk factors or protective factors.

The determinants of health are particularly important for explaining and predicting trends in health, and can provide explanations as to why some populations have better or worse health than others. They are at the heart of disease prevention and health promotion.[34]

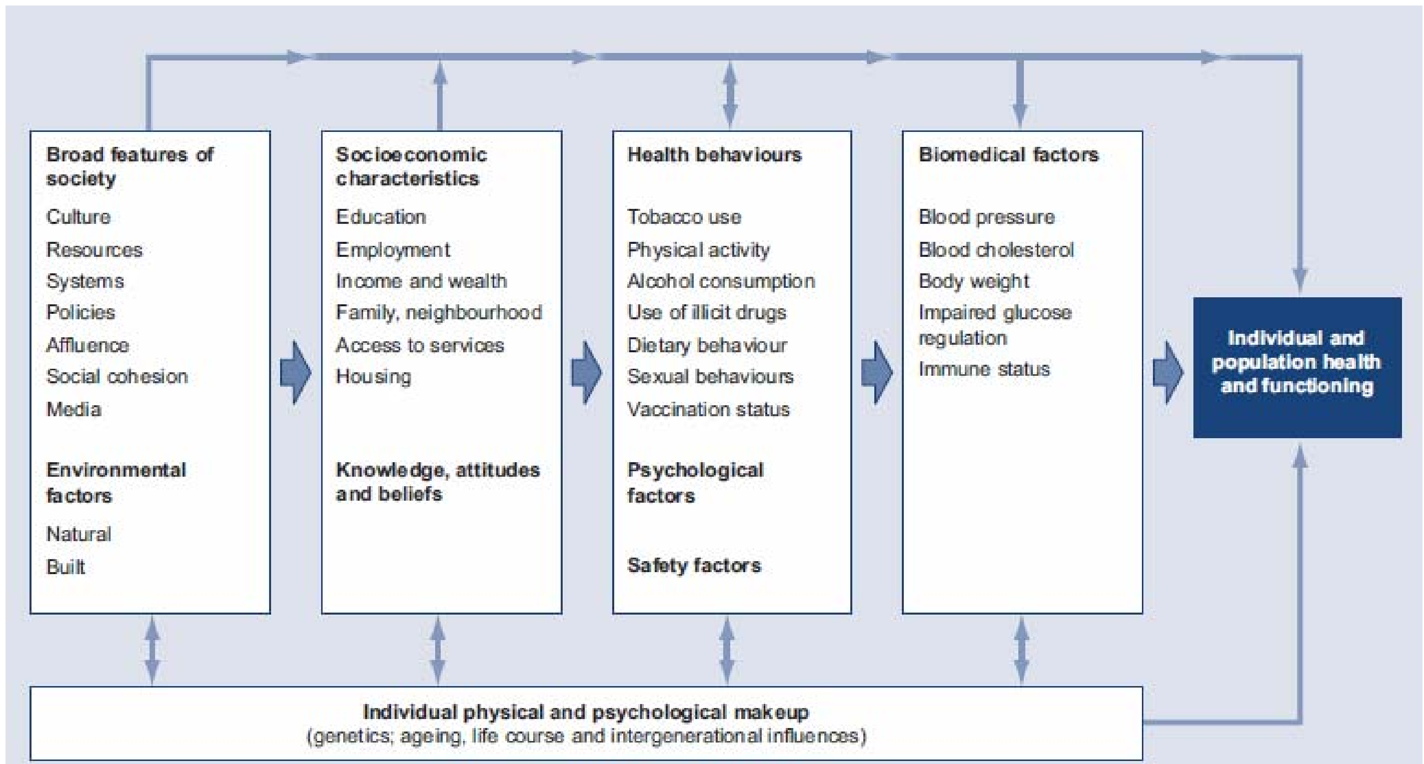

Figure 2 Conceptual framework for the determinants of health
(Source: Australian Institute of Health and Welfare[34])

This chapter documents the determinants of health and wellbeing.

5.3 Broad features of society

The Fijian population in Queensland, like other Pacific Islander populations, is in cultural transition. indigenous Fijians are immigrants from a country where, as the indigenous peoples, they had cultural, social and spiritual ties to their land. Fiji Indians, while enjoying strong ties to Fiji, experienced dispossession from their country after the military coups removed democratic and other rights. Like many other Pacific Islander communities, indigenous Fijians do not identify themselves as 'ethnic migrants', and rather see themselves as indigenous people of the Pacific region. Fiji Indians, while claiming a distinct cultural identity as Fiji Indians, are reclaiming lost identities with India and Indian cultures.

Social cohesion was high within both communities but people were not necessarily well networked or linked to the wider community. There was strong evidence of low access to mainstream media messages with all six focus groups identifying these messages either did not reach their community, or were not understood.

Despite having a more favourable weekly income, all three Fijian focus groups and two out of three Fiji Indian focus groups identified economic barriers. The official weekly income data could be inflated by professional or business migrants who migrated to Australia after the political unrest, but may not reflect the reality of more recent family reunion migrants.

5.4 Health behaviours

5.4.1 Tobacco use

Tobacco smoking is a leading risk factor in Queensland. It is known to contribute strongly to lung and related cancers, cardiovascular disease and diabetes regardless of country of birth.[31]

International literature reports high prevalence of smoking among Fijians. In the 2002 Steps Survey in Fiji 36.6 per cent were current smokers with a greater proportion being male (53 per cent) than female (18 per cent). There were also a higher proportion of current smokers among indigenous Fijians (45.1 per cent) as compared to Fiji Indians (24.1 per cent).[35]

In New Zealand, indigenous Fijians have a smoking prevalence of 20 per cent.[36]

The National Health Survey 2007-08 asked participants about a number of risk factors including smoking. Of those people born in Australia, 19.9 per cent reported being a daily smoker. Of those people born in Oceania, 22.2 per cent reported being a daily smoker[1].

Smoking was identified as a concern by Fiji Indian community members in the context of tobacco, alcohol, drugs and kava use. Both community focus groups identified these as problematic in the community. The following comment was typical:

> *"Smoking occurs among the young. Drugs and alcohol [occurs]f, especially among young people. Alcohol is becoming an issue for the young. Kava is an issue for the older people." – Fiji Indian female*

Smoking was not identified as a problem in the indigenous Fijian focus groups.

5.4.2 Alcohol and kava consumption

Alcohol is the most commonly used drug in Australia. There is evidence that, from middle-age onwards, relatively low levels of alcohol have some health benefits.[37] However, drinking regularly and drinking at levels higher than the recommended National Health and Medical Research Council (NHMRC) guidelines increases the risk of acute and chronic health and social impacts, and premature death.

Kava and alcohol have repeatedly been identified as key substances of concern in Fiji.[38] In the 2002 Steps Survey in Fiji the mean number of standard drinks consumed per drinking day was approximately twice as much for indigenous Fijians (17.4 drinks) as compared to Fiji Indians (8.4 drinks) and this difference was seen in both genders.[35] Of current drinkers, 77.3 per cent were 'binge drinkers' and it was more common in younger indigenous Fijian males. Binge drinking was lowest among Fiji Indian females.

In the National Health Survey 2007-08, participants were asked about a number of risk factors including high risk alcohol consumption. Of those people born in Australia, 14 per cent reported consuming alcohol considered high risk. Of those people born in Oceania, 16 per cent reported consuming alcohol considered high risk.[1]

The Fiji Steps Survey found 65 per cent had ever consumed kava and among these, 79.6 per cent were current users. There was a higher proportion of ever and current users of kava among males compared to females and indigenous Fijians compared to Fiji Indians. Kava was seen as an important risk factor of chronic diseases because of its close link to tobacco and alcohol use.[35]

Alcohol and kava abuse were discussed in all three focus groups with the indigenous Fijian community. The drinking and abuse of kava was a vigorously debated topic in two focus groups (leaders and one community) and in the other community focus group there was consensus that kava abuse is widespread and serious in Queensland. Most of the debate centred on perceptions by male participants that kava is a social drink that does not have major consequences, versus perceptions by both female and male participants that kava is widely abused and its impact is serious. Many participants related kava abuse to other social and personal problems. The following comment from one participants provides a good explanation of the related issues:

> *"Kava abuse – they don't think its abuse, they think it's socialising. But it's abuse. Then they eat and sleep straight away and get stomach problems. A kava abuser will never accept they abuse kava. How do we deal with that? Kava abuse is the number one problem – [among Fiji] Indians, Fijians and Chinese… Indians especially. You get diabetes, family break up, abuse, violence. They need facts about what this does. They are aware of the problems but when they want it, they'll go ahead and have it. They'll only give it up when they're really sick and end up in hospital. Kava is the main problem in our community. We should put kava at the top – it is the number one problem from which the other problems come."* – Fijian male

