

Queensland Health

Queensland Health response to Pacific Islander and Māori health needs assessment



Queensland Health's response to Pacific Islander and Māori health needs assessment

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Executive Summary

In 2008-09 the Queensland Government prioritised Pacific Islander populations as a whole-of-government priority group as a way to start addressing their relative social disadvantage. Queensland Health's response to this prioritisation was to conduct a needs assessment - to firstly understand health needs and priorities so that an effective response can be developed.

This document summarises the findings of the Pacific Islander and Māori Health Needs Assessment and Consultation. It summarises the health profile of five Queensland Pacific Islander communities – Māori, Samoan, Papua New Guinean, indigenous Fijian and Fiji Indian, and outlines a response for improving the health of these communities. Detailed community data documents are available for each community.

Data sources and quality

Data was drawn from several sources:

- literature reviews
- Queensland Hospital Admitted Patient Data Collection data
- Australian Bureau of Statistics
- focus groups with 191 Pacific Islander community members and leaders
- telephone survey with 54 health service providers.

Data are unavailable for several sections of each community data report and consequently the analysis in this document. Quantitative data on the determinants of health relies on overseas studies and aggregated Australian data that place Pacific Islander people into the category 'Oceania' or 'other Pacific Islands'. Queensland data on several health indicators and outcomes are not available for any of the communities. Health status data for the Māori community are not available because all data are based on country of birth which does not identify Māori people, who are included in the New Zealand category.

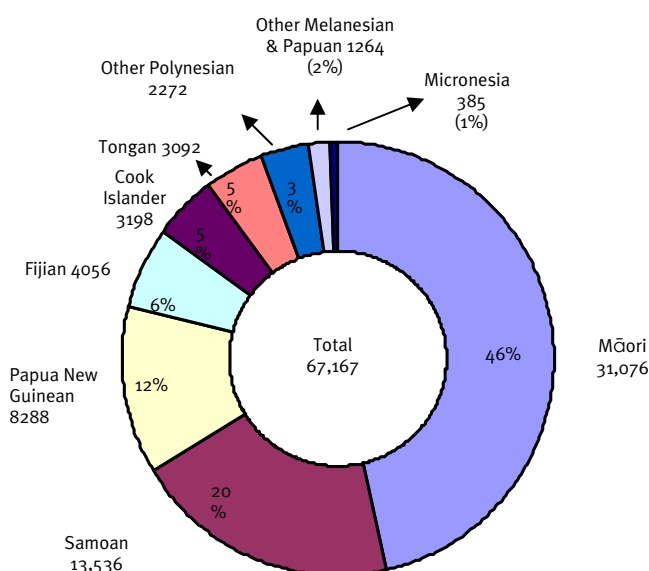
Demographic profile

Pacific Islander people migrated to Australia from the island groups of Micronesia, Melanesia and Polynesia. They are referred to collectively as 'Pacific Islander people'. Despite often being grouped together in this way, populations from these different regions are heterogeneous with diverse cultures, languages and religions.

Ancestry data, rather than country of birth, are a more accurate reflection of population size for Pacific Islander communities.

As shown, 67,167 Queenslanders identified a Pacific Islander ancestry in the 2006 Census. In addition, 5336 Queenslanders identified an Indian ancestry and were born in Fiji. In total, there were 72,503 Queenslanders from Pacific Islander backgrounds, comprising at least 1.9% of the Queensland population. However the current true figure is likely to be significantly higher based on community informant advice that this data is under-representative, rapid population growth in the Māori and Samoan populations, and research which indicates underreporting of Māori ancestry in the Australian Census.¹

Pacific Islander populations are growing rapidly in Queensland. According to the 2006 Census, the total number of Pacific Islander people and New Zealanders in Queensland rose by approximately 30 per cent between 2001 and 2006. These communities are projected to continue to grow rapidly with 21 per cent of migrants from New Zealand identifying as either Māori or Polynesian² and New Zealand remaining Queensland's largest source of migrants³. In comparison, the total Queensland population grew by 2.4 per cent between 2001 and 2006.



Pacific Islander people speak a variety of languages at home with the Samoan and Fiji Indian communities having the highest rates of first language retention. The five Pacific Islander populations are predominantly located in South-East Queensland with the exception of the PNG population which has its second largest community living in Cairns.

Pacific Islander and Māori health status and ways forward

Using the Australian Institute of Health and Welfare’s health determinants framework the key determinants of Pacific Islander health are presented. Findings are first presented in a summary format across the framework using a traffic light legend. It is clear that there is a high level of inequality across all elements of the framework. Findings are then presented for each broad element of the framework (e.g. Broad features of society) along with a summary of evidence and current approaches to the issues identified, and lastly, evidence-informed responses. (Source: Australian Institute of Health and Welfare)

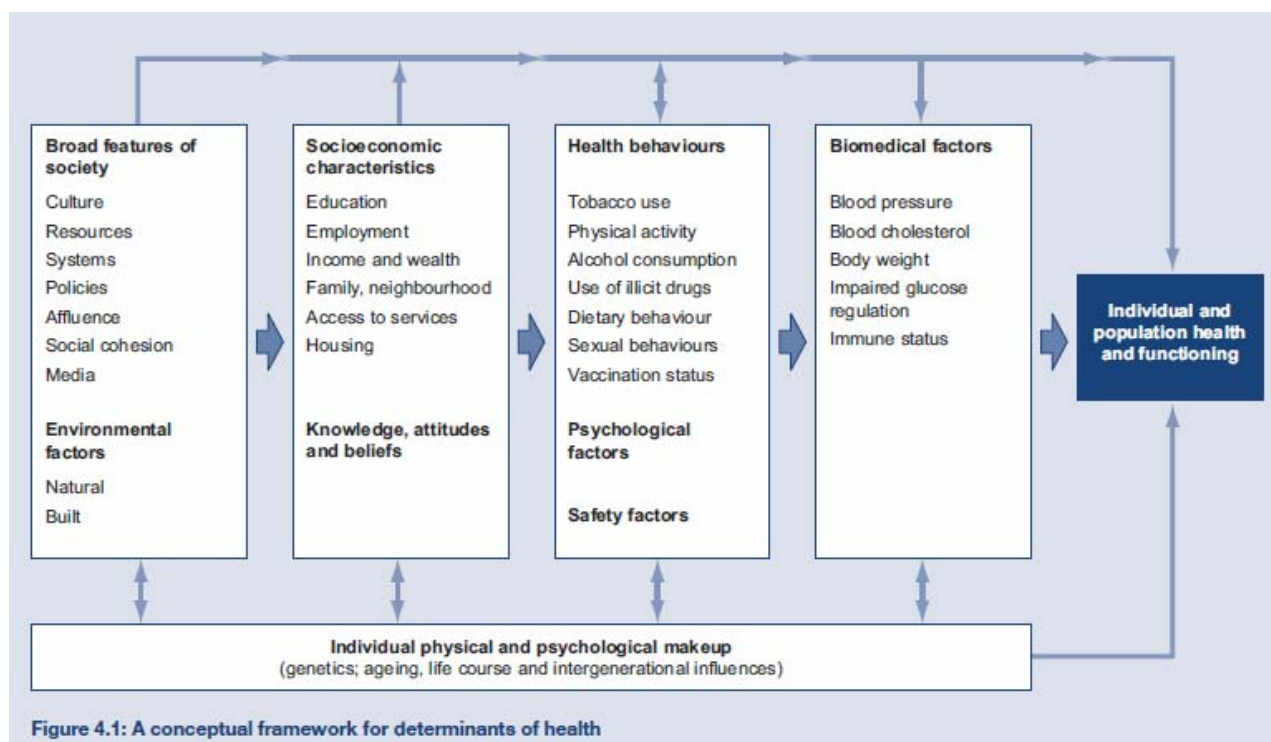
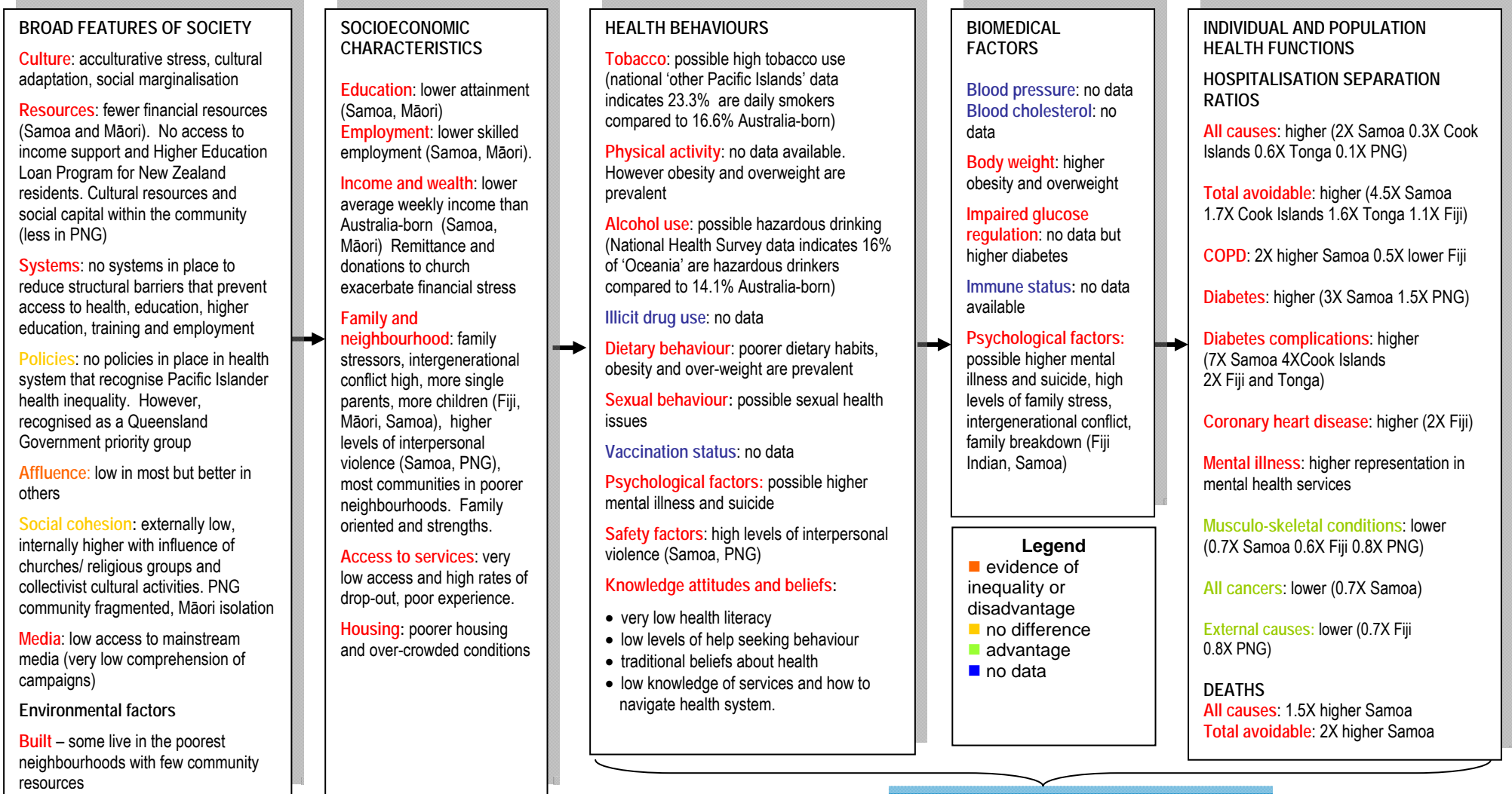


Figure 4.1: A conceptual framework for determinants of health

Summary of Pacific Islander and Māori disadvantage



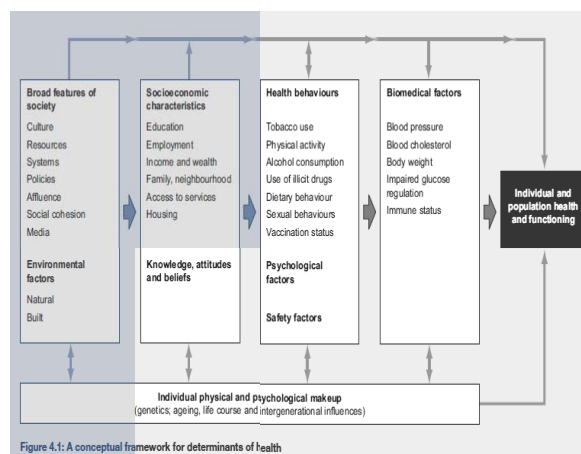
OUTSIDE THE HEALTH SYSTEM

WITHIN SCOPE OF THE HEALTH SYSTEM

Broad features of society and socioeconomic characteristics

Summary of findings

All of the Pacific Islander communities displayed strong cultural values, relationships, traditions and practices. Acculturative stress was evident and many cultural barriers were identified with the health system. Social connection was higher within the Samoan, Fiji Indian and indigenous Fijian communities, but not externally with the wider population. In contrast was the social isolation found in the Papua New Guinean and Māori communities. Social exclusion was identified for all of the communities. In terms of policy, Pacific Islander people are recognised as a whole-of-government priority group. However, there is little coordinated effort across departments on actions to address this priority group. Access to mainstream media messages was very low among Pacific Islander communities and any government strategies that use a mainstream media-based approach would most likely be missed by these communities.



The Samoan, Māori and possibly PNG communities have access to fewer financial resources and All of the communities are largely located in poorer neighbourhoods in the urban fringes of Brisbane, Logan, Ipswich and Redcliffe. Major barriers to service access were identified.

In terms of socio-economic characteristics, disadvantage was identified for all of the communities, but this was more evident for the Māori, Samoan and possibly PNG communities. The Samoan and Māori populations also had a higher proportion represented in the labouring and production worker occupational groups and fewer represented in the managerial and professional groups. The Samoan and Māori populations were also less likely to have a post-school qualification. Economic stress was a stronger theme in the Samoan focus groups than in focus group with other communities. Clinician interviews validated this finding, with Polynesians in particular identified as living in the poorest neighbourhoods, living in overcrowded housing and being the most socially excluded.

Family stressors featured in the Samoan and Fiji Indian focus groups. This included intergenerational conflict, family breakdown, acculturative stress and cultural conflict. The importance of family and lack of access to extended family support after migration was widely discussed across all communities. Housing issues of significance did not arise in the focus groups. However, some of the clinician surveys raised concerns about the number of families living in small houses, particularly in the Samoan community. School-based clinicians in different locations independently reported concerns about children living in overcrowded conditions and consequently not having a place in which to do homework, having no privacy or having personal safety concerns.

Current evidence to address socioeconomic determinants of health

The finding of inequalities in immigrant populations, particularly those experiencing socioeconomic disadvantage is consistent with international studies in the UK^{4,6}, the US^{7,8}, Canada⁹ and New Zealand.^{10,11} In a review of policy in 13 developed countries, the World Health Organisation concluded that approaches which tackle the macroenvironmental factors (income and education) and the physical and social environment, rather than simply adverse health behaviours, are more likely to be successful.¹²

Frameworks, plans, policies and legislation have been developed internationally for the reduction of health inequalities.¹³ In New Zealand, where the focus of health inequality is on ethnic inequality, an intervention framework was developed for reducing health inequalities with four target areas – social and economic determinants, intermediate determinants (such as housing and workplaces), health and disability services (improving access and cultural competency), and the feedback effect of ill health (disability support, accident compensation).¹⁰ This approach is particularly relevant as it targets Pacific Islander communities. Other literature identifies the target areas as: improving the environments of people affected by health inequalities; increasing access to health care; improving the quality of care; research and data; and supporting policies.^{14,15}

Many of the issues identified in the needs assessment in relation to social and economic determinants of health are interrelated and complex and are outside the jurisdiction of the health sector. The key issues identified include social exclusion, high levels of interpersonal violence, economic disadvantage, overcrowded and inadequate

housing, parenting issues, low literacy and educational attainment, and overrepresentation in low paid employment. These issues represent the social determinants of health which are powerful predictors of who is healthy and who is not.¹⁶ There is a growing recognition in Queensland to be most effective, that the health sector needs to engage with other departments and sectors for preventative strategies.¹⁷ It is also recognised in Australia and internationally, that efforts to reduce health inequality must address factors that lie largely outside the health care system.^{12,16-20} These include social, economic and community-level determinants of health.

Although the Queensland Government, through Multicultural Affairs Queensland, has recognised the relative disadvantage of Pacific Islander populations²¹ and has required all government departments to prioritise action on these populations, there is no whole-of-government Pacific Islander response to coordinate, support and implement actions. The extent of social disadvantage and the number of determinants negatively affecting the health and wellbeing of Pacific Islander people will require a concerted and coordinated effort to significantly impact on this disadvantage.