Many participants perceived kava as being central to other problems within indigenous Fijian families such as family disharmony and violence. Many participants agreed that there is a strong link between kava abuse, alcohol abuse and violence. As this issue may have affected families for generations, the problems are passed down. The following comment relates to alcohol abuse and family violence:

> *"Alcohol problems - violence that comes from that is also a problem. It comes from our upbringing. When we got in trouble they not only talked to us but gave us a hiding as well. When you get older you do that to your wife. Rearing of children, we do it the same way. Discipline and all that stuff…"*- Fijian male

Similarly, in the three Fiji Indian focus groups, the widespread use of_alcohol, drugs and kava was discussed in all three focus groups. Drinking too much alcohol was perceived as a problem among young Fiji Indians and drinking too much kava among older people. The issue of kava abuse was also a contentious topic in two focus groups and there were gender differences in the perception of whether kava use is problematic in the Fiji Indian community. Generally, it was perceived as a problem among the women, but not among the primary consumers, the men. The leaders discussed that kava is used widely in the Fiji Indian community, but there is a lack of knowledge about the health impact by both community members and health workers. Marijuana use was mentioned in one focus group.

The following comment was typical, reflecting the gender differences in perception of the problem:

> *"Kava does not create any problems so we don't want to put it up on the board. Lack of availability is the problem – the government has banned the import.[5] Kava is a social drink." – Fiji Indian male*

5.4.3 Dietary behaviour

Nutrition is an important determinant of health and wellbeing. Good nutrition is essential for the normal growth and the physical and cognitive development of infants and children, healthy weight, enhanced resilience and quality of life, good physical and mental health throughout life, resistance to infection, and protection against chronic disease and premature death[32].

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[5] In 2007, the Commonwealth Government introduced new restrictions on importing kava into Australia mainly to reduce concerns about the health and social impact of kava abuse in indigenous communities. The restrictions include:

- The importation of kava in Australia is only permitted for medical or scientific purposes.
- People aged over 18 years entering Australia can bring in up to 2kg of kava in their accompanied baggage.

Nutrition data are limited in Queensland and Australia and country of birth data is not available for Queensland. The National Health Survey 2007-08 reported 93.4 per cent of Australia-born people had inadequate fruit and vegetable consumption and 93.0 per cent of Oceania-born people had inadequate intakes.

The Fijian Steps Survey found 65.9 per cent ate less than one serving of fruit per day. This was the case for both indigenous Fijians and Fiji Indians. For vegetable consumption, 2.4 of indigenous Fijians ate five serves or more per day, compared to 1.5 per cent of Fiji Indians. However, 52.7 per cent of indigenous Fijians ate one or less serve per day compared to 42.9 per cent of Fiji Indians. Overall, Fiji Indians ate more serves of vegetables per day than indigenous Fijians.

Longitudinal studies of dietary trends among indigenous Fijians and Fiji Indians living in Fiji show a shift from traditional staples to introduced foods such as bread, biscuits, flour, sugar, noodles and rice and an increase of overall energy intake and an increase in mean BMI from 24.3 to 25.3 for males and 23.8 to 26.5 for females from 1952 to 1994 [39]. In a comparison of energy intake, physical activity and BMI among indigenous Fijian, Japanese and Vietnamese populations, 63 per cent of indigenous Fijians were obese, compared to 1.8 per cent of Japanese and 1.1 per cent of Vietnamese [40].

The Fiji Indian focus groups attributed obesity and being overweight, poor lifestyle habits and poor health knowledge to coronary heart disease and diabetes. All three groups discussed the need for healthy lifestyle campaigns to be culturally relevant, for information to be culturally tailored and translated and the need for community education. The need for culturally tailored nutritional information was a theme in these discussions. One participant gave an example of the lack of knowledge people have about the importance of healthy lifestyles as it is believed that medication can 'neutralise' the effect of bad dietary habits:

> *"I am a heart patient ... there was a guy from the pharmacy who gave a lecture. He said take these tablets for high blood pressure – but generally the feeling was if you eat what's forbidden eg duck meat, then you just take your tablet to neutralise the effect. So you can eat what you want but then you take your tablets after you eat to neutralise it."* – Fiji Indian male

There was agreement that this comment reflected a widespread belief in the Fiji Indian community.

Fiji Indians also discussed the trend that most Fiji Indians think diabetes is only related to sugar, for example, whether sugar is added to tea/coffee or the consumption of sweets. It is not thought of as relating to the whole diet, nor to its complications. Some people also expressed a fear that a new generation of children with diabetes was coming, since parents had very poor lifestyle habits and were transferring these to their children.

One focus group discussed a prevalent mindset in the Fiji Indian community that people only have to observe healthy lifestyles over the age of 50. Until a health problem exists, no precautions are necessary. It was observed that health is given low priority among younger and middle aged people and that economic issues are given higher priority. One participant summed up a widespread problem in the community with people not understanding the ingredients in products and not taking the impact of hidden sugars seriously:

> *"We Fiji Indians are not taking the intake of sugar products very seriously. There is lots of hidden sugar in lots of products. We take it very casually. We need education for our elders who can't read the labels on products. It will help our people. They'll think they can take cereals which are safe but don't know what's in there and can't read it. There are no printed materials in our language".* – Fiji Indian female

There was agreement that a major contributing factor to people's low comprehension of health issues was a lack of translated information targeted at the Fiji Indian community. One participant summed it up:

> *"Diabetes – the rates of diabetes complications are so high because we don't understand, the information is not in our language. Brochures and literature are not available."* -Fiji Indian male

Similarly, in all three indigenous Fijian focus groups, diabetes, coronary heart disease and obesity were related as the most prevalent health problems in the indigenous Fijian community. There was also

discussion about the lack of information on the causes of diabetes and that most indigenous Fijians think it only relates to sugar. It was discussed that when people have more money available, their dietary habits change. indigenous Fijian people's reluctance to seek medical assistance and tendency to wait until problems become urgent, were seen as contributing factors. The following comment was typical:

> *"But there is not a lot of information there, we all think it only relates to sugar. But there is probably a lot more to it than that".* – Fijian female

The cultural issues related to eating and obesity was also discussed. It was perceived that eating large portions was an indigenous Fijian cultural trait and that eating socially is the foundation of indigenous Fijian social life.

Breastfeeding

Infants and children depend on good nutrition for normal growth and development. Breastfeeding is associated with a reduction in the incidence and impact of childhood infections, allergic disease, diabetes, obesity, some childhood cancers and Sudden Infant Death Syndrome. Breastfeeding is also associated with reduced risk of cardiovascular disease in adulthood.[32]

In 2006, of the 196 Fiji-born women who gave birth in Queensland Health facilities, at the time of discharge, 77 per cent (150) exclusively breastfed, 15 per cent (30) breastfed and formula fed and 8 per cent (16) exclusively formula fed. This is lower than exclusive breastfeeding rates for Australia-born mothers (83.3 per cent). No breastfeeding data are available at six months of age by mothers' country of birth; however, all Queensland rates at 2006 were known to be 57 per cent, which fell well below the national objective of 80 per cent.

5.4.4 Physical activity

Physical activity is essential for maintaining good physical and mental health and general wellbeing of adults and children. Regular physical activity reduces the risks of many chronic diseases, particularly cardiovascular disease and Type 2 diabetes. Half the adult population in Queensland is not sufficiently active and there is great potential to improve physical activity.[32]

Data relating to levels of physical activity for Queenslanders by country of birth is not available. The National Health Survey 2007-08 found that adults born in Oceania had slightly lower sedentary levels compared to adults born in Australia.[41]

The Fiji Steps Survey categorised physical activity as work related, travel related and leisure time. The results show that almost half the population was insufficiently active at work and three-quarters during leisure time. There were no significant differences by ethnicity. However, in the transported domain, only 7.7 per cent of indigenous Fijians were insufficiently physically active compared to 24.7 per cent of Fiji Indians.

Table 5 Insufficient physical activity participation by ethnicity, Fiji Steps Survey 2002

Ethnic group	Work	Transport	Leisure
Fijian	43.1%	7.7%	74.6%
Fiji Indian	48.7%	24.7%	78%

The survey also found that indigenous Fijians had a higher mean body mass index (BMI) than Fiji Indians. The proportion of overweight/obesity in males rose sharply in the 35-44 age group and continued to rise with age before a decline in the much older age group. In females the proportion was significantly higher overall rose most sharply at the 25-34 age group and then again 45-54 age group.