Response to findings

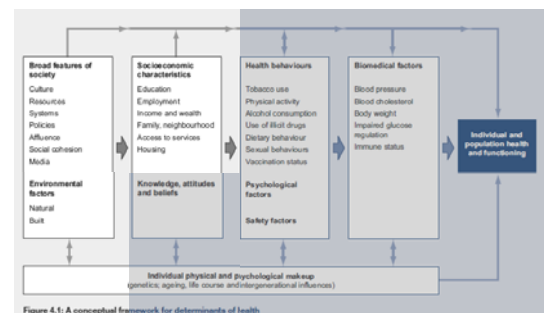
Multicultural Affairs Queensland to lead the establishment of a key agency leadership and coordination group on Pacific Islander and Māori disadvantage.

Key agencies will seek to lead culturally appropriate responses in current services and programs for accessibility to Pacific Islander communities.

Health knowledge, behaviours, status and outcomes

Summary of findings

Health literacy was found to be very poor among all Pacific Islander communities. Many examples and anecdotes were provided in most of the focus groups that demonstrate people’s low knowledge about health and health services. The low levels of knowledge about health and services were largely related to poor system navigation skills in the community. It is clear from the focus groups that Pacific Islander communities are disengaged from the mainstream service sector. Another strong theme in the focus groups was a cultural reluctance among Pacific Islander people to seek help. This was raised in all of the focus groups with the indigenous Fijian, Fiji Indian and Samoan communities. Pacific Islander people identified themselves as generally reserved, shy and ashamed to seek assistance from services and this was one of the primary factors in communication barriers, lack of uptake on preventive health and self management.



Indications from aggregated data from the National Health Survey suggest a higher prevalence of tobacco smoking, higher prevalence of hazardous alcohol consumption, significantly higher likelihood of obesity despite a comparable intake of fruit and vegetables, and a comparable sedentary level to the Australia-born population. Snap-shot country of birth data of Queensland mental health service usage (July 2008) suggests a higher use of mental health services for the Samoa-born, PNG-born and Fiji-born populations than what would be expected based on population size ranking. This was supported by the focus groups where mental health issues featured in every focus group.

Interpersonal violence, including domestic violence, family violence, and violence against children; sexual abuse; and youth violence were discussed in 11 of the 19 focus groups. It featured most prominently in the Samoan focus groups followed by the PNG focus groups. Similarly, the health service providers had observed violence in the Samoan and PNG communities.

Data are available for the Fiji-born, Samoa-born and PNG-born populations in Queensland on mortality and total hospital separations. Data for the Tonga-born and Cook Islands-born were also obtained to complement a health needs assessment undertaken with these communities by the Ethnic Communities Council of Queensland. (‘All Queensland’ is the reference group with a ratio of 100 for each health outcome). The table below presents the summary of findings on health outcome indicators for Fiji-born, Samoa-born, PNG-born, Tonga-born and Cook Islands-born Queenslanders.

Health outcome	Findings compared to all Queensland (100)
Deaths –standardised mortality rate for avoidable conditions (2005-2006)	Samoa-born: 192.3
Deaths –standardised mortality rate for all causes (2005-2006)	Samoa-born: 147.8
Standardised hospital separations – avoidable (2006-2008)	Samoa-born: 460.2 Cook Islands-born: 508.7 (excluding renal dialysis 170.5) Tonga-born: 420.1 (excluding renal dialysis 163.1) Fiji-born: 116.5
Standardised hospital separations – all causes (2006-2008)	Samoa-born: 198.3 Cook Islands-born: 131.0 Tonga-born: 164 PNG-born: 109.2

This data indicates that the Samoa-born population in particular has poorer health outcomes than the total Queensland population, with significantly higher mortality rates for all causes and avoidable conditions. Similarly, the standardised hospital separation rates for avoidable conditions and all causes were significantly higher. The Cook Islands-born, Tonga-born, Fiji-born and PNG-born populations also recorded higher hospital separations than the total Queensland population.

Queensland Hospital Admitted Patient Data Collection data for July 2006 to June 2008 indicate a high burden of chronic disease, particularly among the Samoa-born, Tonga-born, Cook Islands-born and Fiji-born and also the PNG-born population. No data are available for the Māori population as this data is based on country of birth. ('All Queensland' is the reference group with a ratio of 100).

Cause of hospitalisation	Findings (separation ratios for all Queensland = 100) June 2006 to July 2008
Cancer	Samoa-born: 72.2
Diabetes	Samoa-born: 284.7 PNG-born: 149.2
Diabetes complications	Samoa-born: 735.5^ Cook Islands-born: 955.2 (excluding renal dialysis 402.9) Tonga-born: 581.1 (excluding renal dialysis 211.7) Fiji-born: 199.8^
Coronary heart disease	Fiji-born: 212.8
COPD	Samoa-born: 229.4 Fiji-born: 45.9
Musculo-skeletal disease	Samoa-born 72.9 Fiji-born 67.4 PNG-born: 84.4
External causes	Fiji-born: 70.1 PNG-born: 84.6

[^] renal dialysis did not contribute significantly to this rate

Current evidence and approaches to address inequalities in health knowledge, behaviour, status and outcomes

A key finding of the needs assessment was the lack of knowledge of or engagement with mainstream health campaigns and health services by Pacific Islander communities. According to the literature, improving health literacy is linked to reducing health inequality and among ethnic communities, requires dedicated approaches that understand attitudes and beliefs towards health to inform interventions.^{22,23} These approaches may involve culturally-specific health workers, community engagement with the target community and the development of culturally tailored delivery methods, such as working with community leaders, community education sessions, engagement with multicultural media, and the development of translated materials.²²⁻²⁷ There is growing local evidence that culturally-specific health workers are fundamental to building health knowledge among culturally diverse communities.²⁴

Identifying barriers and increasing service access to prevention and screening programs for people from a culturally and linguistically diverse background are other features of international approaches to improving health behaviour.²⁷⁻³¹ Local evidence for increasing access to health services for people from a culturally and linguistically diverse background has been identified through the Multicultural Health Worker program implemented by the Ethnic Communities Council of Queensland, and the Community Navigator role which was piloted in Logan in 2009-10.^{24,32} The availability of dedicated health workers has been integral to improving the health of other

disadvantaged communities in Queensland such as homeless people and Aboriginal and Torres Strait Islander peoples.

International approaches to reducing inequities in health status and outcomes for people from a culturally and linguistically diverse background focus on providing culturally-tailored services through culturally-specific staff, increasing the cultural diversity of the health workforce, and improving the cultural competency of the wider health system and health workforce.

The importance of culturally tailoring prevention, screening and self-management programs is highlighted in the literature.^{22-24,26} International evidence suggests that the use of culturally tailored programs and services achieve better health outcomes for individuals.

There are two main approaches to providing culturally tailored health services: culturally dedicated health services that are run by the target community for the target community, and the employment by health services of culturally-specific health workers who culturally tailor programs and services and deliver them to target communities. There is mounting international evidence for the second approach – culturally-specific health workers. Whether they be lay health workers, system navigators, clinicians or health promotion officers, culturally-specific workers produce better clinical and health outcomes for people from a culturally and linguistically diverse background than the mainstream approach used for the general population.^{7,27-30,33-36} The Queensland Health position has been to support trained multicultural health workers.

Beyond culturally-specific positions, there is also evidence that having a culturally diverse workforce that reflects the same cultural and ethnic background as the disadvantaged populations served has multiple beneficial outcomes.^{7,23,37-39} An ethnically diverse clinical workforce has also been shown to reduce racial discrimination, diagnosis and treatment differences, and biases based on ethnicity.²³

Improving the cultural appropriateness of health programs and services is also achieved through the provision of culturally competent health services and through culturally competent health workers.^{23,40,41} The *Queensland Health Organisational Cultural Competency Framework* was developed in 2009 in recognition of the need for a culturally competent organisation. The eight outcome areas and four foundation areas of the framework represent areas that require action within health services for cultural competency.

Response to findings

Six high level strategies are required to address the identified level of inequality in health knowledge, behaviour, status and outcomes. The following table details each strategy, provides a summary of the underpinning evidence for each strategy, and identifies the area responsible for leading implementation of each strategy.

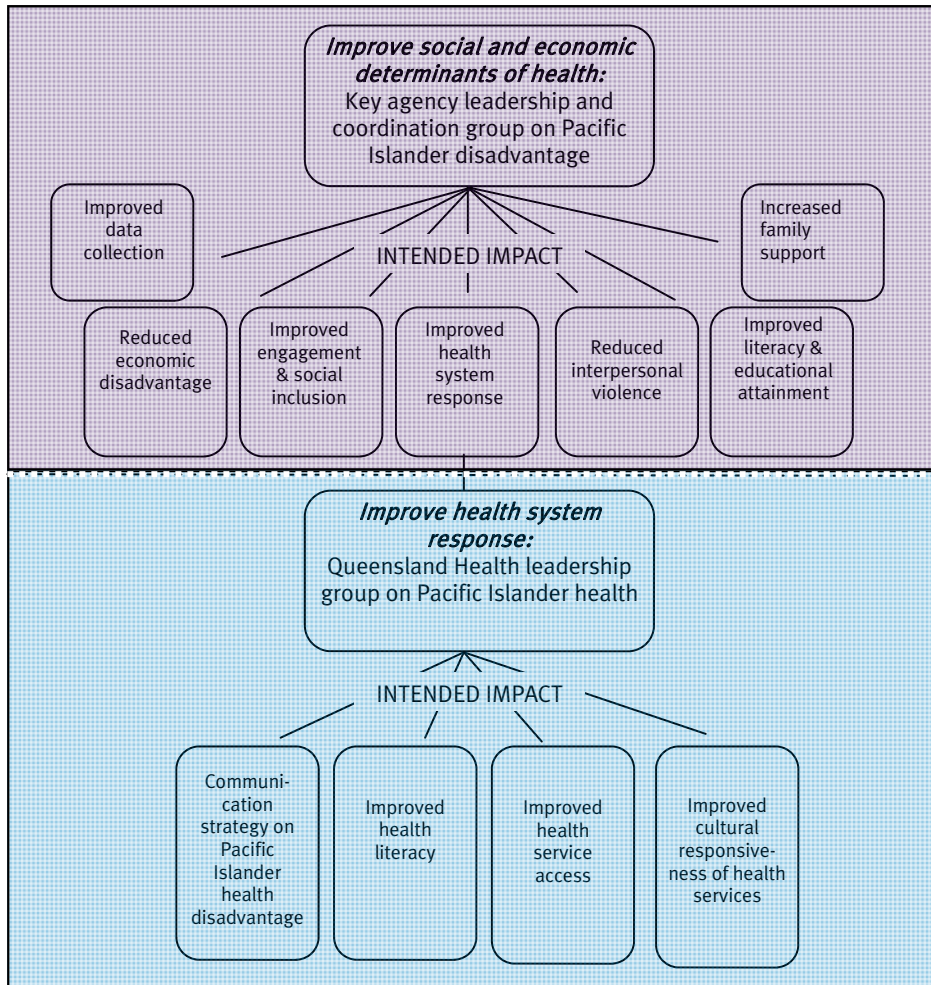
Strategies	Lead	Summary of rationale
<p>1. Establish and implement a Queensland Health Leadership Group on Pacific Islander and Māori Health to discuss, coordinate, monitor and report on activity to improve Pacific Islander and Māori health.</p>	<p>Queensland Health Multicultural Services</p>	<ul style="list-style-type: none"> • It is well recognised that addressing health inequities requires strategic and long term action^{12,42,43} • Strategic partnerships and leadership will be required to drive the implementation • The extent of health inequities found suggest improvement will be challenging. A strategic and coordinated focus will be required • Given the indication of the high chronic disease burden, including mental illness, key internal and external stakeholders working in targeted areas such as primary health, diabetes, cardiovascular disease, mental health, health promotion, workforce planning and data collection will need to be engaged.
<p>2. Develop and implement a communication strategy targeting relevant organisations and areas within Queensland Health and highlighting the major findings of the Pacific Islander and Māori needs assessment.</p>	<p>Queensland Health Multicultural Services</p>	<ul style="list-style-type: none"> • Many positive benefits could come from the existing Queensland Health workforce having a better understanding of the needs of Pacific Islander people and communities. • A targeted communication strategy to Health Service Districts and business units could raise the profile of Pacific Islander health needs and lead to improve targeting of services.
<p>3. Improve the nutrition and physical health literacy of Pacific Islander and Māori people by:</p> <p>a. developing culturally tailored programs and resources to improve lifestyle risk factors</p>	<p>Healthy Living Branch</p>	<ul style="list-style-type: none"> • Health literacy was found to be very poor among Pacific Islander communities • Evidence-based interventions for increasing the health literacy of people from culturally and linguistically diverse backgrounds include the use of culturally-specific health workers, the development of culturally tailored resources, delivery methods responsive to community cultural needs, and engagement with the community • The primary mechanism is the use of culturally-specific health workers who are from the target community, who deliver the identified interventions • The prioritisation of Pacific Islander communities in current and future campaigns such as <i>Measure Up, Swap It</i> and tobacco cessation programs will be required to reduce lifestyle risk factors.
<p>b. developing culturally tailored health promotion resources targeting children and families to reduce lifestyle risk factors</p>	<p>Children's Health Services</p>	<ul style="list-style-type: none"> • As Pacific Islander cultures are strongly family oriented, a culturally appropriate approach to increasing health literacy among Pacific Islander families is to focus on children and families
<p>c. exploring workforce roles required for implementation</p>	<p>Workforce Planning Unit, Clinical Workforce Planning and Development Branch</p>	<ul style="list-style-type: none"> • The need to investigate a suitable health workforce for Queensland's multicultural population was recognised in 2007 in the development of the <i>Queensland Health Strategic Plan for Multicultural Health 2007-2012</i>, with this investigation identified as a five year strategy • This issue has been identified more recently in the development of a 30 year workforce plan for Queensland Health • Exploration of existing workforce models for health promotion in the context of the Queensland health sector is required, including models such as Multicultural Community Health Workers.

Strategies	Lead	Summary of rationale
<p>4. Increase the service access of Pacific Islander and Māori people by:</p> <p>a. exploring workforce roles required to facilitate improved health service access</p>	<p>Workforce Planning Unit, Clinical Workforce Planning and Development Branch</p>	<ul style="list-style-type: none"> • Low service access was found among all Pacific Islander and Māori communities • Evidence-based interventions that increase health service access of people from culturally and linguistically diverse backgrounds focus on reducing the barriers to access, which are primarily language and culture. The most effective strategies to increase access are culturally-specific workers such as community navigators and multicultural health workers. These are required across the health continuum • Exploration is required of existing workforce models for facilitating service access in the context of the Queensland health sector, including models such as health system navigators, Pacific Islander health case managers and liaison officers.
<p>b. exploring the viability of a Pacific Islander Health Centre by the primary care sector in a geographic location with large Pacific Islander and Māori communities.</p>	<p>Queensland Health Multicultural Services in consultation with Medicare Locals when established</p>	<ul style="list-style-type: none"> • Pacific Islander and Māori communities prioritise culturally dedicated programs and services. Approaches in New Zealand reflect this with many Pacific Islander primary health care organisations operating • One of the challenges for the Queensland context is that there are only generic Pacific Islander organisations. There are no Pacific Islander health organisations that could be funded to deliver health programs to the Pacific Islander populations and partnerships with the primary care sector remain unexplored.
<p>5. Improve the cultural competency of health services particularly in the priority areas of diabetes, mental health and primary care by:</p> <p>a. exploring the feasibility of a Pacific Islander Workforce strategy for Queensland Health to increase the number of Pacific Islander and Māori people in the workforce, along with a range of supporting strategies such as scholarships and awards</p>	<p>Workforce Planning Unit, Clinical Workforce Planning and Development Branch</p>	<ul style="list-style-type: none"> • Pacific Islander and Māori people experienced health services as culturally inappropriate and unsafe • Evidence-based interventions are the use of culturally-specific health workers, the provision of culturally tailored programs and services, the provision of culturally dedicated health services by the target community for the target community, and strategies that increase organisational cultural competency • Cultural competency at the organisational level and the individual health worker level are required for most effective impact • There is evidence that a culturally diverse health workforce produces better outcomes and also provides economic benefits to the communities. Filling Pacific Islander workforce positions and also generic positions with people from a Pacific Islander background may require a targeted strategy which could attract Pacific Islander people into general positions in Queensland Health as well as dedicated positions.
<p>b. developing a culturally appropriate response to Pacific Islander diabetes management and clinical care</p>	<p>Metro South, Metro North and Darling Downs West Moreton HSDs</p>	<ul style="list-style-type: none"> • Higher hospitalisations for diabetes were found for every Pacific Islander community • Evidence-based interventions that increase health service access and health management of people from culturally and linguistically diverse backgrounds focus on reducing the barriers and increasing cultural competency. • The most effective strategies include culturally-specific workers such as culturally-specific case managers. The financial viability of this approach requires further evidence. • Exploration and demonstration of the most effective and financially viable interventions is required by the Health Service Districts with the largest Pacific Islander populations.
<p>c. exploring how the Queensland Health <i>Cultural Competency Framework</i> can be implemented in target districts in the priority areas of health</p>	<p>Metro South, Metro North and Darling Downs West</p>	<ul style="list-style-type: none"> • The <i>Queensland Health Cultural Competency Framework</i> has eight core outcome areas that require consideration in the priority service areas in districts with large Pacific Islander populations.

Strategies	Lead	Summary of rationale
promotion, diabetes, cardiovascular disease, and mental health	Moreton, Gold Coast, Cairns and Interland HSDs	
<p>6. Improve the cultural competency of health staff, particularly in the priority areas of health promotion, diabetes, cardiovascular, mental health and primary care by:</p> <p>a. implementing cultural competency training for staff working in the priority areas in Health Service Districts with large populations of Pacific Islander people</p>	Metro South, Metro North, Darling Downs -West Moreton, Gold Coast, Cairns and Hinterland HSDs	<ul style="list-style-type: none"> • Cultural competency training is required at the local level, targeting staff working in the priority areas • People and Culture units will need to work collaboratively with Statewide training programs to implement this potential response within Health Service Districts • One of the eight principles of Queensland Health's People and Culture Plan is cultural diversity. One strategy is to "ensure all staff are able to interact effectively with people across different culture".
<p>b. District Multicultural Mental Health Coordinators providing cultural competency training to mental health staff and using Pacific Islander focussed case studies in relevant HealthService Districts to build staff capability to respond to Pacific Islander community mental health needs.</p>	Queensland Transcultural Mental Health Centre	<ul style="list-style-type: none"> • This builds on existing mechanisms in place at the Health Service District level to improve staff cultural competency. • By working together with staff implementing Queensland Health's Cross Cultural Learning and Development Strategy, district transcultural mental health training could be further targeted to incorporate Pacific Islander community mental health needs
<p>c. developing resources to increase cultural competency for emergency services staff involved in the suicide prevention pilot who identify people at risk of suicide</p>	Queensland Centre for Mental Health Promotion, Prevention and Early Intervention	<ul style="list-style-type: none"> • Suicide was identified in a number of communities. • The pilot emergency services project aims to train emergency services workers from a number of agencies to identify people at risk of suicide and facilitate their pathway to care. • The development of cultural competency skills will be important to ensure that emergency workers are able to recognise and respond to suicide risk among culturally diverse population groups, particularly Pacific Islander groups. Resources will be an important component of developing this cultural competency.
<p>d. exploring the evaluated Multicultural Clinical Support Officer role to support the development of cultural competency of staff in priority areas.</p>	Workforce Planning Unit, Clinical Workforce Planning and Development Branch with Queensland Health Multicultural Services	<ul style="list-style-type: none"> • Queensland Health Multicultural Services piloted the Multicultural Clinical Support Officer position in two Health Service Districts to provide on-the-job cultural coaching to health staff. The positions were established to provide leadership and specialist support within clinical teams. • As these positions have evaluated positively, the results could be further considered by Clinical Workforce and Planning Branch.

Summary of way forward

Pacific Islander and Māori communities experience health inequalities at higher rates than the total Queensland population. These inequalities centre on chronic disease. Contributors to this equality are both health system issues, such as low health literacy, service access barriers and the need for improved culturally responsive health service delivery, and broader social determinants of health including economic and educational disadvantage, social exclusion and isolation, interpersonal violence, and family support issues. The figure below summarises the overall response to these findings, detailing the leadership mechanism and intended impact of the response. Key agencies will seek to lead culturally appropriate responses in current services and programs for improved accessibility to Pacific Islander and Māori communities. The health system response will also include identifying opportunities for new resources to enhance implementation of the strategies.



About the document

Background

In 2008-09 the Queensland Government identified Pacific Islander¹ 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).

This document summarises the findings of the Pacific Islander and Māori Health Needs Assessment and Consultation. It summarises the health profile of five Queensland Pacific Islander communities – Māori, Samoan, Papua New Guinean, indigenous Fijian and Fiji Indian - and outlines a response for improving the health of these communities. Community data documents are available for each community.

Document structure

Section one, *Data sources and methods*, describes the main data sources and methodologies used in the needs assessment project and the limitations of the data used in the Pacific Islander and Māori health data documents and in this document.

Section two, *A demographic profile of Queensland's Pacific Islander and Māori populations*, includes the population size and growth, languages spoken, year of arrival and geographic distribution of the five communities.

Section three, *Pacific Islander and Māori health: current status and ways forward*, provides an outline of the major findings for the five communities, presents the frameworks and research that form the basis for the development of strategies, provides an analysis of all of the data presented, and identifies evidence based responses to reduce the identified health inequalities among Pacific Islander communities.

Section four, *Summary of response to address health inequalities*, presents a summary of the potential responses to reduce the identified health inequalities among Pacific Islander and Māori communities.

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.

1 Data sources

This document is one in a series of documents on the health of Pacific Islander and Māori communities in Queensland. There is a series of community specific documents that detail health status findings. This document summarises this data and presents potential responses to the findings. The other documents in the series are:

- The health Queensland's Samoan population 2009
- The health Queensland's Māori population 2009
- The health Queensland's Papua New Guinean population 2009
- The health Queensland's Fijian population 2009

1.1 Literature review

A literature review was conducted for 1998 to 2010 using search terms for the Samoan, Māori, indigenous Fijian, Fiji Indian and Papua New Guinean communities. Each document details the search terms used.

Databases searched:

- Medline
- Meditext
- Austhealth.

References in articles obtained were followed up and internet searches were also conducted.

Articles were prioritised to include studies on immigrant Pacific Islander and Māori populations, including those in Australia. However, little has been published on the health of Pacific Islander and Māori people in Australia.

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 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.

1.2.2 Australian Bureau of Statistics

Several data were obtained from the Australian Bureau of Statistics - National Health Survey 2007-08⁴⁴, Health Literacy⁴⁵, Australian Social Trends⁴⁶ and 2006 Census of Population and Housing.⁴⁷

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.

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 Pacific Islander and Māori community members and leaders

Between April and August 2009 a total of 15 focus groups were held with leaders and community members of five Pacific Islander communities in Queensland. In addition, one consultation took place with a Pacific Islander peak organisation in Far North Queensland. In total, 191 Pacific Islander and Māori people participated in the focus groups and consultation. A break-down of participants by community group is presented in Table 1. All of the communities were based in South-East Queensland, except for the Papua New Guinea (PNG) community in Cairns.

Table 1 Focus group participants by community group

Community	Leaders	Community members
PNG (Cairns)	10	18
Māori	5	21
PNG	5	24
Fiji Indian	4	24
Indigenous Fijian	4	23
Samoan	6	39
PCCFNQ consultation	8	
Total	42	149

In Brisbane, one consultation with community leaders from all of the target communities took place in a workshop format. A minimum of four community leaders from each community participated. Small group work took place to enable leaders to provide information specific to their respective communities.

A consultation was held with the Pacific Communities Council of Far North Queensland (PCCFNQ) involving eight participants representing the Cook Islands, Māori, PNG, Samoan and Tongan communities. The contribution of these leaders is incorporated into the Cairns PNG focus group analysis.

Organisation of focus groups

All focus groups were organised by bilingual/bicultural co-facilitators. Only the community leaders' workshop in Brisbane was organised by the Project Officer and Project Manager, with the assistance of the co-facilitators who provided community leader names and contacts.

Each co-facilitator contacted people in their respective community, arranged a venue familiar and convenient for participants and organised culturally appropriate catering. Co-facilitators were instructed to organise the focus groups by:

- promotion to or inviting participants beyond their own social networks
- being mindful of gender issues, age distribution and religious background
- taking into consideration location of focus group.

Role of bilingual co-facilitators

The bilingual co-facilitator provided access to members of the Pacific Islander and Māori communities that Queensland Health otherwise would have been unable to access. They also:

- ensured that a variety of groups and networks were involved to decrease potential community criticism of bias and community politics
- provided cultural advice to the project
- provided linguistic skills to the focus groups
- acted as cultural brokers to ensure that correct cultural protocols were followed in the focus groups such as opening prayers; appropriate acknowledgment of leaders, elders and chiefs; and blessing of food
- ensured that catering was culturally appropriate.

Each focus group was facilitated jointly by the Project Officer and a bilingual co-facilitator. Most focus groups were held predominantly in English. At times, participants reverted to their first language to more adequately explain an

issue or tell a story. This was then recapped in English by the co-facilitator. Notes were taken by the Project Manager.

Prompting points

A standard list of prompting points was used for the focus groups and can be found in the community data documents.

1.4 Health service provider survey

A potential sample of health services was developed for each community. Participants were randomly selected and contacted for a telephone interview. However, as many 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, 54 participants participated in the survey. However, 14 (25 per cent) were not able to complete the questionnaire as they had not seen Pacific Islander consumers in their health service, or did not know whether they had. This varied across communities – all of the health service providers contacted about their experiences with Samoan clients were able to complete the questionnaire, three providers did not know if they had seen Māori clients, three did not know if they had seen PNG clients, and eight did not know if they had seen indigenous Fijian or Fiji Indian clients.

1.5 Data quality

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 any of the communities.

Health status data for the Māori community are not available because the data is based on country of birth and does not identify Māori people who are included in the New Zealand category. Ethnicity or ancestry data are not collected in Queensland Health data collections.

The *Standards for Statistics on Cultural and Language Diversity* (Attachment 1) provide a minimum set of indicators for cultural and linguistic diversity. The standards recommend the use of indicators as a minimum, not one in isolation. This rarely happens in practice and the lack of available health data using these indicators is a major gap that prevents complete analysis of the health of Pacific Islander and Māori people in Queensland.

2 A demographic profile of Queensland's Pacific Islander and Māori populations

2.1 Who are Pacific Islander and Māori people?

Migrants to Australia from the island groups of Micronesia, Melanesia and Polynesia are referred to collectively as 'Pacific Islander people'. Despite often being grouped together in this way, populations from these different regions are heterogeneous with diverse cultures, languages and religions.



Figure 1 Map of Oceania
(Source: www.graphicmaps.com)

It is important to distinguish between Pacific Islander people and Australian South Sea Islander people. Pacific Islander people are migrants to Australia, whereas Australian South Sea Islander people are the Australia-born descendants of predominantly Melanesian people who were brought to Queensland between 1863 and 1904 as indentured labourers. Australian South Sea Islander people originate from 80 different Pacific Islands, but are primarily from Vanuatu and the Solomon Islands.⁴⁸ There are some Australian South Sea Islander people with Papua New Guinean ancestry.

2.2 Population size and growth

Pacific Islander people have been described as 'statistically invisible' in Australia because many have migrated from or through New Zealand and are identified in Australian Census data as New Zealanders. The number of Pacific Islander people in Queensland may be significantly higher than what is captured in official data. Community informants advise that people may tick 'other' and not their country of birth on forms such as the Census form.

Anecdotal information from community leaders indicates that Pacific Islander communities are significantly larger than reflected in the Census. The Samoan community is estimated to be closer to 26,000 based on attendance at festivals and events and the Tongan community is estimated to be closer to 10,000.

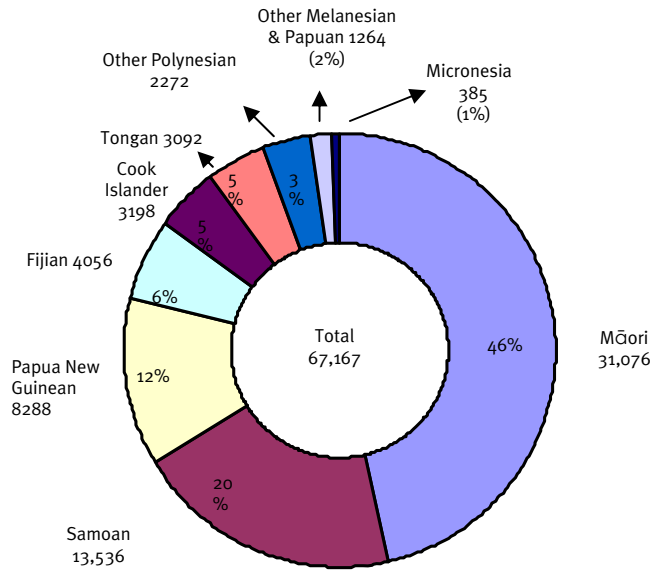


Figure 2 Queenslanders who identified Pacific and Māori ancestry, Census 2006

As shown in Figure 2, 67,167 Queenslanders identified a Pacific Islander ancestry in the 2006 Census. In addition to this, 5,336 Queenslanders identified an Indian ancestry and were born in Fiji. In total there were 72,503 Queenslanders from Pacific Islander backgrounds, comprising at least 1.9 per cent of the Queensland population. However, the current true figure is likely to be significantly higher based on community informant advice that this data is under-representative, rapid population growth in the Māori and Samoan populations, and research which indicates underreporting of Māori ancestry in the Australia Census.¹

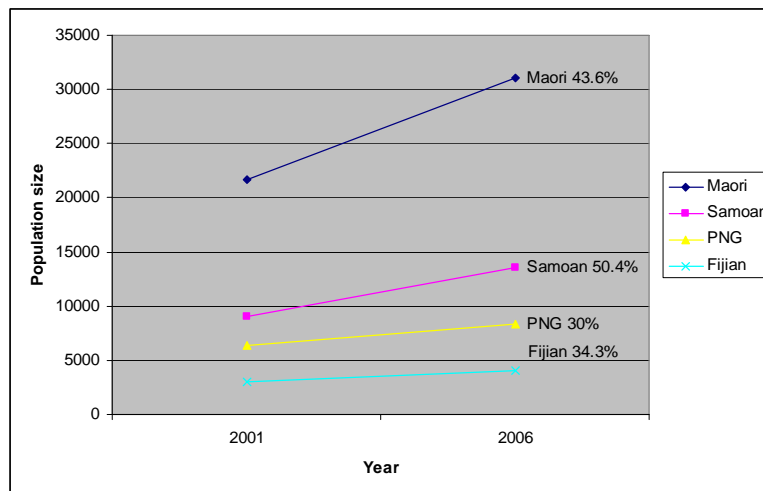


Figure 3 Pacific Islander and Māori population growth in Qld 2001-2006

As shown in Figure 3, the Pacific Islander populations are growing rapidly in Queensland. According to the 2006 Census, the total number of Pacific Islander people and New Zealanders in Queensland rose by approximately 30 per cent between 2001 and 2006. These communities are projected to continue to grow rapidly with 21 per cent of migrants from New Zealand identifying as either Māori or Polynesian² and New Zealand remaining Queensland's largest source of migrants³. In comparison, the total Queensland population grew by 2.4 per cent between 2001 and 2006.

2.3 Languages spoken at home

The Samoan and Fiji Indian populations had a high level of language retention. In the 2006 Census, 9,367 Queenslanders indicated they spoke Samoan at home and 4,491 indicated they spoke Hindi and were born in Fiji. Smaller numbers indicated they spoke Māori (1,891), Tok Pisin (886) and Fijian (843) at home.

2.4 Year of arrival

Figure 4 depicts year of arrival for the four Pacific Islander communities, showing that the PNG community is longer established and that the Māori community is relatively new and still growing rapidly. It should be noted that the data for the Samoan, PNG and Fijian populations is based on country of birth, while the data for the Māori population is based on ancestry.