Table 6 Proportion of obesity (BMI⟶29.9) by gender, age group & ethnicity, Fiji Steps Survey 2002

Age	Percentage obese males	Percentage obese females
15-24	2.3%	8.9%
25-34	9.2%	29.2%
35-44	13.2%	28.5%
45-54	17.3%	43.6%
55-64	18.9%	44.8%
Total Fijian	***11.3%***	***32.0%***
Total Fiji Indian	***5.9%***	***15.8%***

The indigenous Fijian focus groups discussed the lack of physical activity and obesity. Accessibility to fast foods in Australia and lack of physical activity contributed to the problem. The following comment explains the cultural issues related to food:

> *"Obesity – it's a cultural thing. When I go home, my aunts who are very big women think I'm sick. They say, is there no food in Australia? What's wrong with you? It's a cultural thing, we eat a lot. Culture is related to our sicknesses. We don't eat the wrong stuff but we eat too much. It is also a social thing. When there's a social gathering we eat a lot. You enjoy eating when there are people with you. That is our way of life."* – Fijian male

In one Fiji Indian focus group participants explored the reasons why the level of physical activity is low among Fiji Indians and the discussion focused on the fact that as immigrants, the priority for most families is to financially re-establish themselves and therefore there is little time for recreation. What little sporting activities do exist in the community generally involves most of the community (especially women) sitting along the side lines with only a few engaged in physical activity. It was suggested that physical activities tailored to Fiji Indian families, where the whole family could participate, would be successful as people would be more likely to be active together than separately. This also reflects the collectivist culture of Fiji Indians, who are less likely to engage in individualistic pursuits than collectivist ones. One participant described the barriers to physical activity in these words:

> *"People often don't respond [to sport], they don't support it. They have family and work pressure and so they don't come out. How do we promote it? We've got some things organised.. But the younger ones go along. But something needs to be targeted at our age. We need family based activity. The women will sit on the sides and watch the men run around but we don't get the exercise then."* - Fiji Indian female

5.4.5 Sexual behaviours

Safe sexual behaviour is another factor affecting health and wellbeing[42]. Unsafe sex, unplanned pregnancies, sexually transmitted infections, HIV infection and unwanted sex are some of the issues related to sexual behaviour.

There are no Queensland or national data on the prevalence of these sexual health behaviours and health outcomes among the Fiji-born community specifically.

In Queensland, of the 166 new Human Immunodeficiency Virus (HIV) notifications in 2008, 65.1 per cent (108) were Australia-born. Countries of birth reported for the remaining 34.9 per cent (58) of notifications included Pacific Islands (9.6 per cent), Africa (7.8 per cent), Europe (6.0 per cent), Asia (4.2 per cent), the Americas (1.8 per cent), and unknown (5.4 per cent)[43].

The pandemic of HIV infection has not yet been established in most Pacific island countries with the exception of Papua New Guinea. In Fiji, the HIV epidemic has been expanding steadily over the last two decades and, though the numbers of infected persons are small compared with Papua New Guinea, the pattern is similar to that experienced in many sub-Saharan African countries in the 1980s and 1990s. Over a period of 18 years, 236 persons in Fiji were found to have HIV infections. Of these, 135 were men and 101 women, and 16 were children under the age of 10 years. The pandemic in Fiji is steadily increasing [44].

In 2005 a World Health Organisation survey of sexually transmitted infections and HIV prevalence in Fiji, the prevalence of Chlamydia in pregnant women was high at 29 per cent, gonorrhoea was 1.7 per cent and syphilis was 2.6 per cent [44].

There is no country of birth data available for terminated pregnancies in Queensland. In New Zealand, where the 'Indian' category comprises more than 50 per cent Fiji Indians, high levels of terminations occur among this group compared to other Asian groups [45]:

Table 7 Age-standardised termination of pregnancy rate (per 1,000) in Counties Manukau, New Zealand by ethnicity

Age	Indian	Chinese	All Asian
⇠19 years	10.3	6.0	9.2
20-29 years	33.2	13.9	23.8
⇢30 years	22.3	12.2	15.9

Sexual health issues did not feature in the focus groups with indigenous Fijians or Fiji Indians. The indigenous Fijian focus groups only mentioned that sexually transmitted infections are of concern in the community but with little further discussion. The Fiji Indian focus groups made no mention of sexual health issues.

5.4.6 Vaccination status

Data are not available to provide vaccination rates by specific country of birth.

5.5 Psychosocial factors

5.5.1 Psychological and mental health

There are no data available on the prevalence of mental illness in the Fiji-born population in Queensland. The 2007 National Survey of Mental Health and Wellbeing reported prevalence data at the regional level, for example, Oceania.

In Queensland, mental health service snap-shot data (July 2008) showed Fiji-born as the ninth largest group of overseas-born of consumers. This ninth ranking is disproportionate from population size, as the Fiji-born population ranked 17th in population size among overseas born populations.

Fiji has a high suicide rate with a rate of 15 per 100,000 population for males and 11 for females.[46] There are considerable differences between ethnic groups with the rate for indigenous Fijians being four and for Fiji Indians 24 per 100,000. An unusually high rate, 60 per 100,000 for young Fiji Indian females has been reported.[47]

Mental health issues including stress, dementia, depression and suicide were discussed in the indigenous Fijian community focus groups. In one focus group it was perceived that in the indigenous Fijian community stress and mental health issues are dealt with in the indigenous Fijian way with drinking kava, going to church and talking with close friends. Suicide was perceived to be a growing problem in Fiji, but not in Australia. One participant said:

> *"We haven't heard of much suicide here in Australia. But in Fiji it is bad, and getting worse."*- Fijian female

Long discussions took place in the Fiji Indian focus groups about mental health in the context of social and emotional wellbeing and family conflict. These were reported in the section 4.4.4 on family issues.

5.5.2 Interpersonal violence

Abuse and steep power hierarchy within a community are recognised as risk factors to health and wellbeing [34,42]. Queensland and Australian data on the prevalence of interpersonal and domestic violence in the Fijian population are not available. National surveys such as the Personal Safety Survey (2005) are not reported by country of birth.

As many people in the Fiji-born population are reluctant to use services or report incidents of violence to the police, service data are also not an accurate reflection of the extent of the problem.

According to the United Nations Population Fund "violence and the threat or fear of violence forms a part of many women's daily realities in Fiji. A range of social, economic, political, and cultural factors combine to create an environment where women are particularly vulnerable to abuse".[48p. 6]) National research conducted in Fiji found:

- 80 per cent of survey respondents had witnessed some form of violence in the home
- 60 per cent had been abused by their partners
- 30 per cent of these suffered repeated physical abuse
- 44 per cent reported being hit while pregnant
- 74 per cent of female victims did not report violence to the police or seek medical attention.[48]

Violence did not feature in the Fiji Indian focus groups. People in one focus group noted that mental abuse was more common than physical abuse in the community in Australia. Similarly in the indigenous Fijian focus groups domestic violence was not identified as an issue of concern. It was observed that family violence is more prevalent in Fiji and than in Australia where family violence is particularly related to kava and alcohol abuse. Participants also said that women have better knowledge about their legal rights in Australia.

5.6 Socioeconomic characteristics

5.6.1 Access to health services

The health system itself is a fundamental determinant of health [49]. The World Health Organisation has identified that in most countries the health care system is inequitably distributed. This is pronounced in low- and middle-income countries, but inequity is prevalent in high income countries such as Australia. There is evidence that people from ethnic minorities and indigenous peoples are less likely to receive recommended health services and treatments that the wider population can expect to receive.[49] Access to culturally appropriate health services is an important protective factor.[42]

Lack of culturally tailored health promotion

In focus groups with indigenous Fijian and Fiji Indian leaders and community members, many issues arose about access to the health system in Queensland. A strong theme throughout all of the focus groups was the lack of culturally tailored health promotion targeting the indigenous Fijian and Fiji Indian communities.

The indigenous Fijian community linked the lack of culturally tailored health promotion, the lack of community education and effective dissemination strategies to the indigenous Fijian community. All groups identified a lack of general community education, health promotion, or simply any communication from Queensland Health specifically targeted at the indigenous Fijian community as a major concern.

Participants discussed the lack of cultural tailoring of the information content and also the lack of culturally appropriate dissemination strategies:

> *"In terms of the information, it is generally for the general public. But we need something more specific for our food for example, giving facts [such as]' this food gives you this sickness' and that*

kind of thing. It would give you a lot of awareness. There needs to be an awareness program around our foods. It comes back to ignorance – we ignore that the food is bad for us".- Fijian female

[There is a] "lack of information for the Fijian community. We do not read the paper or watch TV too much. The use of radio is better, or newsletters, or letterbox drops...in our language. The use of churches and functions, for example, Fiji day – Queensland Health could have a stall there". –Fijian female

The Fiji Indian community described similar experiences. All focus groups identified a lack of general community education, health promotion, or any communication from Queensland Health targeted at the Fiji Indian community, as the main cause of low health literacy in their community.

"Meetings like this are very important, not in a blue moon, but more often. We can then take the information back to our own community." – Fiji Indian male

Participants in both communities discussed the importance of incorporating cultural issues within community education programs. This reflects people's personal experiences with programs that are not culturally competent and therefore experienced as inaccessible. This is congruent with the National Health and Medical Research Council's recommendations for more culturally competent health promotion.[50]

Lack of communication and engagement

Both the indigenous Fijian and Fiji Indian communities identified a lack of communication and engagement as a barrier in the health system. All the Fiji Indian focus groups identified a lack of communication targeted at the Fiji Indian community as the main cause of low health literacy in their community. The lack of ongoing engagement was also discussed. Participants at one focus group discussed their disapproval of temporary projects or once-off activities and highlighted the importance of ongoing health activities. The following comments were typical:

"Queensland Health doesn't communicate with us at the moment... Queensland Health should continue something like this. It should be more frequent. Not just once in a while. We need educational programs." – Fiji Indian male

One of the recommendations made was the need for ongoing community engagement on health issues of concern in the community.

Similarly, all the indigenous Fijian focus groups identified a lack of communication targeted at the indigenous Fijian community. People also attributed this to the low health literary among indigenous Fijians. Numerous examples were provided of people's low comprehension of basic health information. Participants noted that health promotion campaigns in Fiji were easy to access but this was not the case in Australia:

"Community education – we need information about health, symptoms and all that. Community education would take a couple of years for it to work but you'd get there eventually. In Fiji there was a lot of education, they would come to our villages and it would be all about. But here we don't know where to access that information."- Fijian male

Lack of dedicated Pacific Islander programs, services and staff

In both the indigenous Fijian and Fiji Indian focus groups a strong theme was the lack of dedicated Pacific Islander programs, and in particular, Pacific Islander staff.

A lack of Pacific health workers and dedicated Pacific Island programs and services were discussed in all three indigenous Fijian focus groups. The indigenous Fijian community leaders perceived a lack of identified Pacific workers such as liaison officers in the health system and a lack of Fijian interpreters are the primary problems. The community focus groups identified the absence of a Pacific Islander Health Centre and indigenous Fijian health workers as the primary problems. It was perceived that these could assist to deliver community education programs, providing health services and most importantly, provide a central place for access and referral by a community that is marginalised from services and reluctant to seek help early.

> *"Community representation – we need community liaison workers as they share language and upbringing"* – Fijian leader

> *"Does Queensland Health have a Pacific Islander Community Health Centre? Like in New Zealand they have that. There is no-one on the ground as a worker for the Fijians. The Chinese have their own doctors. Us Islanders need our own health centre. Then we would know where to go."* – Fijian female

The need for dedicated Fiji Indian health workers was discussed in all three focus groups with the Fiji Indian community. The leaders called for Fiji Indian health workers who could develop a Fiji health program with specific responses to each age group. One community focus group called for community liaison officers who could help the community navigate not only Queensland Health, but other government departments. There was also the recommendation for discharge briefing to be done by and with bilingual workers who could explain everything to patients in culturally appropriate terms to ensure the information is comprehended. Another community focus group saw a need for Fiji Indian counsellors.

> *"[We] need a community liaison officer for each community – take it back to Anna Bligh. We need this for all the departments. When we need to communicate with any department, we don't know where to go to. If we had a liaison officer we could go there and get help".* – Fiji Indian male

> *"Do we need something where young people can go? It will really help to get counselling services by Fiji Indians."* – Fiji Indian female

Another focus group called for representation in the health system to help break down language and racial barriers and provide advice in important areas such as food preparation. Volunteers were offered to undertake this role:

> *"If we need to have a Muslim person in the kitchen to help and advise, we'll put that person forward. There are not enough people of our culture in the system to help bring understanding of what we want and need." – Fiji Indian male*

Lack of cultural competency in health services

The Fiji Indian focus groups identified many issues they had experienced in the health system that related to the cultural competency of health services. The first issue related to the lack of appropriate cultural foods on the hospital menu. This was particularly important for the Muslim participants who have a religious requirement to only eat *halal* food. As this was unavailable on the hospital menu, this posed a problem for one participant who described the difficulty of not having the option of *halal* food and having 'home food' stopped by the treating doctor. This left the patient with little options:

> *"The problem was there was no food for us. The doctor instructed that you cannot have food from home – that was very difficult for us. They need a halal section on the menu".* – Fiji Indian male

Two focus groups also discussed the lack of vegetarian options on the hospital menu, which was of particular relevance to observing Hindus, who had been given foods such as jelly, which contains gelatine – a non-vegetarian substance. The following comment was typical:

> *"The food – what about the mixing of the pots? Cooking meat and vegetables in the same pot... No cultural food. No real vegetarian food – you ask for vegetarian and still get jelly – with gelatine in it."* – Fiji Indian male

The unavailability of female doctors on request by Muslim patients was another topic discussed at one community focus group. The leaders also discussed the lack of provisions for family carers to stay in hospital to support their relative and one community focus group participant discussed the embarrassment at hospital staff expressing disapproval of the number of visitors he had:

> *"Visitors – very difficult when the whole bus goes! The staff pass comments that the 'whole entourage is here' – you feel bad. Having visitors is good medicine for our people."* – Fiji Indian male

The unavailability of a prayer room for Muslim patients in hospital was also discussed at one community focus group. A prayer room may have been available, but this was not known to the family who experienced distress at long waiting periods for health appointments without the opportunity to meet their prayer requirements – observing Muslims pray at specified times of the day. One participant was vocal about the distress it caused:

> *"If we want to go and pray, where do we go to pray? It is not provided. It becomes very difficult as there's no where to pray. It will benefit not only us" [other Muslims too].* – Fiji Indian male

Two focus groups also discussed the need to have greater cultural awareness in health services and the need for cross-cultural training, particularly for front-line staff. As one participant said:

> *"Staff need cross cultural training. Especially staff in the hospital...needs to be done by cultural people, not just anyone."* – Fiji Indian female

Two Fiji Indian focus groups discussed the lack of cultural competency in aged care services, two in family support services and one in respite services.

The indigenous Fijian focus groups also discussed the need to increase the cultural competency in health services and the need for cross-cultural training for health staff. One community focus group discussed the lack of recognition of culture in people's lives and gave the example of the aged care assessment needing to include people's cultural needs, not just their practical or clinical needs. Similarly, one Fiji Indian focus group recommended the provision of multicultural aged care or a dedicated multicultural ward in existing facilities.

5.6.2 Income, employment and education

Poverty and low social status are risk factors to health and wellbeing while supportive economic and social conditions, income, wealth, employment, and education are protective factors.[34,42]

At the time of the 2006 Census, the median individual weekly income for Fiji-born Australians aged 15 years and over was $562, compared with $431 for all overseas-born and $488 for all Australia-born. The total Australian population had a median individual weekly income of $466.[51] This may reflect the large number of skilled migrants and business people who migrated from Fiji since the military coups in 1987.[52]

The Fiji-born population profile for non-school qualifications is different to that of the total Queensland population. Nineteen per cent of Fiji-born Queenslanders hold a bachelors degree or higher, compared to 11 per cent for total Queensland. Interestingly, a similar percentage of the Fiji-born population earns $1,000 or more per week (41 per cent) to the total Queensland population (39 per cent).

Despite the higher mean weekly income among Fiji-born people, all the indigenous Fijian focus groups and two Fiji Indian focus groups discussed the economic barriers to health care. The increasing cost of health care, medicines and even parking at hospitals were seen as barriers for members of the indigenous Fijian community. Fiji Indian participants said that people often do not go to health services early enough or at all, due to the cost of health care.