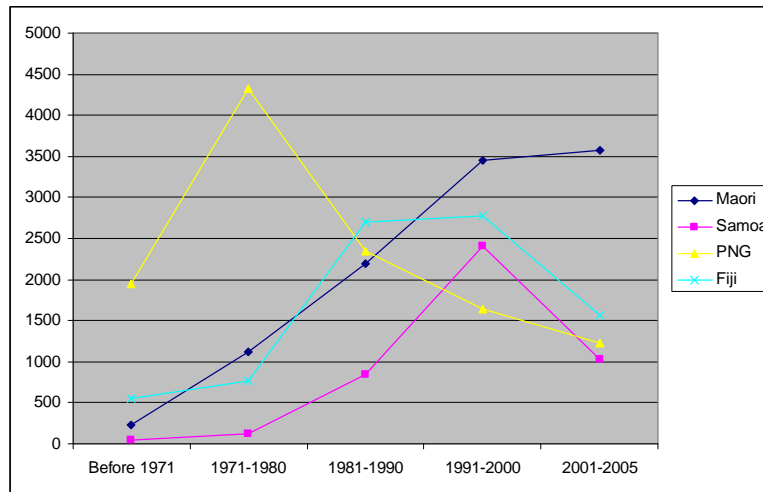


Figure 4 Year of arrival for four Qld Pacific Islander communities

2.5 Geographic distribution

The five Pacific Islander populations were predominantly located in South-East Queensland with the exception of the PNG population which has its second largest community living in Cairns.

3. Pacific Islander and Māori health: current health status and ways forward

This section presents a summary and analysis of findings based on the available qualitative and quantitative data on the health determinants, health status and health outcomes for Māori, Samoan, Papua New Guinean, Fiji Indian and indigenous Fijian populations in Queensland. The findings and analysis are presented using the health determinants framework structure (Figure 5). Based on the analysis, evidence based strategies to reduce the identified health inequalities among Pacific Islander communities are presented.

3.1 Health determinants framework

Determinants of health and wellbeing refer to the factors that influence the health status of populations and individuals.⁴⁹ These factors act in various combinations; that is, health is multi-causal.⁵⁰ 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 integral to disease prevention and health promotion⁵⁰. Using the health determinants framework, the key determinants of Pacific Islander health are presented.

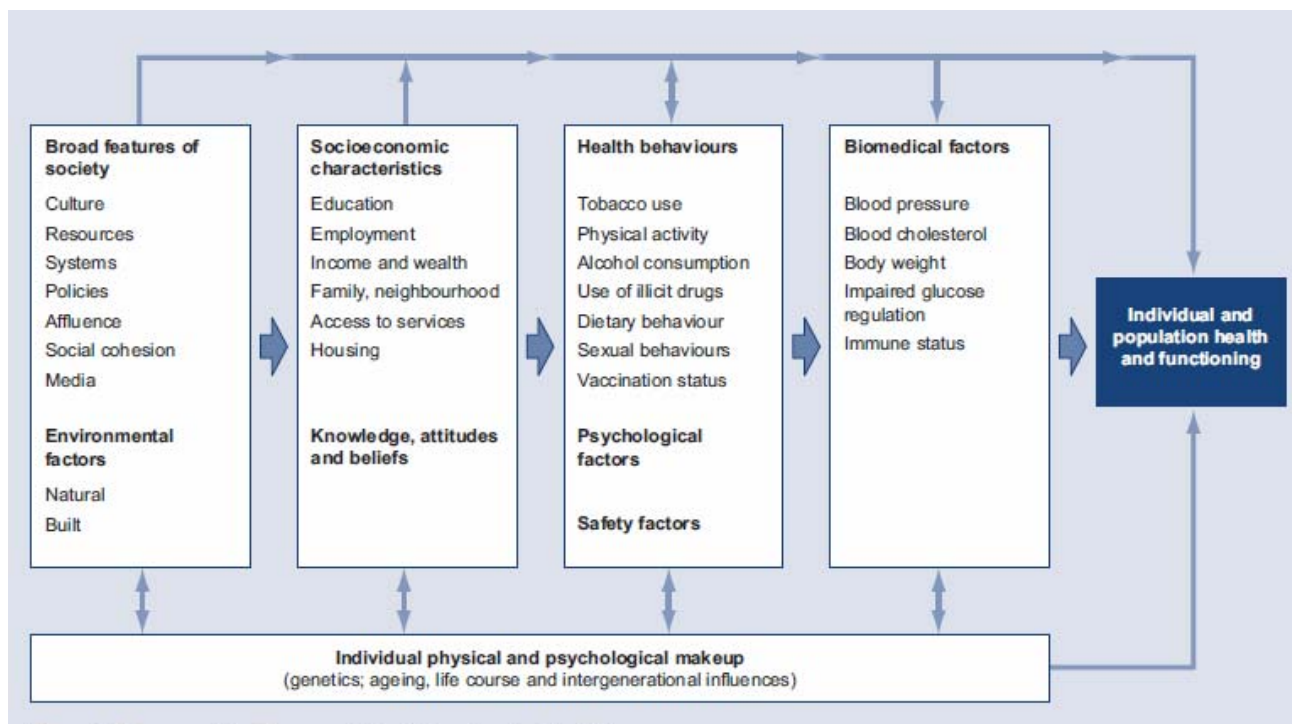


Figure 5 Conceptual framework for the determinants of health (Source: Australian Institute of Health and Welfare⁵⁰)

3.2 Broad features of society, environmental and socioeconomic factors

3.2.1 Findings

Culture - All of the Pacific Islander communities displayed strong cultural values, relationships, traditions and practices. Acculturative stress was evident, particularly in the Samoan focus groups, with descriptions of family conflict and breakdown. Out of 19 focus groups, 16 identified low cultural competency in health services, sixteen identified communication barriers, and 15 identified culturally determined behaviours for seeking assistance and accessing services. The cultural environment of Pacific Islander communities, and of the services they encounter, is a consideration in their health status.

Resources and affluence – The Samoan, Māori and possibly PNG communities have access to fewer financial resources. Social connection was higher within the Samoan, Fiji Indian and indigenous Fijian communities but not externally with the wider population. These communities were engaged with members of their own communities through religious and cultural organisations, but not with wider society – people, services or activities. In contrast was the social isolation found in the Papua New Guinean and Māori communities who also described being disconnected from members of their own ethnic communities. Community leaders and members expressed frustration at their inability to influence decisions and the lack of engagement from Government.

Systems and policies – There were no systems identified that address the inequalities experienced by Pacific Islander communities. In terms of policy, Pacific Islander people are recognised as a whole-of-government priority group. However, there is little coordinated effort across departments on actions to address this priority group.

Social cohesion – Only the PNG community identified a lack of social cohesion within the community. All of the PNG focus groups identified that their community is fragmented, not cohesive and poorly organised. This contributed to the social isolation described by people from the PNG community.

Media – All 19 focus groups identified that health promotion messages had not reached their community. Access to media messages was very low among Pacific Islander communities and government strategies that use a media-based approach would most likely be missed.

Built environment – Pacific Islander communities are largely located in lower socioeconomic neighbourhoods in the urban fringes of Brisbane, Logan, Ipswich and Redcliffe.

Access to services – Major barriers experienced in the health system by Pacific Islander people were identified in all 19 focus groups. Some were related to the socioeconomic characteristics of the communities, while many others were related to the health system.

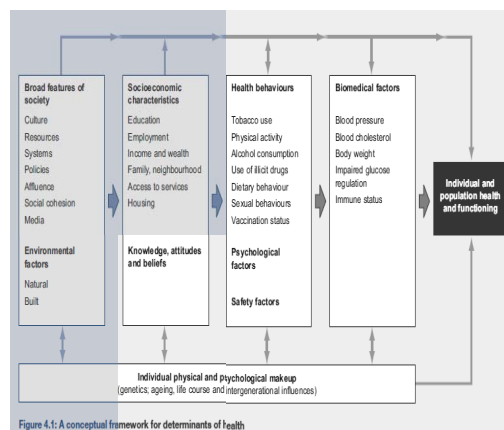


Figure 4.1: A conceptual framework for determinants of health

Table 2 Summary of focus group findings – barriers in health system

Health system issues	Māori	Samoaan	Indigenous Fijian	Fiji Indian	PNG Cairns	PNG South-East Qld	Total no. of focus groups
Lack of culturally tailored health promotion	3/3*	4/4	3/3	3/3	3/3	3/3	19/19
Unavailability of Pacific Islander health staff	3/3	3/4	3/3	3/3	3/3	3/3	18/19
Low health literacy - lack of knowledge of health issues and services	2/3	4/4	2/3	3/3	3/3	3/3	17/19
Lack of cultural competency in health services	3/3	3/4	1/3	3/3	3/3	3/3	16/19
Communication barriers	2/3	4/4	3/3	2/3	3/3	2/3	16/19
Cultural reluctance to seek help	1/3	4/4	3/3	3/3	2/3	2/3	15/19
Economic barriers (cost of health care a barrier)	0/3	4/4	3/3	2/3	3/3	2/3	14/19
Unavailability of Pacific Islander dedicated services and programs	2/3	4/4	1/3	2/3	2/3	3/3	14/19

*number denotes the number of focus groups in which the issue was raised

The remaining health system issues were identified in fewer than half of the focus groups:

Health system issue	Number of focus groups identified
Lack of community engagement	5/19
Different health models	4/19 (in all 3 Māori focus groups)
Satisfaction with health system	3/19
Lack of cohesive community and networks in community	3/19 (only in PNG focus groups)
Physical barriers to access (eg transport)	2/19
Reliance on unpaid work in the community	2/19
Racial/religious discrimination	2/19
General dissatisfaction (eg waiting times)	2/19
Housing issues	1/19

Income, employment and education – The median individual weekly income for Samoa-born Australians and Māori people was less than the total Australian population. Similarly, the Samoan and Māori populations had a higher proportion represented in the labouring and production workers occupational groups and fewer represented in the managers and professional groups. The Samoan and Māori populations were also less likely to have a post-school qualification. For example, while 18 per cent of the total Queensland population had a bachelor or post-graduate level of education, only three per cent of the Māori population had the same level of education. Economic stress was a stronger theme in the Samoan focus groups than in focus group with other communities. Clinician interviews validated this finding, with particularly Polynesians identified as living in the poorest neighbourhoods, living in overcrowded housing and the most socially excluded. Those from the Samoan and Māori populations are more likely than people from other Pacific Islander communities to have entered Australia through the Trans-Tasman Travel Arrangement that allows Australian and New Zealand citizens to freely move between each country to visit, live and work, without the need to apply for authority to enter.⁵¹ However, the economic and educational situation of the Samoan and Māori communities is exacerbated by the ineligibility of

“It is expensive to go to the doctors. It is an issue... Medicare doesn’t cover dental.” – PNG female

those people who entered Australia after 2001 from New Zealand, to access the Higher Education Loan Program and other forms of income support.

The median individual weekly income for PNG-born and Fiji-born Australians was higher than for the total Australian population. The Fiji- and PNG-born populations were more likely to have a post-school qualification, reflecting Australia's immigration policies favouring skilled migration. However, data on the PNG-born population may be skewed by PNG-born Australians born to expatriate Australian professionals working in PNG. Five out of six PNG focus groups identified economic barriers.

Despite some communities having a more favourable educational, employment and income profile, 14 out of 19 focus groups identified economic barriers to healthcare, with the cost of seeing a doctor and buying medicines identified as too high for most families.

Family and neighbourhood – The profile of families in three Pacific Islander communities was different to that of the total population. A larger proportion of Samoan families were single-parent families; a larger proportion of Fiji-born and Māori families had children; a smaller proportion of Māori people lived in a registered marriage spousal relationship; and a larger proportion of Māori people lived in a partner de facto relationship.

"...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

Family stressors, including intergenerational conflict, family breakdown, acculturative stress and cultural conflict, featured in the Samoan and Fiji Indian focus groups. The importance of family and the lack of access to extended family support after migration was widely discussed across all communities.

Housing – Housing issues of significance did not arise in the focus groups. However, some of the clinician surveys raised concerns about the number of families living in small houses, particularly in the Samoan community. School based clinicians in different locations independently reported concerns about children living in extremely overcrowded conditions and consequently not having a place in which to do homework, having no privacy or having personal safety concerns. This is consistent with New Zealand data which indicates Pacific Islander communities in New Zealand live in the most overcrowded and adverse housing conditions⁵². Pacific Islander populations are also most likely to live in multi-family households and have the largest household size⁵³. However, some caution should be taken to ensure that not all larger households are assumed to be due to poverty; the decision may be due to cultural choice.

3.2.2 Current evidence and approaches to address socioeconomic issues in health determinants

The finding of inequalities in immigrant populations, particularly those experiencing socioeconomic disadvantage, is consistent with international studies. For example, ethnic health inequalities have been found in the UK⁴⁻⁶, the US^{7,8}, Canada⁹ and New Zealand.^{10,11}

In a review of policy in 13 developed countries, the World Health Organisation found that health inequalities based on ethnicity, employment status, gender and geographic location were recognised as a major problem in all of the countries studied.¹² It was concluded that approaches which tackle the macro environmental factors (income and education), the physical environment and the social environment, rather than simply adverse health behaviours, are more likely to be successful.

Frameworks, plans, policies and legislation have been developed internationally for the reduction of health inequalities.¹³ In Canada, four major health sector policy directions were introduced to reduce health inequalities including integrating inequality reduction into health programs and services.⁵⁴ In the UK, the Marmot Review set an ambitious and far reaching agenda for health inequality reduction with six broad policy objectives.⁴² In the US, the blueprint for the reduction of health inequalities is *Healthy People 2010*.⁴³

In New Zealand, where the focus of health inequality is on ethnic inequality, an intervention framework was developed for reducing health inequalities with four target areas.¹⁰ This approach is particularly relevant as it targets Pacific Islander communities. Examples of actions in the areas of social and economic determinants are:

Table 3 Summary New Zealand ethnic health inequity intervention framework

Target area	Actions
Social and economic determinants	<ul style="list-style-type: none"> • Systematic implementation of the provisions of the Treaty of Waitangi in policy, planning and service delivery • Development of Māori and Pacific Islander providers and workforce • Health funding arrangements that distribute resources according to need • Exploration of health impact assessment tools • Monitoring of health inequalities, social determinants and the relationship between the two
Intermediate determinants	<ul style="list-style-type: none"> • Housing initiatives • Community development programmes • Settings-based programmes, such as healthy cities and health-promoting schools • Workplace interventions (e.g. Occupational Safety and Health) • Local authority policies (e.g. in relation to cycle ways, lighting, playgrounds and transport) • Health education and the development of personal skills • Health protection
Health and disability services	<ul style="list-style-type: none"> • Improved access to appropriate, high-quality health care and disability services • Ethnic-specific service delivery • Collection of accurate ethnicity data • Implementation of the elective services booking system based on need • Monitoring of service delivery to ensure equitable intervention rates according to ethnicity, gender, socioeconomic status and region • Primary care initiatives that reduce access barriers for Māori, Pacific Islander peoples and other disadvantaged groups • Community participation in the health sector at a governance level and in resource allocation decision-making • Equitable resource allocation by District Health Boards as funders and by providers, including hospitals • Collaborative partnerships within the health sector and intersectorally
Feedback effect (of ill health on socioeconomic position)	<ul style="list-style-type: none"> • Income support (for example, sickness benefits) • Disability allowance • Accident compensation • Antidiscrimination legislation and education • Support services for people with disabilities, chronic illness and mental health illness • Living in the community and their carers (for example, respite care)

Other literature indicates that strategies for reducing or eliminating ethnic health inequalities should include strategies that target social and economic disadvantage, such as^{14,15}:

Table 4 Summary of strategies for reducing ethnic health inequalities from literature

Strategies	Examples
Improving the environments of people affected by health inequalities	<ul style="list-style-type: none"> • Improve performance of schools in poor neighbourhoods • Improve housing • Improve access to healthy food choices • Crime reduction programs • Provision of community health services
Increasing access to health care	<ul style="list-style-type: none"> • Culturally diverse workforce • Peer educators and outreach workers • Reduce financial barriers • Reduce structural barriers (e.g. location or transport).
Improving quality of care	<ul style="list-style-type: none"> • Culturally diverse workforce • Reducing language barriers (e.g. interpreter services, translated information and consent forms) • Cultural competency training of staff • Data collection
Research and data	<ul style="list-style-type: none"> • Gather knowledge and evidence about the determinants of health inequalities, effective interventions for prevention and treatment • Best practice of inequality reduction • Data on specific populations • Inclusion in national and other health surveys
Policy changes and laws	<ul style="list-style-type: none"> • Mandatory cultural diversity training for health workers • Policy change that mandates prioritisation of particular population groups • Legislation that mandates compulsory inclusion of cultural competency in all medical education curricula

In Australia, the Commonwealth Government's health agenda is focussed on health system and hospital reform. Actions to tackle the social determinants of health do not feature in the reform plans. Similarly, the National Preventative Health Taskforce terms of reference focused on tobacco, obesity and alcohol. While there is recognition of the social determinants of health, most recommendations relate to downstream lifestyle factors. International evidence supports upstream intervention as the most successful strategies.

The recognition and policy responses to health inequality vary across jurisdictions. Victoria is most notable with a comprehensive approach and suite of resources for the implementation of strategies that address disadvantage. New South Wales and South Australia have statements on health inequality and other jurisdictions have actions on inequality integrated into their strategic documents. The key documents in Australian jurisdictions are:

Table 5 Australian jurisdiction responses to health inequality

Jurisdiction	Key documents relating to health inequality
Victoria	<p>(2009) Fairer health: case studies on improving health for all (2008) People, Places, Processes: Reducing health inequalities through balanced health approaches. (2008) Burden of disease due to health inequalities (2008) Key influences on health inequalities (2007) Vichealth investment for reducing health inequalities (2007) Vichealth action on health inequalities all documents: http://www.vichealth.vic.gov.au/en/Resource-Centre/Publications-and-Resources/Health-Inequalities.aspx</p> <p>(2005) A Fairer Victoria and (2006) A Fairer Victoria: Progress & Next Steps http://www.dpc.vic.gov.au/CA256D800027B102/Lookup/SocialPolicyActionPlan/\$file/faire%20vic.pdf</p> <p>(2005) VicHealth Position Paper on Health Inequalities http://www.vichealth.vic.gov.au/Content.aspx?topicID=102</p>
New South Wales	<p>(2004) Health and equity in New South Wales http://www.health.nsw.gov.au/resources/publichealth/phb/healthequity_pdf.asp</p> <p>(2004) In all fairness: increasing equity in health across New South Wales http://www.health.nsw.gov.au/pubs/2004/fairness.html</p> <p>(2004) Four Steps Towards Equity: A Tool for Health Promotion Practice http://www.health.nsw.gov.au/pubs/2003/4stepstowardsequi.html</p>
South Australia	<p>(2004) Inequality in South Australia: Vol 1 The Evidence http://www.publichealth.gov.au/inequality.html (ND) Strategic Plan Health Equity Actions http://www.health.sa.gov.au/Default.aspx?tabid=594</p>
Tasmania	<p>(2006) Tasmania Together 2020; and Tasmania Together Review http://www.tasmaniatgether.tas.gov.au/</p>
Western Australia	<p>Department of Health Strategic Intent 2005-2010. n.d. http://www.health.wa.gov.au/HRIT/publications/docs/Strategic_Intent_2005-2010.pdf</p>
Northern Territory	<p>Corporate Plan 2009-2012 http://www.health.nt.gov.au/Publications/Corporate_Publications/index.aspx</p>

These international and national approaches have informed the development of responses to the health inequalities found among Queensland's Pacific Islander communities.

3.2.3 Potential responses to address socioeconomic issues in health determinants

Many of the issues identified in the needs assessment in relation to social and economic determinants of health are interrelated and complex. The key issues identified include social exclusion, high levels of interpersonal violence, economic disadvantage, overcrowded and inadequate housing, parenting issues, low literacy and educational attainment, and overrepresentation in low-paid employment. Not all of the communities were equally affected. Those with greater socioeconomic disadvantage - the Samoan, Māori and PNG communities - experienced these barriers to a greater extent.

Many of these identified issues affecting Pacific Islander communities are outside the jurisdiction of the health sector. These issues represent the social determinants of health which are powerful predictors of who is healthy and who is not.¹⁶ There is a growing recognition in Queensland that the health sector must engage with other departments and sectors for preventative strategies to be most effective¹⁷. It is also recognised internationally and in Australia that efforts to reduce health inequality must address factors that lie largely outside of the health care system.^{12,16-20} These include social, economic and community-level determinants of health. According to the World Health Organisation:

“Interventions which only tackle adverse health behaviours will have little success: they offer microenvironmental solutions to a macroenvironmental problem”^{18,2 (p.9)}

Social and economic disadvantage lies at the centre of many health inequalities,^{12,13} but cannot explain all ethnic health inequality.^{5,8,55} However, for the purpose of developing responses, many of the adverse determinants of health identified can be categorised under social exclusion and its effects, and economic disadvantage and its effects. Therefore, for most impact, strategies across government should have a specific focus on social exclusion and economic disadvantage.

Social exclusion

Social exclusion underlies many of the other determinants, particularly in the category ‘broad features of society’. Social isolation is linked to many health outcomes, including all-cause mortality¹⁹, and it is recognised internationally that social inclusion policies are a fundamental component of strategic approaches to tackling health inequalities.¹²

The Commonwealth Government social inclusion toolkit for government departments recommends a coordinated approach through cross-departmental work as the most effective method for addressing long-term and complex issues related to disadvantage.⁵⁶ This is also consistent with the recommendations of the World Health Organisation and the approaches to addressing health inequality in other countries.^{10,12,42}

Although the Queensland Government, through Multicultural Affairs Queensland, has recognised the relative disadvantage of Pacific Islander populations²¹ and has required all government departments to prioritise action on these populations, there is no whole-of-government Pacific Islander strategy to coordinate, support and implement actions. The extent of social disadvantage and the number of determinants negatively affecting the health and wellbeing of Pacific Islander people will require a concerted and coordinated effort to significantly impact on this disadvantage.

Economic disadvantage

Addressing economic disadvantage is fundamental to addressing the health inequality of Pacific Islander people. The World Health Organisation states:

“Poverty is the most important determinant of inequalities in health. Income depends on access to employment, which in turn is often influenced by educational level. Also included in this category are housing quality, access to health care and working conditions.”^{12 (p.18)}

Improving the economic position of Pacific Islander communities will require effort in the areas of education, employment and training. By improving access to these factors other areas of disadvantage, such as housing and neighbourhood, will improve. The Queensland Government has a number of employment initiatives provided through the Department of Employment, Economic Development and Innovation, including Skilling Queenslanders

for Work Initiatives and Upgrade your Work Skills, which if specifically targeted to Pacific Islander people and organisations and culturally accessible programs, have the potential to improve uptake and outcomes.

In New Zealand, the Ministry of Pacific Islander Affairs leads the government’s work on Pacific Islander community issues. One of the core strategy areas is economic development which is achieved through education access programs, workforce development, business development and leadership development programs.⁵⁷

Response:

Multicultural Affairs Queensland to lead the establishment of a key agency leadership and coordination group on Pacific Islander and Maori disadvantage.

Key agencies will seek to lead culturally appropriate responses in current services and programs for accessibility to Pacific Islander communities.

3.3 Health knowledge, behaviours, status and outcomes

3.3.1 Findings

Health knowledge - 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 population⁴⁵.

Seventeen out of 19 focus groups identified low health literacy as a problem within the community. This is consistent with the 2006 Adult Literacy and Life Skills Survey (ALLS) which found education, occupation, parental characteristics and English as a second language influenced people’s health literacy.⁴⁵

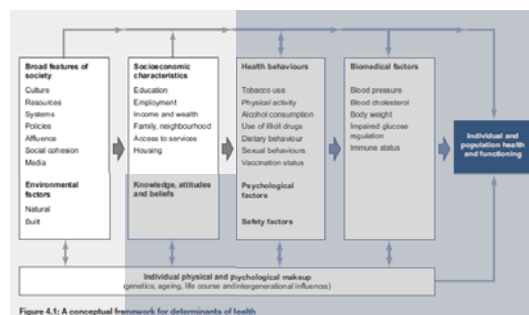


Figure 4.1: A conceptual framework for determinants of health

Many examples and anecdotes were provided in most focus groups that demonstrate Pacific Islander people’s low knowledge about health and health services. The Fiji Indian focus groups in particular discussed low levels of understanding of preventive health and chronic disease self management. The PNG focus groups described people’s complete lack of information about health services and also the common misconceptions people have about procedures or preventive health. The Samoan focus groups discussed people’s lack of knowledge about health and health services and the unnecessary suffering in the community. Anecdotes were given about people struggling to care for sick people without service assistance and, in particular, carer burnout. Both of the Māori community focus groups discussed people’s low knowledge of health services and health issues and linked this problem largely to the lack of culturally tailored health promotion in Queensland.

The low levels of knowledge about health and services were largely related to poor system navigation skills in the community. Many examples were provided of people not understanding how to access services, or even knowing of the existence of services. It is clear from these focus groups that these Pacific Islander communities are disengaged from the mainstream service sector.

Attitudes, belief systems, cultural values and world views also influence health and health choices.^{29,58} Internationally, it is observed that collectivist cultures, such as the Pacific Islander cultures, have a high reliance on their own social group for care and support and may delay their use of health services, especially preventive health services.²⁹ Minor health issues are often expected to be cared for within the family or social unit and health services are used only if emergency care is required.

“Our island people procrastinate and procrastinate. Then the child, for example, gets worse and then they rush to the doctors. They are shy and can’t express what the problem is. We need to educate mothers and young people that life is important, so express yourself.”- Samoan male leader

A strong theme in 14 of the focus groups was Pacific Islander people’s cultural reluctance to seek help. It was discussed by all focus groups in the indigenous Fijian, Fiji Indian and Samoan communities. However, it was discussed across all communities with similar issues raised. It was discussed that Pacific Islander people are generally reserved, shy and embarrassed to seek assistance from services and this was one of the primary factors

in the communication barrier, lack of uptake of preventive health and self management. Fear was also mentioned as a factor, with people afraid to find out if they have an illness and, as a result, delay in seeking assistance.

This avoidance behaviour was perceived to be linked to a number of factors. Firstly, there is a cultural tendency to down-play the seriousness of situations and problems and to have a casual attitude in general. Secondly, the cost of medical care and treatment is prohibitive, exacerbating people's reluctance to seek help. Health has a lower priority and economic issues are seen as more important. Thirdly, the indigenous Fijians in particular expressed a lack of confidence in doctors and services. Finally, there is a lack of support to seek help. In Samoa for example, relatives, friends or even neighbours were available to attend appointments or provide transport to appointments. In Australia, people have to attend appointments alone, once again exacerbating their reluctance to seek help. Avoidance behaviour could also be exacerbated by a lack of cultural competence in health services.

Health behaviours - Quantitative data on key health behaviours by country of birth or ancestry are not available. Aggregated data which groups Pacific Islander populations together as 'Oceania' are available for some behaviours from national surveys. Extensive focus group data are available for each community from the community data documents. A summary table for each health determinant and corresponding data for each community is presented in Attachment 2.

- **Tobacco smoking** - Lack of country of birth data precludes a robust analysis for all health behaviours. However, indications from overseas studies and aggregated data from national Australian surveys suggest a higher prevalence across all communities.
- **Alcohol consumption** - Indications from overseas studies and aggregated data from one national Australian survey suggest a higher prevalence across all communities. Focus group data from the indigenous Fijian, Fiji Indian and PNG communities suggest hazardous drinking is common in these communities and to a lesser extent in the Māori and Samoan communities. However, health service providers surveyed had observed the problem among Samoan and Māori clients only. The focus groups also linked violence and problem gambling to hazardous drinking. Kava abuse was described as widespread in the indigenous Fijian and Fiji Indian communities.
- **Dietary behaviour** - Overseas studies indicate poor dietary habits in Samoa and Fiji and an emerging obesity problem among the urban population in PNG. National Health Survey data suggest a significantly higher likelihood of obesity among Oceania-born people despite a comparable intake of fruit and vegetables to Australia-born people. This may suggest that fruit and vegetable intake is not a culturally appropriate indicator of good nutrition, as the traditional diet of Pacific Islander people features a variety of root crops and a preference for large portion size. This would facilitate meeting the required five servings of vegetables per day. Daily fat, salt and sugar intake are also important considerations.

"Nutrition – what do we know? From birth our parents lived off the land....that's how we were brought up - shot pigeons and killed a pig. If you had fruit, you were pretty rich. When you ate bread, butter and jam that was nice. In this generation, and in this time we are teaching our children, but we need education." – Māori female

All of the focus groups in every community identified poor dietary habits, poor nutritional understanding and a lack of culturally tailored health promotion as the major health issues facing their community. The dietary and nutritional issues raised for each community are summarised in Attachment 3. Poor dietary habits were particularly observed for the Samoan and PNG communities in the health service provider survey.

Queensland data indicates that compared to Australia-born women, PNG-born women had a higher rate of exclusive breastfeeding at the time of discharge, while Fiji and Samoa-born had a lower rate.

- **Physical activity** - Overseas studies indicate comparable physical activity levels for Māori in New Zealand and better levels in Samoa and Fiji to that in Australia. The integration of physical activity into employment and transport is likely to be high in these countries. National Health Survey data suggest a comparable sedentary level among Oceania-born people to the Australia-born population. Physical activity did not feature in the Māori and Cairns PNG focus groups but did feature in the Samoan, South-East Queensland PNG, indigenous Fijian and Fiji Indian focus groups where people stated low physical activity was a problem in their community.

"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

- **Sexual behaviours** - There is no Australian data on sexual health by country of birth. Overseas studies indicate high levels of sexually transmitted infections for all of the communities and in the case of PNG, HIV infection. Teenage terminations were also higher among Māori, Samoan and Fiji Indian women in overseas studies. Sexual health did not feature in the Māori, indigenous Fijian and Fiji Indian focus groups. Shame, secrecy and cultural expectations about sexual behaviour was discussed in the Samoan focus groups and sexually transmitted infections were identified as a matter of concern among young people in the PNG focus groups.

Psychological factors - Snap-shot country of birth data of Queensland mental health service usage (July 2008) indicates a higher use of mental health services than what would be expected, based on population size ranking for the Samoa-born PNG-born and Fiji-born populations. Overseas studies indicate high levels of suicide in Samoa and Fiji, particularly among young Fiji Indian women. The Māori suicide rate in New Zealand is also significantly higher than the total New Zealand population. Mental illness, and in particular, depression was discussed in all of the focus groups and described as prevalent in all communities. It was linked to acculturation, stress, family disharmony, cultural and intergenerational conflicts, and loneliness. The PNG and Māori participants in particular discussed the serious difficulties people experience after migration, and also in subsequent years, as they cope to adjust to a life without extended family and village support. Suicide was discussed in the PNG focus groups in Cairns as being a problem among young people but the PNG community in South-East Queensland only discussed the impact of depression on the community. In contrast, the Māori focus groups said that suicide is a problem in the community and that it affects both young and old people.

“Mental health – our community has a very narrow understanding. Mental health is a taboo subject – everyone is affected. In the old days it was more taboo – now as everything becomes more westernised in PNG things are changing a bit. People don’t talk about how they are feeling. I was never asked when I was growing up, how I feel.” – PNG young woman

Safety factors - Interpersonal violence, including domestic violence, family violence and violence against children; sexual abuse; and youth violence was discussed in 11 out of 19 focus groups. It featured most in the Samoan focus groups, followed by the PNG focus groups. Similarly, the health service providers had observed violence in the Samoan and PNG communities. Surveys with youth workers and health staff based in schools found particular concerns about the levels of interpersonal violence among young Polynesian people, particularly girls.

Health status and outcomes - There is no Australian or Queensland data available on self-reported health and quality of life by country of birth and life expectancy by country of birth. There is also no health status data available on the Māori population in Australia or Queensland. These are major gaps in data that prevent a full analysis of the health status of Pacific Islander people.

Data are available for the Fiji-born, Samoa-born and PNG-born populations in Queensland on mortality and total hospital separations. Data for the Tonga-born and Cook Islands-born population were also obtained to complement a health needs assessment undertaken with these communities by the Ethnic Communities Council of Queensland. (‘All Queensland’ is the reference group with a ratio of 100 for each indicator).

Table 6 Summary of health outcomes for Fiji, Samoa, PNG, Tonga and Cook Islands-born

Health outcome	Statistically significant findings compared to all Queensland (100)
Deaths –standardised mortality rate for avoidable conditions (2005-2006)	Samoa-born: 192.3
Deaths –standardised mortality rate for all causes (2005-2006)	Samoa-born: 147.8
Standardised hospital separations – avoidable (2006-2008)	Samoa-born: 460.2 Cook Islands-born: 508.7 (excluding renal dialysis 170.5) Tonga-born: 420.1 (excluding renal dialysis 163.1) Fiji-born: 116.5
Standardised hospital separations – all causes (2006-2008)	Samoa-born: 198.3 Cook Islands-born: 131.0 Tonga-born: 164 PNG-born: 109.2

This data indicates that the Samoa-born population has poorer health than the total Queensland population, with significantly higher mortality rates for all causes and avoidable conditions. Similarly, the standardised hospital

separation rates for avoidable conditions and all causes were significantly higher. The Cook Islands-born, Tonga-born, Fiji-born and PNG-born populations also recorded higher hospital separations than the total Queensland population.