5.6.4 Family and neighbourhood

Family and in particular, marital status is an important protective factor. Married people tend to be healthier and live longer than those who are unmarried. Research also shows that children and young people in lone-parent households have poor health status than those in two-parent households. This appears to be due to material disadvantage, rather than the family structure itself.[34]

Family stressors including intergenerational conflict, family breakdown, acculturative stress and cultural conflict featured in the Fiji Indian focus groups. Much time was spent on issues related to family health and wellbeing. All focus groups discussed the impact of the change of lifestyle after migrating to Australia with high levels of stress, loneliness and homesickness most common. The stressors associated with living in a family in cultural transition were particularly highlighted by both young and old. One young participant wanted to highlight the complexities of a bicultural identity:

> *"…Fiji Indian kids live two lives – one with their parents and one with their friends. Parents don't know what their kids do and they don't know how to talk to them. Kids hide a lot of what goes on with their lives from their parents…. They say you should be an Indian girl, but I'm an Australian – we live in this country"* – young Fiji Indian, female

Older participants with children discussed the challenges of raising children in Australia. The following comments were typical:

> *"We need educational session for parents, not counselling. We need to learn how to respond. We come with our traditional thinking, with our 50 year old brain. What I learned [when I was young] is not working now. We need to educate our parents. This is the lifestyle. Our children don't have one lifestyle – they have two – one in the home and one outside. [We] should ask, 'does your child have a supportive person who they can confide in?' They won't come to you, but who can they go to? You can save a disaster from happening."* -Fiji Indian male

> *"I feel so sorry for the children sometimes. We are trying to socialise in our community but our children are growing up in western society. They are trying to adapt with their school friends. It is very difficult to live two lives. They are very stressed as well. We have to understand that."* – Fiji Indian female

One focus group talked at length about widespread cultural conflicts within families and the lack of culturally tailored programs to deal with this. It was felt that prevention programs were needed to prevent family conflict and breakdown and also the availability of cultural counselling. Fiji Indian family support programs were strongly recommended by the Fiji Indian focus groups.

The indigenous Fijian focus groups focussed more on the issues of family violence and conflict in the context of alcohol and kava abuse. Many participants perceived kava as being central to other problems within indigenous Fijian families such as family disharmony and violence:

> *"I worked in this area in Fiji– it all starts with kava. They start with kava, they abuse their wives, and then they move to alcohol. Then you get family break down."*- Fijian male

There is increasing evidence that neighbourhoods affect health, particularly children's health.[33,53] The neighbourhood environment was not specifically discussed in the community and leader focus groups.

Both the indigenous Fijian and Fiji Indian focus groups identified the lack of transport support for elderly people to get to health appointments as a barrier to health care. However this was not widespread. Australian literature linking social exclusion and transport disadvantage is growing and focussed on social excluded communities living in the outer urban fringes of cities and in regional and rural areas [54-57]. This is could be a pertinent issue for the indigenous Fijian and Fiji Indian population, which is concentrated in the outer urban fringes.

A recent Melbourne study found that socially excluded populations living in the outer fringes of Melbourne were more likely to be 'forced car ownership' users rather than 'zero car ownership'. There was evidence of financial stress associated with owning and running cars in 'forced car ownership' households. These households also operated smaller and older cars than other households. There is no Australian data on transport disadvantage in the indigenous Fijian and Fiji Indian population.

5.6.5 Housing

Housing conditions are recognised as a factor affecting health and wellbeing [34]. Poor housing and ill health are linked.[58] In particular, there is an increasing body of evidence associating housing quality with infectious diseases, chronic illnesses, injuries, poor nutrition and mental disorders.[59] There is also a relationship between health and whether a family lives in owner-occupied housing, privately rented housing or public housing.[60]

In Victoria, Fiji-born people have lower rates of home ownership and higher rates of renting accommodation than the wider population. However, if the 'being purchased' and 'fully owned' categories are combined, then the rates are comparable to the wider population.

Table 8 Housing tenure all Victoria and Fiji-born persons (Vic), 2006

Tenure type	*Per cent of all Fiji-born (Vic)*	*Per cent of all Victoria population*
Fully owned	18.5	30.1
Being purchased	51.3	39.8
Rented & rent free	26.4	21.1
Other	0.3	0.5
Not stated	2.3	5.8
Not applicable	1.2	2.7

Source: [6]

Housing issues did not arise in the community focus groups.

5.7 Knowledge, attitudes and beliefs

5.7.1 Health literacy

The National Preventative Health Taskforce recognises that knowledge, attitudes and beliefs are important factors in the health of individuals and populations.[33] Health literacy refers to the knowledge and skills required to understand and use information relating to health issues such as drugs and alcohol, disease prevention and treatment, safety and accident prevention, first aid, emergencies, and staying healthy.[2] Health literacy is particularly important to understanding the health of immigrant populations, as education and health literacy have an integral relationship with the overall health of a society's population, as well as inequalities within the population.[2]

The 2006 Adult Literacy and Life Skills Survey (ALLS) contained 191 health-related items across four domains (health promotion, health protection, disease prevention and systems navigation). For each of these domains, proficiency was measured on a scale. Scores were grouped into five skill levels with level one the lowest and level five the highest.

The ALLS found particular factors influenced people's health literacy. These included education, occupation, parental characteristics, and English as a second language. As indigenous Fijians and Fiji Indians are from a non-English speaking background, this would influence their level of health literacy.

Focus groups with community members and leaders found very poor health literacy among both the indigenous Fijian and Fiji Indian communities in Queensland. Leaders and community members provided many anecdotes that described people's low knowledge of health issues and services.

The indigenous Fijian participants discussed the difficulty of accessing information in Australia as health promotion materials had been easily available in Fiji. Many anecdotes were provided of people's lack of understanding of health issues and health services. Participants discussed the lack of culturally

appropriate information, the lack of culturally appropriate promotion and dissemination strategies as the major issues.

> *"There is no literature at all in Fijian. In Fiji there is a lot of information but no one has brought it over here – may be bring it over here."* – Fijian male

The Fiji Indian participants discussed similar issues. In particular they discussed the lack of a basic understanding of diabetes or cardiovascular disease among those with the illness.

Both leaders and community members also gave examples of people in their community not understanding what services are available from Queensland Health, or any other department or level of government. Numerous examples were also provided of people's low comprehension of basic health information. One participant gave an example of people's lack of understanding of their own role in health, healing and recovery:

> *"People come to the temple and want instant healing. They think you just pray and get instant healing. But you can see that most of their health problems come from what they eat."– Fiji Indian male*

There was agreement that this comment reflected a widespread belief in the Fiji Indian community and that the lack of understanding of the health system was also widespread.

5.7.2 Help seeking behaviour

Attitudes and belief systems affect health and health choices. Cultural values and world views also influence health and health choices.[61,62]

Internationally it is observed that collectivist cultures such as Pacific Islander cultures have a high reliance on their own social group for care and support and may delay their use of Western medicine, especially preventive health services [62]. Minor health issues are often expected to be cared for within the family or social unit and Western medicine is used only if emergency care is required. However, once in the health system, the health care provider is seen as wise and authoritative.

All the Fiji Indian focus groups discussed the Fiji Indian cultural reluctance to seek help. The community participants discussed people's fear to get tested or screened and all three groups discussed the perception that health has a low priority and that economic issues are more important than health.

All the indigenous Fijian focus groups extensively discussed indigenous Fijian people's cultural reluctance to seek help. This reluctance led to health problems being addressed when very serious or acute, and people being perceived as neglecting their health. Cultural traits such as a tendency to ignore, wait and not take problems seriously were the reasons given for this reluctance. A lack of confidence in doctors and services and the cost of health care also contributed to this problem. Participants at one focus group agreed that indigenous Fijians do not go for regular check ups. One participant tried to explain what this reluctance relates to:

> *"You ignore it. It's a cultural thing. Not visiting the doctor on time or seeking medical help when required...lack of funds...scared to go. Lack of confidence to go. Fear of the unknown..."*-Fijian male

Related to this issue is that of communication barriers. People's reluctance to access health services is compounded by their reserved communication styles when they do go to a health service. All of the focus groups discussed a range of communication barriers – from a tendency to hide, downplay or lie about health issues, to the need for interpreters.

This experience is consistent with overseas experiences indicating that minority ethnic communities have poor access to the health system for a range of complex reasons including cultural and language barriers.[62-64]

6 Health outcomes

The data presented in this chapter relates to Fiji-born Queenslanders. It should be noted that it cannot be disaggregated into indigenous Fijian and Fiji Indian groups.

6.1 Cancer

Cancer is not just one disease, but a diverse group of diseases. Although there are many types of cancer, they all start because abnormal cells grow out of control. Cancers were the leading cause of the burden of disease and injury in Queensland in 2006, causing 18.9 per cent of the total burden of premature death and disability. Lung, colorectal, breast and prostate cancers caused half the cancer burden (49.2 per cent)[32].