Hospitalisations - Queensland Hospital Admitted Patient Data Collection data for July 2006 to June 2008 indicate a high burden of chronic disease, particularly among the Samoa-born, Tonga-born, Cook Islands-born and Fiji-born and also the PNG-born populations. No data is available for the Māori population as this data is based on country of birth. ('All Queensland' is the reference group with a ratio of 100).

Table 7 Summary of hospitalisations by cause for Fiji-born, Samoa-born, PNG-born, Cook Islands-born and Tonga-born Queenslanders 2006-2008

Cause of hospitalisation	Findings (separation ratios for all Queensland = 100) June 2006 to July 2008
Cancer	Samoa-born: 72.2
Diabetes	Samoa-born: 284.7 PNG-born: 149.2
Diabetes complications	Samoa-born: 735.5 [^] Cook Islands born: 955.2 (excluding renal dialysis 402.9) Tonga-born: 581.1 (excluding renal dialysis 211.7) Fiji-born: 199.8 [^]
Coronary heart disease	Fiji-born: 212.8
COPD	Samoa-born: 229.4 Fiji-born: 45.9
Musculo-skeletal disease	Samoa-born: 72.9 Fiji-born: 67.4 PNG-born: 84.4
External causes	Fiji-born: 70.1 PNG-born: 84.6

[^] renal dialysis did not contribute significantly to this rate

This data indicates significant health inequalities for the Samoa-born, Cook Islands-born, Tonga-born and Fiji-born populations on several causes of hospitalisation and for the PNG-born population for diabetes.

3.3.2 Current evidence and approaches to address inequalities in health knowledge, behaviour, status and outcomes

The findings that Pacific Islander communities have low health literacy, engage in harmful health behaviours (e.g. tobacco smoking and hazardous alcohol consumption), experience high levels of mental health stressors and interpersonal violence, and have poor health status and outcomes is consistent with international literature on other disadvantaged and ethnic minority populations, and Pacific Islander people residing as immigrants elsewhere.^{5,23}

Approaches internationally and in Australia to improve these health factors involve interventions across the health care continuum such as health promotion, primary and secondary prevention and management, and tertiary prevention that aim to reduce the barriers experienced by these communities.^{4,23,25,59-62}

Health literacy - A key finding of the needs assessment was the lack of knowledge of or engagement with mainstream health campaigns and health services by Pacific Islander communities. According to the literature, improving health literacy is linked to reducing health inequality. A US quality study into the key success factors of interventions to reduce ethnic health inequalities found that low health literacy and lack of patient empowerment in health care encounters were some of the major contributors to inequalities in health care.²⁰

Increasing health literacy among ethnic communities requires dedicated approaches that understand attitudes and beliefs towards health to inform interventions.^{22,23} These approaches may involve culturally-specific health workers, community engagement with the target community and the development of culturally tailored delivery methods, such as working with community leaders, community education sessions, multicultural media, and translated materials.²²⁻²⁷

There is growing local evidence that culturally-specific health workers are fundamental to building health knowledge among culturally diverse communities. A study of selected culturally diverse communities in South-

East Queensland and North Queensland found that the national *Measure UP* campaign did not effectively reach the selected culturally diverse communities. While some communities, predominantly those longer established, had seen the campaign, most study participants did not understand the campaign message. The use of culturally-specific Multicultural Health Workers in explaining the campaign message using culturally tailored materials resulted in a marked increase in knowledge of the campaign message.^{24,63}

Health behaviour: improving access to programs and services - The barriers to health care associated with culture and language are well established.^{15,23,41,59,64-66} However, these are not the only barriers.³¹ Identifying barriers and increasing the access of culturally and linguistically diverse people to prevention and screening programs is another feature of international approaches.²⁷⁻³¹ In the US, it is recognised that each stage of the health continuum occurs within the biopsychosocial-cultural milieu of the wider mainstream society, and that culture impacts at every stage; from prevention through to palliative care.⁶⁷

Local evidence for increasing access of culturally and linguistically diverse people to health services has been identified through the Multicultural Health Worker program implemented by the Ethnic Communities Council of Queensland, and the Community Navigator role which was piloted in Logan in 2009-10. Multicultural Health Workers engage with their communities, devise culturally tailored health resources and deliver health promotion activities in culturally accessible ways. The Community Navigator role specifically aims to reduce barriers to access by assisting individuals and groups to navigate the health system and thereby facilitating access directly. Process evaluation identified the key strength of the navigator role as the ability to facilitate health service access for Pacific Islander and other ethnic communities³².

The availability of dedicated health workers has been integral to improving the health of other disadvantaged communities in Queensland such as homeless people and Aboriginal and Torres Strait Islander peoples. The Homeless Health Outreach Teams and Aboriginal and Torres Strait Islander health workforce are the primary vehicles to outreach disadvantaged communities and facilitate their access to health services. Given this experience, and recognition of the importance of a dedicated workforce to engage with disadvantaged communities, the rationale for a dedicated workforce is a well established one.

Health status and outcomes: reducing inequalities through culturally inclusive programs and services – International approaches to reducing inequalities in health status and outcomes for people from culturally and linguistically diverse backgrounds focus on providing culturally-tailored services through culturally-specific staff, increasing the cultural diversity of the health workforce, and improving the cultural competency of the wider health system and health workforce.

The importance of culturally tailoring prevention, screening and self-management programs is highlighted in the literature.^{22-24,26} International evidence suggests that the use of culturally tailored programs and services achieves better health outcomes for individuals. There is also evidence that broadly-focused approaches may fail to reduce health inequalities and may even increase existing inequalities.²⁰

There are two main approaches to providing culturally tailored health services: culturally dedicated health services that are run by the target community for the target community, and the employment of culturally-specific health workers in health services who culturally tailor programs and services and deliver them to target communities.

For example, in New Zealand the approach involves dedicated Pacific Islander health services. Over the past 10 years, the Ministry of Health funded 40 Pacific Islander health organisations, including three Pacific Primary Health Organisations, to provide health services to the Pacific populations in New Zealand. There is an implicit recognition that to promote maximum access and quality of service, ‘for Pacific by Pacific’ is the most effective strategy for this population.⁶⁸ The New Zealand approach highlights the need to ensure that the primary health care sector is engaged in the reduction of health inequality.

There is mounting international evidence for the second approach – culturally-specific health workers. Whether they be lay health workers, system navigators, clinicians or health promotion officers, culturally-specific workers produce better clinical and health outcomes than the mainstream approach for the population as a whole.^{7,27-30,33-36} In the US, the Center for Disease Control has collected evidence for these workers since 1993 and there are major efforts underway to integrate this workforce into the US health system based on the mounting evidence of their efficacy.²⁷

Beyond culturally-specific positions, there is also evidence from the literature that having a culturally diverse workforce that reflects the same cultural and ethnic background as the disadvantaged populations served has multiple beneficial outcomes. Racial or ethnic concordance between health service providers and patients has

been associated with improved communication, compliance, participatory decision-making, patient satisfaction and reduced likelihood that a patient will change physicians over time.^{7,23,37-39} An ethnically diverse clinical workforce has also been shown to reduce racial discrimination, and diagnosis and treatment differences, and biases based on ethnicity.²³

In New Zealand, the approach involves actively assisting Pacific Islander people to take up health jobs. *Serau* is the blueprint for strengthening and accelerating the development of the Pacific Islander health workforce in the Ministry of Health and Pacific providers in New Zealand.⁶⁹ It outlines a five strategy approach to attracting, training, strengthening, up-skilling and retaining Pacific Islander people in health jobs, providing benefits to the health care system and to Pacific Islander communities.

In Queensland, a comparable workforce strategy exists for the Aboriginal and Torres Strait Islander population and targets are in place to increase the employment of Aboriginal and Torres Strait Islander people in Queensland Health. The *Queensland Health Aboriginal and Torres Strait Islander Workforce Strategy 2009-2012* recognises that by increasing the number of Aboriginal and Torres Strait Islander people in the Queensland Health workforce, positive health outcomes and increased knowledge, understanding and exposure to cultural issues will be gained by the wider health workforce.

Improving the cultural appropriateness of health programs and services is also achieved through culturally competent health services and culturally competent health workers.^{23,40,41} In recognition of the need for a culturally competent organisation, the *Queensland Health Organisational Cultural Competency Framework* was developed in 2009. The framework is based on a review of guides, standards and policies on organisational cultural competency used nationally and internationally, and on expert consultations. The eight outcome areas and four foundation areas of the framework represent areas that require action within health services for cultural competency.

3.3.3 Strategies to respond to the inequalities in health knowledge, behaviour, status and outcomes

Implementation - It is well recognised that addressing health inequalities requires strategic and long term action.^{12,42,43} Strategic partnerships and leadership will be required to drive the implementation of the findings of this needs assessment. There is also evidence that interventions across the care continuum that specifically address ethnic health inequalities are more likely to be successful if there is external accountability, alignment of incentives to improve quality/reduce inequality, organisational commitment, minority population health focus, use of data to inform solutions, and a comprehensive approach to quality³¹.

There was some caution and scepticism expressed by focus group members, particularly leaders, that Queensland Health would not respond in a strategic and long-term manner to their health needs. Several short term or one-off projects have occurred in the past, with little or no impact on the magnitude of health inequality in this population.

The extent of health inequalities found suggest improvement will be challenging. Given the indication of the high burden of chronic disease and high level of mental health issues identified through the needs assessment, key internal and external stakeholders working in targeted areas such as primary health, diabetes, cardiovascular disease, mental health, health promotion, workforce planning and data collection need to be engaged. A strategic and coordinated focus will be required to achieve meaningful improvements.

A leadership group will be established to coordinate actions. This group will represent appropriate Health Service Districts and strategic areas of Queensland Health, and non-government organisations. The purpose of the group will be to identify and review implementation of activities to increase health literacy, access to chronic disease and mental health programs and services, cultural competency of services and staff, and workforce issues. Queensland Health Multicultural Services will provide secretariat support to this group.

1. **Response: Establish and implement a Queensland Health Leadership Group on Pacific Islander and Māori Health to discuss, coordinate, monitor and report on activity to improve Pacific Islander and Māori health.**

Lead: Queensland Health Multicultural Services

Promotion of the findings of the needs assessment to the strategic areas of Queensland Health, particularly chronic disease teams, will be required to encourage initiatives and services to be targeted to Pacific Islander and Māori communities. It will also be beneficial to promote the findings to peak non-government organisations and the non-

government primary health care sector. This strategy is particularly important to facilitating optimal use and targeting of existing resources.

2. Response: Develop and implement a communication strategy targeting relevant organisations and areas within Queensland Health and highlighting the major findings of the Pacific Islander and Māori needs assessment.

Lead: Queensland Health Multicultural Services

Health literacy – Health literacy was found to be very poor among Pacific Islander communities. Evidence-based interventions for increasing the health literacy of people from culturally and linguistically diverse backgrounds include the use of culturally-specific health workers, the development of culturally tailored resources, delivery methods responsive to community cultural needs, and engagement with the community. The primary mechanism is the use of culturally-specific health workers who are from the target community to deliver the identified interventions.

The prioritisation of Pacific Islander communities in current and future campaigns such as *Measure Up, Swap It* and tobacco cessation programs will be required to reduce lifestyle risk factors. Exploration of partnerships to incorporate mental health literacy would also be beneficial.

3. Response: Improve the nutrition and physical health literacy of Pacific Islander and Māori people by:
a. developing culturally tailored programs and resources to improve lifestyle risk factors

Lead: Healthy Living Branch, Queensland Health

As Pacific Islander and Māori cultures are strongly family oriented, a culturally appropriate approach to increasing health literacy among Pacific Islander and Māori families is to focus on children and families.

b. Developing culturally tailored health promotion resources targeting children and families to reduce lifestyle risk factors

Lead: Children’s Health Services, Queensland Health

The need to investigate a suitable health workforce for Queensland’s multicultural population was recognised in 2007 in the development of the *Queensland Health Strategic Plan for Multicultural Health 2007-2012*, with this investigation identified as a five year strategy. This issue has been identified more recently in the development of a 30 year workforce plan for Queensland Health.

Exploration of existing workforce models for health promotion in the context of the Queensland health sector is required, including models such as:

Workforce	Primary role	Where
Pacific Islander Multicultural Health Workers	<ul style="list-style-type: none"> - Cultural tailoring of health promotion and prevention programs - Delivery of health promotion and prevention programs - Facilitate service access - Work with groups 	<ul style="list-style-type: none"> - Best located within the health system, integrated into health promotion and self management teams ^{27,28,35}. - Therefore, located in Queensland Health and/or CALD health non-government organisation

Exploration of the integration of physical and mental health promotion is also required, as this would be a more culturally appropriate approach for Pacific Islander communities and would build the capability of Pacific Islander health workers across a number of health domains, leading to efficiencies rather than a fragmented workforce.

c. exploring workforce roles required for implementation

Lead: Workforce Planning Unit, Clinical Workforce Planning and Development Branch, Queensland Health

Low service access – Low service access was found among all Pacific Islander communities. Evidence-based interventions that increase health service access of people from culturally and linguistically diverse backgrounds

focus on reducing the barriers to access, which are primarily language and culture. The most effective strategies to increase access are the use of culturally-specific workers such as community navigators and multicultural health workers. These are required across the health continuum.

Exploration of existing workforce models for facilitating service access in the context of the Queensland health sector is required, including models such as:

Workforce	Primary role	Where
Pacific Islander health system navigators (also called Natural Helpers or Lay Health Workers)	<ul style="list-style-type: none"> - Facilitate service access - Work with individuals and groups - Act as a bridge between community and services.²⁹ 	<ul style="list-style-type: none"> - CALD health non-government organisation - Primary care sector
Pacific Islander Health Case Management	<ul style="list-style-type: none"> - Case management to facilitate service access, compliance, follow-up - Work with individuals 	<ul style="list-style-type: none"> - In New Zealand, Māori and Pacific Islander case management programs implemented in primary care⁷⁰ - Primary care sector
Pacific Islander Cultural Liaison Workers	<ul style="list-style-type: none"> - Liaise between health services (particularly hospitals) and the Pacific Islander community - Facilitate service access - Contact point in the health system - Work with individuals and groups 	<ul style="list-style-type: none"> - Queensland Health
Bilingual allied health workers	<ul style="list-style-type: none"> - Facilitate mental health service engagement - Undertake culturally appropriate mental health assessments and/or provide psycho-education 	<ul style="list-style-type: none"> - Queensland Health, Queensland Transcultural Mental Health Centre
Cultural consultants	<ul style="list-style-type: none"> - Facilitate mental health service access - Provide cultural advice to mental health clinicians/ treatment teams 	<ul style="list-style-type: none"> - Queensland Health, Queensland Transcultural Mental Health Centre

4. Response: Increase the service access of Pacific Islander and Māori people by:

a. exploring the workforce roles required to facilitate improved health service access

Lead: Workforce Planning Unit, Clinical Workforce Planning and Development Branch, Queensland Health.

Another key finding of this needs assessment was the prioritisation of culturally dedicated programs and services by Pacific Islander communities, which was supported by approaches in New Zealand where many Pacific Islander primary health care organisations operate. One of the challenges for the Queensland context is that only generic Pacific Islander organisations exist. There are no Pacific Islander or Māori specific health organisations that could be funded to deliver health programs to the Pacific Islander and Māori populations, and partnerships with the primary care sector remain unexplored. However, with the establishment of Medicare Locals, there could be opportunities for the primary care sector to partner with Pacific Islander organisations.

b. exploring the viability of a Pacific Islander Health Centre by the primary care sector in a geographic location with large Pacific Islander communities.

Lead: Queensland Health Multicultural Services in consultation with Medicare Locals when established.

Cultural competency – Pacific Islander and Māori people experienced health services as culturally inappropriate and unsafe. According to the literature, the most effective interventions to achieve a service which is culturally inclusive are the use of culturally-specific health workers, the provision of culturally tailored programs and services, the provision of culturally dedicated health services by the target community for the target community, and strategies that increase organisational cultural competency. Cultural competency at the organisational level and the individual health worker level are required for the most effective impact.

The need for health services to become culturally competent at the organisational level is clearly recognised in the literature. *The Queensland Health Organisational Cultural Competency Framework* supports work in this area as it highlights the core outcome areas that services and business units should consider and action in order to become more culturally competent.

5. Response: Improve the cultural competency of health services, particularly in the priority areas of diabetes, mental health and primary care by:

There is evidence that a culturally diverse health workforce produces better outcomes and also provides economic benefits to the communities. Filling Pacific Islander and Māori workforce positions, and also generic positions, with people from Pacific Islander and Māori backgrounds may require a targeted strategy.