During the period July 2006 to June 2008, there was no difference in the standardised separation ratio for all cancers excluding non-melanocytic skin cancers among Fiji-born Queenslanders compared to the total Queensland population.

Prevalence and trends in all types of cancer by Australia and Fiji-born Queenslanders are found in Table 9. Among the Fiji-born population, the number of cancer sufferers increased from 18 in 2000 to 32 in 2006, an increase of 77.8 per cent. However, due to the very small number of cases, no conclusions can be made.

Table 9 Cancer incidence by Australia and Fiji country of birth 2000-2006

Country of birth	Year				
	2000	2002	2004	2006	Percentage change 2000-06
Australia	11850	12799	13471	14507	22.4
Fiji	18	23	32	32	77.8

(Source: Cancer Registry, Queensland)

6.2 Cardiovascular disease

Cardiovascular health refers to any disease of the heart and blood vessels and is the leading cause of death in Australia. Cardiovascular disease (CVD) is also a major source of burden of disease in Queensland, where, in 2006, it accounted for 16.3 per cent of the total burden of disease. It is important to note that coronary heart disease accounts for a substantial proportion of morbidity and mortality associated with CVD. CVD, diabetes and chronic kidney disease account for about a quarter of the burden of disease in Australia.

In New South Wales, higher rates of hospitalisation for coronary heart disease and revascularisation procedures were recorded for Fiji-born residents than the total population for the period 2002-07[65].

Coronary heart disease (heart attack and angina)

The standardised hospital separation ratio for coronary heart disease for the July 2006 to June 2008 period was 212.8% for the Fiji-born, more than double the Queensland base of 100.

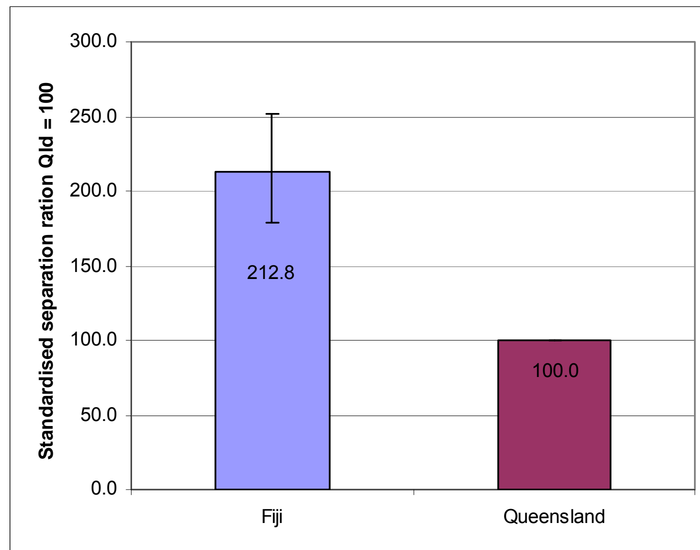

Figure 3 Coronary heart disease standardised hospital separation ratio all Queensland and Fiji-born persons July 2006 to June 2008

Stroke

There was no difference in the standardised separation ratio for stroke for Fiji-born Queenslanders (103.8) compared to the total Queensland population (100).

6.3 Diabetes

Diabetes mellitus (diabetes) is a chronic metabolic condition in which the body produces inadequate insulin or is unable to properly use the insulin it produces, resulting in improper control of blood glucose.

Diabetes was the sixth leading broad cause of premature death and disability in Queensland in 2006, and was responsible for 5.7 per cent of the total burden of disease and injury. Type 2 diabetes caused 92 per cent of the total diabetes burden. Type 2 diabetes was the third largest specific cause of burden of disease (5.2 per cent), after coronary heart disease, and anxiety and depression. Diabetes is one of the few conditions for which death rates and prevalence are increasing.

There was no difference in the standardised separation ratio for diabetes for Fiji-born Queenslanders (129.6) for diabetes compared to the total Queensland population. However, the ratio for diabetes complications was double, at 199.8.

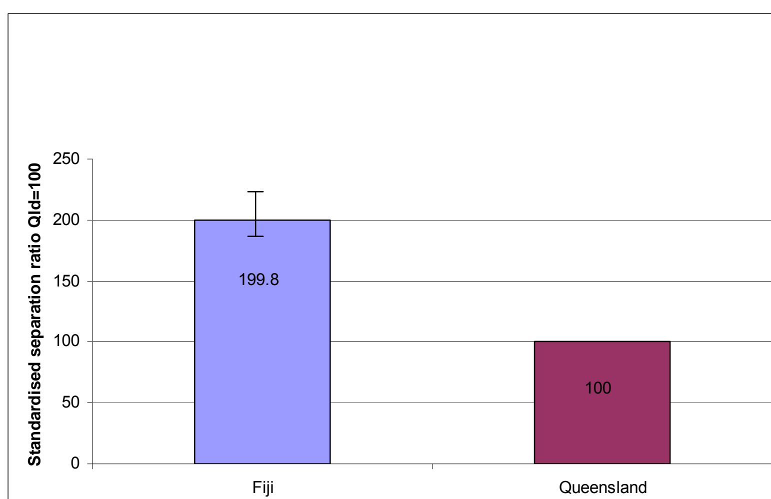

Figure 4 Diabetes complications standardised hospital separation ratio all Queensland and Fiji born persons July 2006 to June 2008

6.4 Mental health

Mental health is the ability for people to interact with one another and the environment, in ways that promote subjective wellbeing, optimal development and the use of cognitive, affective and relational abilities. An individual's mental health is derived from their genetic makeup and general life circumstances, including their social, economic and environmental situation. Mental health problems and mental disorders refer to the spectrum of cognitive, emotional and behavioural disorders that interfere with the lives and productivity of people.[66]

Queensland Health mental health service data relating to mental health by country of birth were unavailable at the time of this needs assessment.. However, by examining the country of birth of all consumers of Queensland mental health service on a given date, it is possible to gain a 'snap-shot' of the level of service usage by country of birth. In Queensland, mental health service snap-shot data (July 2008) shows Fiji-born as the ninth largest group of overseas-born consumers. This ranking is disproportionate with the size of the population, with the Fiji-born population ranked 17th in size among overseas born populations. This could indicate a higher use of mental health services than what would be expected, based on population size.

The Australian National Survey of Mental Health and Wellbeing does not report the prevalence of mental disorders by country of birth. Therefore, Australian data is not available.

6.5 Respiratory disease

Asthma

Asthma is a chronic disease characterised by recurrent attacks of breathlessness and wheezing, which vary in severity and frequency from person to person. While the cause of asthma is unknown, there are factors that may increase the risk of developing the condition, including environmental exposures such as tobacco smoke, specific allergens, lack of physical activity and stressful life events.[31]

There was no difference in the standardised separation ratio for asthma for Fiji-born Queenslanders (56.7) compared to the total Queensland population (100).

Chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease (COPD) is a specific health condition which affects the lungs. It is characterised by a persistent blockage of airflow from the lung and can be life threatening. The condition cannot be reversed. The main form of COPD is emphysema. The main cause of COPD is tobacco smoking.

Figure 5 presents the standardised hospital separation ratio for COPD, Fiji-born Queenslanders compared to all Queenslanders, for the period July 2006 to June 2008. Fiji-born Queenslanders had a ratio of 46.9 which is significantly lower than the total Queensland population.

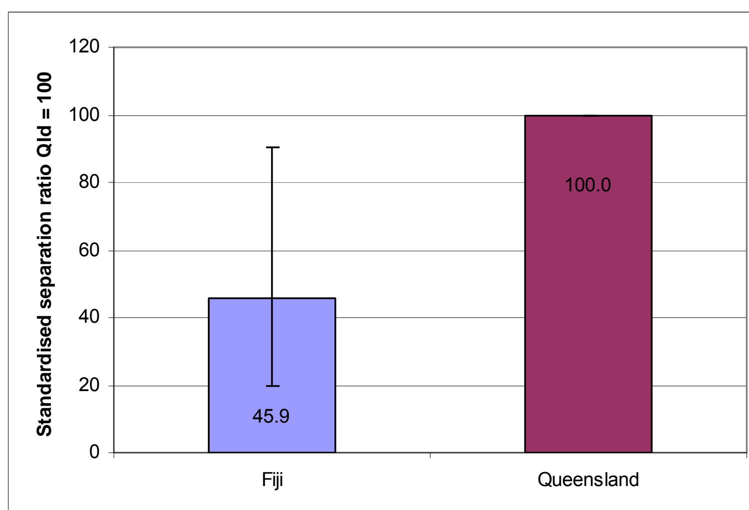

Figure 5 COPD standardised hospital separation ratio all Queensland and Fiji-born persons July 2006 and June 2008

6.6 External causes

Injury resulting from an external cause

In 2003, in Queensland, intentional and unintentional injury was the cause of 7.9 per cent of the total burden of disease; 10.6 per cent for males and 4.7 per cent for females. One third of the burden due to injury is due to seven risk factors. Alcohol is by far the biggest contributor. Injury prevention was designated a national priority in 1986 in recognition of the national burden of injury, its high importance to the community, the potential for gain through preventing or lessening the impact and because the extent of injury can be measured through a number of relevant indicators.

While deaths from injury have declined, rates of hospitalisation for many injuries have increased over the past decade, in particular, fire, burns and scald injury in young children, and fall related injuries in older people.

Fiji-born recorded a lower standardised separation ratio for external causes (70.1) compared to the total Queensland population (100).

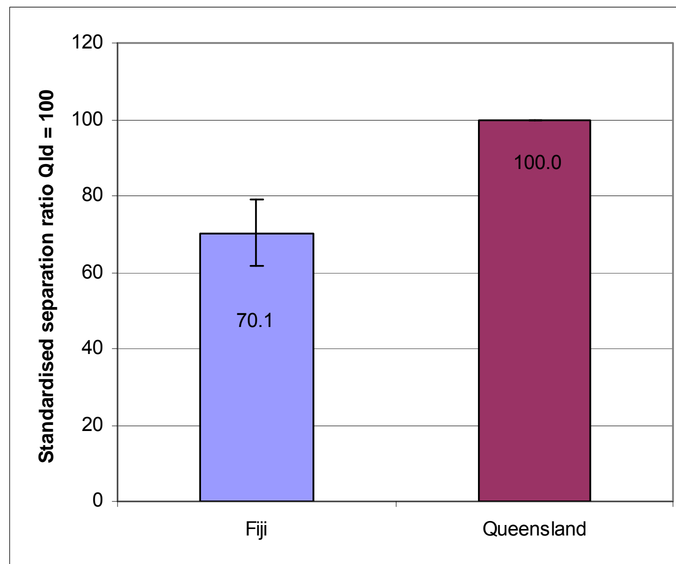

Figure 6 External causes standardised hospital separation ratio all Queensland and Fiji-born persons July 2006 and June 2008

6.7 Musculoskeletal disease

Musculoskeletal conditions include arthritis and other joint problems, and disorders of the bones, muscles and their attachments to each other. Arthritis and musculoskeletal conditions are the world's most common cause of severe, long term pain and physical disability.

Fiji-born had a lower standardised separation ratio for musculoskeletal disease (67.4) compared to the total Queensland population.

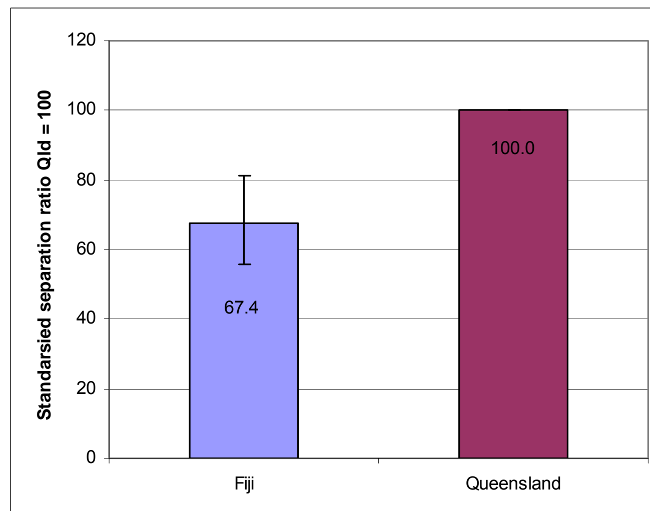

Figure 7 Musculoskeletal disease standardised hospital separation ratio all Queensland and Fiji-born persons July 2006 and June 2008

6.8 Communicable disease

In Queensland, infectious and parasitic diseases account for a low level of the burden of disease. This is due to current levels of investment in communicable disease surveillance and control.

Prevention (including vaccination), screening, treatment, control and monitoring of a range of communicable diseases are undertaken in Queensland. Communicable diseases include: mumps, measles, rubella, hepatitis, pertussis, tetanus, influenza, sexually transmissible diseases, food borne illnesses, vector (such as mosquito) borne diseases, tuberculosis, and diseases transmitted by animals (zoonotic diseases).

Due to data collection methodology and the small numbers involved, it is not possible to report communicable diseases by country of birth.

7 The way forward to improve Fijian health

The health experiences and needs of people in the indigenous Fijian and Fiji Indian communities in Queensland are largely similar across the two communities.

A segment of these communities, the Fiji-born, display a number of positive health outcomes including lower ratios for COPD, musculoskeletal disease and external causes. However, the chronic disease burden is high with more than double the ratio for coronary heart disease and diabetes complications and a hospital separation ratio for total avoidable admissions 16 per cent higher than all Queenslanders. This may indicate that diabetes is not well managed among the Fiji-born. This was supported by the focus groups which indicated low health literacy among indigenous Fijians and Fiji Indians including those with chronic disease. The mental health snap-shot data also suggests that the burden of mental illness could be higher among the Fiji-born. Fiji-born women had lower exclusive breastfeeding rates than Australia-born women, indicating that additional support and information may be required.

Similar findings were made across other Pacific Islander and Māori communities in Queensland, highlighting what focus group participants themselves stated – Pacific Islander people have more similarities than differences regarding health status and belief systems. Therefore, the strategies to improve Pacific Islander and Māori health in Queensland have been compiled into a separate document, *Queensland Health response to the Pacific Islander and Māori health needs assessment*. Separate documents have been prepared for other Pacific Islander communities in Queensland.

Attachment 1 - Data and methodology

All data sources are cited. For further information contact the program manager, Queensland Health Multicultural Services.

Unless otherwise indicated all data refer to the total population (0-85+ years).

Australian Bureau of Statistics (ABS) data are used with permission from the ABS. Copyright in ABS data vests with the Commonwealth of Australia.

Hospital separation data were derived from the Queensland Hospital Admitted Patient Data Collection, including private and public hospitals. All disease specific hospital separations were derived using the principal diagnosis of inpatient episodes of care. All separations were coded using the International Classification of Diseases version 10 Clinical Modification (ICD-10-CM) using standard code sets.[67]

Death, cancer incidence and hospitalisation rates for all diseases and conditions are reported as age standardised rates. Standardisation minimises the differences in age composition among populations and facilitates comparisons among populations. Queensland total population (person) data is directly standardised to the 2001 Queensland Census data. Country of birth population data is indirectly standardised to the 2006 Queensland Census data.

With the method of direct standardisation, the proportional age distribution of the standard population is applied to the rates to obtain age standardised rates, which minimise or remove the distorting effects of age. Indirect standardisation uses the age distribution of the standard population to obtain expected counts, total number of expected counts and subsequently standardised ratios (standardised mortality ratio or standardised separation ratio etc). The end product of direct standardisation is age-adjusted rates, while the end products of indirect standardisation are expected counts and standardised ratios.

Survey data are reported as percentage and 95 per cent confidence intervals. Unless otherwise noted, all survey data refer to self report and are not standardised. All sources are cited and information about specific surveys including sample size can be obtained from the custodian.

Attachment 2 – Focus group prompting points (community members)

1. Arrival and refreshments (30 mins)

2. Facilitators introduce themselves and explain the process (10 mins)

Traditional welcome and Aboriginal and Torres Strait Islander acknowledgement

Today we are going to talk about the health needs of our community. Queensland Health, who we both work for, is interested in finding out about the health needs of our community and most importantly, what you think are the best ways to address them. Firstly, I want to check whether you prefer to speak in [**] or in English, or both.

We want this to be like an informal chat, so there are no right or wrong answers. All details you provide will be completely confidential; we do not use names or any other personal details.

Does anyone have any questions before we start?

3. Introductions (15 mins)

Let's all introduce ourselves. Could you please introduce yourself and tell us what you think the number one health problem in our community is. Just be brief – no more than one minute per person.

4. Health priorities from community perspective (20 mins)

What are the health conditions common in our community?
- what about younger people?
- what about older people?
- what about mental or emotional health? (if only physical health is mentioned)

What are the issues with the health system common in our community?

- what about health promotion campaigns?
- what about community health services?
- what about hospital services?

5. Present literature review (15 mins)

Distribute the hand-out on the literature review findings and go through it

What do you think about these research findings? Does it apply to the community here?