A Pacific Islander Workforce Strategy could attract Pacific Islander and Māori people into general positions in Queensland Health as well as dedicated positions. This would not only assist Queensland Health to meet the equity and diversity targets, but would also ensure that Pacific Islander and Māori consumers encounter Pacific Islander and Māori health service providers in many positions in the health system.

- a. exploring the feasibility of a Pacific Islander Workforce strategy for Queensland Health to increase the number of Pacific Islander and Māori people in the workforce, along with a range of supporting strategies such as scholarships and awards**

Lead: Clinical Workforce and Planning Branch in consultation with Queensland Health Multicultural Services.

Cultural responsiveness in diabetes clinical care and management is required to better engage with Pacific Islander people with diabetes and reduce diabetes complications. The Health Service Districts with the largest Pacific Islander populations play an important role to identify, demonstrate and implement culturally responsive approaches such as Pacific Islander Case Managers and cultural competency training for staff. Although the effectiveness of culturally specific case management is established in international literature, the financial viability of this approach requires further evidence. A demonstration project that evaluates the number of hospital bed days saved from the intervention of a Pacific Islander diabetes case manager is required for implementation in Health Services Districts with the largest Pacific Islander populations.

- b. developing a culturally appropriate response to Pacific Islander and Māori diabetes management and clinical care in Queensland**

Lead: Metro South, Darling Downs West Moreton and Metro North Health Service Districts with Queensland Health Multicultural Services

The *Queensland Health Cultural Competency Framework* has eight core outcome areas that require consideration in the priority service areas in districts with large Pacific Islander populations. Examples of expected activity include:

- **Inclusive recruitment and retention** – exploring and establishing Pacific Islander workers in priority areas of diabetes, mental health and cardiovascular health, and implementing the Pacific Islander Workforce Strategy
- **Leadership and partnership** – recognising Pacific Islander need by allocating resources, developing partnerships with local community leaders and strategically aligning local activity to Pacific Islander Health Action Plan
- **Culturally competent staff** – supporting the implementation of cultural competency training for staff
- **Data collection and analysis** – collecting and analysing appropriate Pacific Islander health data to understand local need and monitor impact of activities
- **Community engagement** – engaging local Pacific Islander community leaders and associations to improve service delivery and access
- **Resource development and translation** – developing culturally tailored health information resources in the priority areas to increase Pacific Islander health literacy and improve health management
- **Interpreter services** – engaging professional interpreters for Pacific Islander clients through the Queensland Health Interpreter Service when required
- **Special needs populations** – working at the local level to reduce health inequalities of special needs populations including Pacific Islander people.

- c. **exploring how the Queensland Health *Cultural Competency Framework* can be implemented in target districts in the priority areas of health promotion, diabetes, cardiovascular disease and mental health**

Lead: Metro South HSD, Metro North HSD, Darling Downs -West Moreton HSD, Gold Coast HSD, Cairns and Hinterland HSD,

6. **Response: Improve the cultural competency of health staff, particularly in the priority areas of health promotion, diabetes, cardiovascular, mental health and primary care by:**

The Queensland Health *Cross Cultural Learning and Development Strategy* for non-mental health services and the Queensland Transcultural Mental Health Centre's *Managing Cultural Diversity in Mental Health* program lead the provision of cultural competency training for health staff. These programs can be further targeted to the priority areas to ensure that staff working in these areas develop their cultural competency skills. Case studies involving Pacific Islander people and consumers can be integrated into these existing cross cultural training programs.

People and Culture units will need to work collaboratively with statewide training programs to implement this response within Health Service Districts. One of the eight principles of Queensland Health's *People and Culture Plan* is cultural diversity. One strategy is to "ensure all staff are able to interact effectively with people across different cultures".

- a. **implementing cultural competency training for staff working in the priority areas in Health Service Districts with large Pacific Islander populations**

Lead: Metro South HSD, Metro North HSD, Darling Downs -West Moreton HSD, Gold Coast HSD, Cairns and Hinterland HSD in collaboration with Queensland Health Multicultural Services and Queensland Transcultural Mental Health Centre.

There are mechanisms in place in Health Service Districts with a large proportion of cultural diversity in the local population to improve the cultural competency of mental health staff. The District Multicultural Mental Health Coordinators implement training and resource development and also facilitate input at a clinical level. Working together with staff implementing Queensland Health's *Cross Cultural Learning and Development Strategy* could assist District Multicultural Mental Health Coordinators to use case studies involving Pacific Islander people to further target training and resources.

- b. **District Multicultural Mental Health Coordinators providing cultural competency training to mental health staff and using Pacific Islander focussed case studies in relevant Health Service Districts to build staff capability to respond to Pacific Islander mental health needs**

Lead: Queensland Transcultural Mental Health Centre

Suicide was identified in a number of communities. The pilot emergency services project aims to skill emergency services workers from a number of agencies to identify people at risk of suicide and facilitate their pathway to care. The development of cultural competency resources and skills will be important to ensure that emergency workers are able to recognise and respond to suicide risk among culturally diverse population groups, particularly Pacific Islander and Māori communities.

- c. **developing resources to increase cultural competency for emergency services staff involved in the suicide prevention pilot who identify people at risk of suicide**

Lead: Queensland Centre for Mental Health Promotion, Prevention and Early Intervention

Queensland Health Multicultural Services piloted the Multicultural Clinical Support Officer (MCSO) position in two Health Service Districts to provide on-the-job cultural coaching to health staff. The positions were established to provide leadership and specialist support with the primary duties including:

- facilitating culturally appropriate clinical advice delivery by clinicians, including assessment, planning and delivery within the context of an interdisciplinary environment

- promoting culturally appropriate clinical service delivery through the development and implementation of policies and procedures and the delivery of education, training and coaching in relation to multicultural health issues
- health promotion and the facilitation of equitable access to health services for people from local multicultural communities.

As these positions have been evaluated positively, the results could be further considered by Clinical Workforce and Planning Branch.

- d. **exploring the evaluated Multicultural Clinical Support Officer role to support the development of cultural competency of staff in priority areas.**

Lead: Workforce Planning Unit, Clinical Workforce Planning and Development Branch, Queensland Health with Queensland Health Multicultural Services.

4 Summary of response to address Pacific Islander and Māori health inequalities

Pacific Islander and Māori communities experience health inequalities at higher rates than the rate for the total Queensland population. These inequalities centre on chronic disease. Health system issues such as low health literacy, service access barriers and the need for improved culturally responsive health service delivery, and broader social determinants of health including economic and educational disadvantage, social exclusion and isolation, interpersonal violence and family support issues contribute to this inequality.

Response 1:

Multicultural Affairs Queensland to lead the establishment of a key agency leadership and coordination group on Pacific Islander and Māori disadvantage.

Response 2:

Establish and implement a Queensland Health Leadership Group on Pacific Islander and Māori Health to discuss, coordinate, monitor and report on activity to improve Pacific Islander and Māori health.

Response 3:

Develop and implement a communication strategy targeting relevant organisations and areas within Queensland Health and highlighting the major findings of the Pacific Islander and Māori needs assessment.

Response 4:

Improve the nutrition and physical health literacy of Pacific Islander and Māori people by:

- b. developing culturally tailored programs and resources to improve lifestyle risk factors
- c. developing culturally tailored health promotion resources targeting children and families to reduce lifestyle risk factors
- d. exploring workforce roles required for implementation

Response 5:

Increase the service access of Pacific Islander and Māori people by:

- b. exploring the workforce roles required to facilitate improved health service access
- c. exploring the viability of a Pacific Islander Health Centre by the primary care sector in a geographic location with large Pacific Islander communities.

Response 6:

Improve the cultural competency of health services, particularly in the priority areas of diabetes, mental health and primary care by:

- a. exploring the feasibility of a Pacific Islander Workforce strategy for Queensland Health to increase the number of Pacific Islander and Māori people in the Queensland Health workforce along with a range of supporting strategies such as scholarships and awards
- b. developing a culturally appropriate response to Pacific Islander and Māori diabetes management and clinical care in Queensland
- c. exploring how the Queensland Health *Cultural Competency Framework* can be implemented in target districts in the priority areas of health promotion, diabetes, cardiovascular disease and mental health

Response 7:

Improve the cultural competency of health staff, particularly in the priority areas of health promotion, diabetes, cardiovascular, mental health and primary care by:

- implementing cultural competency training for staff working in the priority areas in Health Service Districts with large Pacific Islander populations
- District Multicultural Mental Health Coordinators providing cultural competency training to mental health staff and using Pacific Islander focussed case studies in relevant Health Service Districts to build staff capability to respond to Pacific Islander mental health needs
- developing resources to increase cultural competency for emergency services staff involved in the suicide prevention pilot who identify people at risk of suicide
- exploring the evaluated Multicultural Clinical Support Officer role to support the development of cultural competency of staff in priority areas.

The way forward

Figure 6 summarises the overall response to these findings, detailing the leadership mechanism and intended impact of the response. Key agencies will seek to lead culturally appropriate responses in current services and programs to improve accessibility and appropriateness for Pacific Islander and Māori communities. The health system response will also include identifying opportunities for new resources to enhance implementation of the strategies.

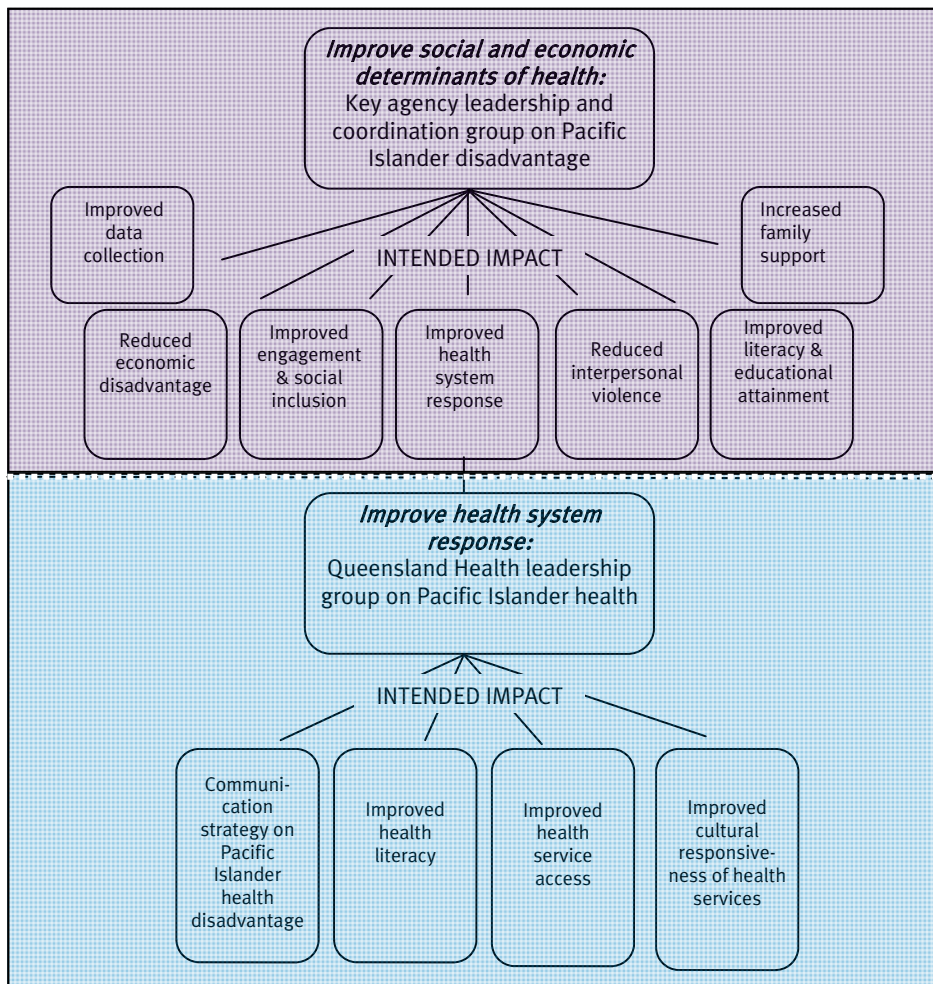


Figure 6 Total response to Pacific Islander and Māori health disadvantage

Attachment 1 – Standards for Statistics on Cultural and Language Diversity

The Australian Bureau of Statistics (ABS) 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*⁷¹ identifies three ‘minimum core set’ items that measure cultural and linguistic diversity (CALD):

- country of birth
- main language other than English spoken at home (this is sometimes also collected as ‘first language’ or ‘preferred language’)
- proficiency in spoken English (sometimes collected as ‘interpreter required’)

The ABS recommends that the indicators be used as a ‘set’ because they can be analysed together in different ways to enhance understanding of multicultural client groups. Country of birth is most easily collected and consistently reported. ‘Main language other than English spoken at home’ captures many second-generation community members as well as immigrants themselves. Proficiency in spoken English is used to assess the English speaking ability of people who speak a language other than English. It is a measure of proficiency in spoken English rather than a measure of proficiency in other aspects of communication English (e.g. listening, writing and reading). This measure is subjective.

The standard set also includes the following variables:

- 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

Attachment 2 - Summary table of findings on determinants of health for Pacific Islander and Māori communities in Queensland

Health behaviour	Community	Literature review	Australian quantitative data	Qualitative data	Analysis ²
<i>Tobacco smoking</i>	Māori	<ul style="list-style-type: none"> 50 per cent of Māori smoke in New Zealand compared to 23 per cent for whole New Zealand population⁷² Māori women 2X more likely to smoke; Māori men 1.5X more likely compared to whole population⁷³ 	Not available	<ul style="list-style-type: none"> Not identified as priority in focus groups but implicit understanding that Māori are heavy smokers in focus groups Not identified in survey of health service providers 	Indications from overseas studies and aggregated data from national Australian surveys suggest a higher prevalence across all communities.
	Samoan	<ul style="list-style-type: none"> 40 per cent of the total population in Samoa are smokers (56.3 per cent of males and 21.8 per cent of females) New Zealand and US studies indicate between 31-46 per cent of Samoan men and 22 to 24 per cent of Samoan women smoke 	Not available	<ul style="list-style-type: none"> Not identified as a priority in focus groups Not identified in survey of health service providers 	
	Papua New Guinean	53 per cent of men and 34 per cent of women smoke in PNG ⁷⁴	Not available	<ul style="list-style-type: none"> Not identified as priority in focus groups Not identified in survey of health service providers 	
	Indigenous Fijian and Fiji Indian	36.6 per cent of population in Fiji smoke (53 per cent men and 18 per cent women) A higher proportion among indigenous Fijians (45.1 per cent) as compared to Fiji Indians (24.1 per cent) ⁷⁵	Not available	<ul style="list-style-type: none"> Identified by both of the Fiji Indian community focus groups as a concern among young people in the community. Not identified as priority in Fijian focus groups 	
	All Pacific Islands		<ul style="list-style-type: none"> National Drug Strategy Household Survey - 16.6 per cent were daily smokers compared to 23.3 per cent for 'other Pacific countries' (excludes Fiji and PNG). 		

² Lack of Australian country of birth data precludes a robust analysis for each indicator.