6. Present leaders' responses (15 mins)

Distribute the hand-out on the health priorities identified by the community leaders

What do you think about what your leaders said? Do you agree?

7. Strategies to address health needs (30 mins)

Let's now talk about what needs to be done about these health needs in the community.

In your opinion/view, what do you think Queensland Health should do to address the health conditions common in our community?
- what could be done to prevent some of these health problems in the community?
- what could be done to help people manage their health problems better?

In your opinion/view, what do you think Queensland Health should do to address the common problems people have with the health system?

- what could be done to improve access to services by people from our community?
- what should Queensland Health do to improve the experiences people have when they go to a community health centre or a hospital?

What should Queensland Health do to ensure that health information reaches our community members? How do people receive information? What is the best way to reach them?

8. Summing up (15 mins)

We have discussed a lot of health needs today. To finish up, can we make a summary that we can all agree on?

If you had an opportunity to present a list of the most important health priorities that Queensland Health should work on with our community, what would be on the list? Please put the list in order of importance.

- have we missed anything?
- is there anything you want to add to the list?

9. Finish

Thank for your time today. If you are interested in knowing about the outcome of our project, please leave us your contact details. We plan to hold a forum in November to share our findings with the communities involved. If you leave your contact details, you will receive an invitation.

Attachment 3 – Focus group prompting points (community leaders)

1. Arrival and refreshments (30 mins)

2. Facilitators introduce themselves and explain the project and workshop process (15 mins)

Traditional opening and Aboriginal and Torres Strait Islander acknowledgement

Introductions (name and community)

Cover following topics:
- Purpose and scope of health needs assessment project
- Which communities involved and why
- Methodology
- Forum

Workshop process:
- Going to do small group work in our community groups
- Going to have big group discussions

Does anyone have any questions before we start?

3. Small group work: health priorities identification (15 mins)

Could you please move into small groups so that you are with people who are also from your community? Please answer the following question:

Q: What are the health conditions common in your community?
- what about younger people?
- what about older people?
- what about mental or emotional health? (if only physical health is mentioned)

Please choose one person to present back to the big group.

Q: What are the issues with the health system common in your community?
- what about access to services?
- what about experiences people have at health services?
- what about health promotion campaigns?
- what about community health services?
- what about hospital services?

4. Big group: presentation of health needs (25 mins)(5 mins per presentation)

5. Small group work: compare with research findings and develop summary list (15 mins)

Could you please move back into your small community groups? We will now present you with a list of health priorities for your community that has come from research. Please note, that some of this research has come from overseas and some from Australia. For some communities more information has come from overseas than for other communities.

Please answer the following questions:

What do you think about this research? Does it apply to your community here?

Please make a list of the most important health needs and priorities in your community in Queensland that you think Queensland Health should be working on. It should be a list that you can all agree on. Please put the list in order of importance.

6. Small group work: Strategies to address health needs (15 mins)

Stay in your small groups. Please now answer the following questions:

Please advise us what Queensland Health could do to:

- **Prevent** some of these health problems in your community.
- Ensure that **health information reaches** your community members? How do people receive information? **What is the best way to reach them**?
- **Improve access** to services by people from your community.
- Help people **manage** their health problems better.
- Improve the **experiences** people have when they use a health service.

7. Presentation (40 mins)(8 mins per presentation)

Please present your small group work. Please tell us:

- whether your list was different from the research findings and why you think this is the case
- what your agreed list of priorities is
- what the major strategies are to address these health needs

8. Finish

We have discussed a lot of health needs today. Please be assured that your contribution will be used in our work. Thank for your time today. If you are interested in knowing about the outcome of our project, please leave us your contact details. We plan to hold a forum in November this year to share our findings with the communities involved. If you leave your contact details, you will receive an invitation.

Traditional close

Attachment 4 – Summary of focus group results

As the Fijian community comprises two ethnically distinct communities –indigenous Fijians and Fiji Indians - separate focus groups were held with these communities.

Three focus groups involving 28 people were held in the indigenous Fijian community – four indigenous Fijian leaders participated in the leaders' focus group in Brisbane, eight community members attended the first community focus group and 16 attended the second community focus group.

Three focus groups involving 28 people were also held In the Fiji Indian community – four Fiji Indian leaders participated in the leaders focus group in Brisbane, 11 community members attended the first community focus group and 13 attended the second community focus group.

Across all focus groups, the following health conditions were identified as being prevalent in the indigenous Fijian and Fiji Indian communities in Queensland. The health conditions identified are similar across the two communities with diabetes, coronary heart disease, mental health issues, alcohol and kava abuse, and cancer featuring in both communities:

Identified by three focus groups	Identified by two focus groups	Identified by one focus group
	INDIGENOUS FIJIAN COMMUNITY	
Diabetes (including kidney disease) Coronary heart disease Hypertension Mental health (including stress, depression, dementia, suicide) Obesity Cancer Alcohol and kava abuse	Hypercholesteremia Oral health Asthma Sexually transmitted infections Malnutrition Eye health Hearing Migraine Menstrual problems	Gout Violence against women Skin conditions
	FIJI INDIAN COMMUNITY	
Diabetes Coronary heart disease (including obesity, hypertension and hypercholesteremia) Mental illness (including depression, anxiety, suicide, Alzheimer's disease, panic attacks, suicide) Alcohol and kava abuse Cancer Asthma	Social and personal wellbeing (family and intergenerational conflict, acculturative stressors) Gastrointestinal disease Smoking	Arthritis Smoking Skin conditions Violence (mental abuse more than physical)

The focus groups were also asked to comment on the Queensland health system and the interaction between community members and the health system. Many barriers and problems were identified. Those common to both communities and discussed in all focus groups were the cultural reluctance to seek help, lack of culturally tailored health promotion, lack of culturally specific workers and the lack of culturally tailored health promotion:

Identified by three focus groups	Identified by two focus groups	Identified by one focus group
	INDIGENOUS FIJIAN COMMUNITY	
Cultural reluctance to seek help Communication barriers Lack of culturally tailored health promotion Lack of Pacific Islander health workers Economic barriers	Low health literacy	Lack of Pacific Islander dedicated services Lack of community engagement Physical barriers to accessing services Unpaid work (that should be paid – health and support related) Lack of cultural competency in services
	FIJI INDIAN COMMUNITY	
Low health literacy Lack of Pacific Islander health workers Lack of culturally tailored health promotion Cultural reluctance to seek help Lack of cultural competency in services – aged care (two focus groups), respite (one focus group), family support (two focus groups)	Communication barriers Economic barriers Lack of Pacific Islander dedicated services	Discrimination

Finally, focus group participants were asked to make recommendations or suggest strategies for remedying the problems identified. Once again, there were overlapping issues across the two communities – with culturally tailored health promotion and dedicated culturally specific health workers recommended in all of the focus groups:

Identified by three focus groups	Identified by two focus groups	Identified by one focus group
	INDIGENOUS FIJIAN COMMUNITY	
Culturally tailored health promotion Dedicated Pacific Islander health workers	Dedicated Pacific Islander health centre Increase cultural competency in health services Dedicated Pacific Islander programs and services Community engagement	Increase knowledge of health services and system Pacific Islander research and data (Fijian health) Up-skilling, training and scholarships (for jobs in health)
	FIJI INDIAN COMMUNITY	
Culturally tailored health promotion Dedicated Pacific Islander health workers Dedicated Pacific Islander programs and services Increase cultural competency in health services		Interpreters Up-skilling and training (to encourage Muslim girls and women to enter health jobs) Community engagement

The major points of discussion are documented in Chapter 5.

Attachment 5 – Standards for Statistics on Cultural and Language Diversity

The Australian Bureau of Statistics Statistical Concepts Library provides authoritative information about the concepts, sources, methods and classifications underlying Australian official statistics. The *Standards for Statistics on Cultural and Language Diversity* [68] identifies three 'minimum core set' items that measure cultural and linguistic diversity (CALD) and an additional eight standard indicators.

The **Minimum** Core Set of Cultural and Language Indicators consists of the following four indicators:

- Country of Birth of Person
- Main Language Other Than English Spoken at Home
- Proficiency in Spoken English
- indigenous Status

The **Standard** Set of Cultural and Language Indicators is as follows:

- Country of Birth of Person
- Main Language Other Than English Spoken at Home
- Proficiency in Spoken English
- indigenous Status
- Ancestry
- Country of Birth of Father
- Country of Birth of Mother
- First Language Spoken
- Languages Spoken at Home
- Main Language Spoken at Home
- Religious Affiliation
- Year of Arrival in Australia

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