Health behaviour	Community	Literature review	Australian quantitative data	Qualitative data	Analysis ²
			<ul style="list-style-type: none"> The 2007-08 National Health Survey - 19.9 per cent of Australia-born were daily smokers compared to 22.2 per cent for Oceania-born ⁴⁴ 		

Health behaviour	Community	Literature review	Australian quantitative data	Qualitative data	Analysis
<i>Alcohol consumption</i>	Māori	Māori women nearly 2X more likely, and Māori men 1.5 X more likely to have potentially hazardous alcohol drinking compared to women and men in the total population in New Zealand ⁷³ .	Not available	<ul style="list-style-type: none"> Hazardous alcohol consumption was discussed in two out of three focus groups. The major theme was the widespread use of alcohol in the Māori community in Queensland Six out of nine health service providers had observed drug and alcohol issues among Māori clients 'sometimes', and two had not observe it. 	Indications from overseas studies and aggregated data from one national Australian survey suggest a higher prevalence across all communities. Focus group data from the Fijian, Fiji Indian and PNG communities suggest hazardous drinking is common in these communities and to a lesser extent in the Māori and Samoan focus groups. However, health service providers had observed the problem among Samoan and Māori clients only. Violence and problem gambling were also linked to hazardous drinking. Kava abuse was described as widespread in the Fijian and Fiji Indian communities.
	Samoan	30.8 per cent of Pacific males in New Zealand and 27.1 per cent of all males; and 7.6 per cent of Pacific females and 11.4 of all females reported hazardous consumption ⁷⁶ .	Not available	<ul style="list-style-type: none"> Hazardous alcohol consumption was discussed in two out of four focus groups. The major theme related to the need for community education on the consequences of alcohol and problem gambling Of the twelve health service providers interviewed, nine had observed drug and alcohol issues 'sometimes' among Samoan clients; two observed it 'often'; and one had never observed it. Two respondents expressed considerable concern about extensive hazardous alcohol consumption and violence among Samoan adolescent girls. 	
	Papua New Guinean	There is no recent data from PNG on the prevalence of hazardous alcohol consumption. However, PNG is renowned for its 'culture of	Not available	<ul style="list-style-type: none"> All of the community focus groups in both locations identified hazardous alcohol consumption and substance 	

Health behaviour	Community	Literature review	Australian quantitative data	Qualitative data	Analysis
		intoxication ⁷⁷ . Local and provincial communities have often adopted a prohibitionist approach to alcohol consumption and media reports indicate that widespread hazardous drinking and violence have placed industrial projects at risk ⁷⁷ . This may indicate that the prevalence of hazardous drinking is likely to be high in PNG.		<p>abuse.</p> <ul style="list-style-type: none"> • In South-East Queensland, hazardous drinking, particularly of spirits, was identified as a common practice among young people. • In Cairns, health and social problems within the PNG community were attributed to hazardous drinking and substance abuse. • Community leader focus groups did not discuss alcohol consumption. • Health service providers were not asked about alcohol consumption, nor did they raise the topic. 	
	Fijian and Fiji Indian	A national study in Fiji found of current drinkers, 77.3 per cent were binge drinkers and it was more common in younger males of Fijian descent. Binge drinking was lowest among Fiji Indian females. The mean number of standard drinks consumed per drinking day was approximately twice as much for Fijians (17.4 drinks) as compared to Fiji Indians (8.4 drinks) and this difference was seen in both genders ⁷⁵ .	Not available	<ul style="list-style-type: none"> • Alcohol and kava abuse were discussed in all of the six focus groups. • Many Fijian participants perceived kava central to other problems such as family disharmony and violence. Many participants agreed that there is a strong link between kava abuse, alcohol abuse and violence. • Fiji Indian participants said kava abuse was widespread among adults and older people while hazardous alcohol consumption was a problem among young people. 	
	All Pacific Islands		<ul style="list-style-type: none"> • The 2007 National Drug Strategy Household Survey found 10.3 per cent of all participants reported alcohol consumption considered risky or high risk compared to 7.1 per cent of participants born in 'other Pacific Islands' 		

Health behaviour	Community	Literature review	Australian quantitative data	Qualitative data	Analysis
			<ul style="list-style-type: none"> 2007-08 National Health Survey found 14.1 per cent of people born in Australia, and 16 per cent of people born in Oceania reported consuming alcohol considered high risk. 		

Health behaviour	Community	Literature review	Australian quantitative data	Qualitative data	Analysis
<i>Dietary behaviour</i>	Māori	The 2006-07 New Zealand National Health Survey found Māori women (0.95) and men (0.98) were slightly less likely than all women and men to have adequate vegetable intake. Māori women were also slightly less likely to have adequate fruit intake than all women but there were no significant differences between men ⁷³ .	Not available	<ul style="list-style-type: none"> All of the focus groups identified chronic disease and obesity as the most prevalent health problems in the Māori community in Queensland. Lack of education and powerlessness and lack of skills to reduce obesity were linked factors. Filling up, rather than having a balanced meal, is common. All of the focus groups identified the lack of culturally tailored health promotion and unavailability of Māori health promotion staff as contributing to this problem Dietary behaviour was not discussed in the health service provider survey 	Overseas studies indicate poor dietary habits in Samoa and Fiji and an emerging obesity problem among the urban in PNG. National Health Survey data suggest a significantly higher likelihood of obesity among the Oceania-born population despite a comparable intake of fruit and vegetables to the Australia-born population. This may suggest that fruit and vegetable intake is not a culturally appropriate indicator of good nutrition, as the diet of Pacific Islander people features a variety of root crops and large portion size. This would facilitate meeting the required five servings of vegetables per day. Daily fat, salt and sugar intake are also important considerations. All of the focus groups in every community identified poor dietary habits, poor nutritional
	Samoan	<ul style="list-style-type: none"> 35.6 per cent of the population in Samoa ate no fruit or less than one serving of fruit per day in one study⁷⁸. 63.3 per cent of all men in New Zealand and 71.1 per cent of women reported adequate vegetable consumption, compared to 42.9 per cent of Pacific Islander men in New Zealand and 39.4 per cent of women. The same survey reported 43.3 per cent of all 	<ul style="list-style-type: none"> Adult data not available In Queensland, 78 per cent of Samoa-born women exclusively breastfed at discharge following birth, compared to 83.3 per cent of Australia-born women in 2006. 	<ul style="list-style-type: none"> There was consensus in all focus groups that poor nutrition and lack of physical activity are the most prevalent health behaviours in the Samoan community. Eating large portions, not eating nutritious food, reliance on fast foods and lack of physical activity were seen to contribute to the widespread obesity in the Samoan community 	

Health behaviour	Community	Literature review	Australian quantitative data	Qualitative data	Analysis
		New Zealand men and 63.6 per cent of women as having adequate fruit intake, compared to 53.5 per cent of Pacific Islander men in New Zealand and 57.5 of women ⁷⁶ .		<ul style="list-style-type: none"> Eating large portions is common at Samoan social gatherings All focus groups identified the lack of culturally tailored health promotion and unavailability of Samoan health promotion staff as contributing to this problem Ten health service providers had observed obesity 'often'; one observed it 'sometimes'; and one had never observed it. Some respondents discussed the importance of culturally tailoring interventions; community engagement; and health promotion conducted by professionals from a Samoan background. 	<p>understanding and a lack of culturally tailored health promotion as the major issues. Poor dietary habits were particularly observed for the Samoan and PNG communities in the health service provider survey.</p> <p>Queensland data indicates PNG-born women had a higher rate of exclusive breastfeeding while Fiji and Samoa-born lower compared to Australia-born.</p>
	Papua New Guinean	<ul style="list-style-type: none"> National health data from PNG is of limited relevance as the majority of the PNG population live in rural areas where malnutrition and underweight are prevalent Port Moresby residents had a mean BMI of 26.5, and obesity among males and females was 16 per cent and 26 per cent respectively ⁷⁹. 	<ul style="list-style-type: none"> Adult data not available In Queensland 91 per cent of PNG-born women exclusively breastfed at discharge following birth, compared to 83.3 per cent of Australia-born women in 2006. 	<ul style="list-style-type: none"> All of the six focus groups identified poor dietary habits, lack of physical activity and an emerging obesity problem as prevalent. All discussions were in the context of the deterioration of healthy eating habits after migration to Australia Three health service providers had observed malnutrition often or sometimes and eight had never observed it. Four health service providers did not answer. Five health service providers had observed obesity often or sometimes while five had never observed it. Five did not answer the question 	
	Fijian and Fiji Indian	<ul style="list-style-type: none"> The Fijian STEP survey found 65.9 per cent ate less than one serving of fruit per day (both indigenous Fijians and Fiji Indians) 	<ul style="list-style-type: none"> Adult data not available In Queensland, 77 per cent of Fiji-born women exclusively breastfed at discharge following birth, compared to 83.3 per cent 	<ul style="list-style-type: none"> All six focus groups identified poor dietary habits and low health literacy The Fiji Indian focus groups discussed the need for healthy 	

Health behaviour	Community	Literature review	Australian quantitative data	Qualitative data	Analysis
		<ul style="list-style-type: none"> Longitudinal studies 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 BMI⁸⁰ 	<p>of Australia-born women in 2006.</p>	<p>lifestyle campaigns to be culturally relevant, for information to be culturally tailored and translated and the need for community education. Interest in healthy lifestyles only starts after the age of 50</p> <ul style="list-style-type: none"> The same issues were discussed in the Fijian focus groups. The cultural issues related to eating were also discussed. It was perceived that eating large portions was a Fijian cultural trait and that eating socially is the foundation of Fijian social life. 	
	All Pacific Islands		<ul style="list-style-type: none"> The National Health Survey 2007-08 reported 93.4 per cent of Australia-born had inadequate fruit and vegetable consumption and 93.0 per cent of Oceania-born had inadequate intakes The National Health Survey 2007-08 found that adults born in Oceania were more likely to be overweight/obese (63.1%) compared to adults born in Australia (55%)⁸¹. The second-highest proportion of overweight/ obesity was recorded for men born in Oceania (68%). The largest proportion of overweight and obese women were those born in the Oceania region and Southern and Eastern Europe (both with 56%). 		

Health behaviour	Community	Literature review	Australian quantitative data	Qualitative data	Analysis
<i>Physical activity</i>	Māori	In the New Zealand National Health Survey, Māori men (1.05) and women (1.03) were more likely to meet the recommendation of 30 minutes of physical activity on five or more days of the week compared to men and women in the total population (1.0).	Not available	None of the community focus groups discussed physical activity in the Māori community.	Overseas studies indicate comparable physical activity levels for Māori in New Zealand and better levels in Samoa and Fiji. The integration of physical activity into employment and transport is likely to be high in these countries. National Health Survey data suggest a comparable sedentary level among Oceania-born people to the Australia-born population. Physical activity did not feature in the Māori and Cairns PNG focus groups but did feature in the Samoan, PNG South-East Queensland, Fijian and Fiji Indian focus groups where people stated low physical activity was a problem in the community.
	Samoan	The World Health Organisation reported that 21 per cent of the population in Samoa do very little or no physical activity and that people in the capital city, Apia, are more likely to be inactive (28 per cent) than people in rural areas (15 per cent). Women (27.3 per cent) are more likely to be inactive than men (14.8 per cent). ⁷⁸	Not available	<ul style="list-style-type: none"> All of the focus groups with community members and leaders discussed the lack of physical activity among Samoans. Lack of physical activity was frequently discussed in tandem with poor nutrition and large portion size. Participants recommended that culturally tailored programs that promote a balance between physical activity and food consumption be implemented. 	
	Papua New Guinean	Not available	Not available	<ul style="list-style-type: none"> The Cairns focus groups did not specifically discuss physical activity. All of the South-East Queensland focus groups discussed the change in lifestyle in Australia, including the lack of physical activity built into people's lifestyles and a reliance on transport to get to places. Obesity was seen to be a problem in the community in Queensland. 	
	Fijian and Fiji Indian	<ul style="list-style-type: none"> The Fiji STEP 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 	Not available	<ul style="list-style-type: none"> Fijian focus groups identified the lack of physical activity among community members. The Fiji Indian focus groups identified low priority attributed to physical activity and lack of 	

Health behaviour	Community	Literature review	Australian quantitative data	Qualitative data	Analysis
		<p>and three-quarters during leisure time.</p> <ul style="list-style-type: none"> There were no significant differences by ethnicity. However, in the transport domain, only 7.7 per cent of Fijians were insufficiently physically active compared to 24.7 per cent of Fiji Indians 		family oriented physical activity opportunities as the major barriers.	
	All Pacific Islands		The National Health Survey 2007-08 found that adults born in Oceania had comparable sedentary levels (69.5 per cent) compared to adults born in Australia (71.3 per cent) ⁸¹		

Health behaviour	Community	Literature review	Australian quantitative data	Qualitative data	Analysis
<i>Sexual behaviours</i>	Māori	<ul style="list-style-type: none"> Chlamydia detection among Māori clients at New Zealand sexual health clinics was double that of New Zealanders from a European background in 2007 In New Zealand, Māori teenagers have the highest fertility rate (70 per 1000 in 2000–2002), compared to Pacific (48) and European (22). The Māori abortion rate was 30 per 1000, compared to Pacific (26) and European (21)⁸². In a Counties Manukau study Māori women had double the hospitalisation rate of European women for pelvic inflammatory disease⁸³. 	Not available	Did not feature in focus groups. Participants discussed sexual health as being important and that health promotion was required around sexually transmitted infections, particularly by Māori health workers who could promote services as trustworthy. However, it was not identified as a priority issue.	Overseas studies indicate high levels of sexually transmitted infections for all communities and in the case of PNG, HIV infection. Teenage terminations were also higher among Māori, Samoan and Fiji Indian women in overseas studies. There is no Australian data on sexual health by country of birth. Sexual health did not feature in the Māori, Fijian and Fiji Indian focus groups. Shame and cultural expectations around sexual behaviour was discussed in the Samoan focus groups and sexually transmitted infections were identified as of concern among young people in the PNG
	Samoan	<ul style="list-style-type: none"> A World Health Organisation survey found that the prevalence of STIs of low-risk to moderate-risk pregnant women was high. The prevalence rates of chlamydial and trichomonal infections were of concern⁸⁴. 	Nota available	Sexual health issues were discussed at some length in two focus groups. Unplanned pregnancy, teenage pregnancy, the 'shame factor', abortion and sexually transmitted infections were all mentioned. The pressure to conform to the	

Health behaviour	Community	Literature review	Australian quantitative data	Qualitative data	Analysis
		<ul style="list-style-type: none"> Young Pacific Islander people in New Zealand have higher rates of Chlamydia, gonorrhoea and teenage pregnancies than Europeans in New Zealand ⁸⁵: 		community's behavioural codes was highlighted. One focus group highlighted the shame and secrecy around sexual issues.	focus groups.
	Papua New Guinean	<ul style="list-style-type: none"> In PNG there is a generalised expanding HIV epidemic with the majority of infections occurring in rural areas, not urban areas. The prevalence of HIV infection in the adult population is two per cent; approximately 64,000 people ⁸⁶. Very high rates of sexually transmitted infections are reported in PNG, with low-risk groups having estimated rates in the range of 18 per cent to 80 per cent for gonorrhoea, four per cent to 30 per cent for syphilis, and 17 per cent to 44 per cent for Chlamydia ⁸⁷. 	Not available	Both the Cairns and South-East Queensland focus groups identified that sexually transmitted infections are a problem among young people.	
	Fijian and Fiji Indian	<ul style="list-style-type: none"> In one Fijian study 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 ⁸⁸. 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 ⁸⁹ 	Not available	Sexual health issues did not feature in the focus groups with Fijians or Fiji Indians.	

Health behaviour	Community	Literature review	Australian quantitative data	Qualitative data	Analysis
<i>Psychological and mental health</i>	Māori	<ul style="list-style-type: none"> In New Zealand, Māori people have the highest prevalence of any mental disorder and, relative to need, are less likely than non-Māori (excluding 	Not available	<ul style="list-style-type: none"> Mental health featured in the Māori focus groups. All of the focus groups identified mental health issues and two identified social and personal well being 	Snap-shot country of birth data of Queensland mental health service usage (July 2008) indicates a higher use of

Health behaviour	Community	Literature review	Australian quantitative data	Qualitative data	Analysis
		<p>Pacific) to have contact with services, regardless of socio-demographic circumstances⁹⁰.</p> <ul style="list-style-type: none"> Māori people in New Zealand have a significantly higher rate of suicide and attempted suicide than the total population⁹¹ 		<p>as significant problems in the Māori community.</p> <ul style="list-style-type: none"> Suicide and depression were particularly discussed and both of the community focus groups mentioned that a large number of deaths due to suicide had occurred in the community in the preceding 18 months. These were of the young and old which reflects a different pattern to that in New Zealand where youth suicide is very high. Social isolation and lack of support were a problem. Lack of <i>whanau</i> (extended family) support and networks were the major issues Among the health service providers interviewed, four had observed mental illness 'sometimes' and four 'never' while one health service provider could not comment. 	<p>mental health services than what would be expected, based on population size ranking for the Samoa-born, PNG-born and Fiji-born populations. Overseas studies indicate high levels of suicide in Samoa and Fiji, particularly among young Fiji Indian women. The Māori suicide rate in New Zealand is also significantly higher than the rate for the total population. Mental illness and in particular, depression, was discussed in all of the focus groups and described as prevalent in all communities. It was linked to acculturation, stress, family disharmony, cultural and intergenerational conflicts and loneliness.</p>
	<p>Samoa</p>	<ul style="list-style-type: none"> Samoa had one of the highest rates of suicide in the world during the 1990s which declined around 2001 and recently increased again. However the proportion resulting in death was only 47.6 per cent in 2003-04 compared with 60.5 per cent in 1999-2000^{78,92,93}. Pacific Islander people in New Zealand had a higher prevalence - 46.5 per cent had experienced a DSM-IV CIDI 3.0 mental disorder in their lifetime compared with 39.5 per cent of the total New Zealand population; 25 per cent had experienced a disorder in 	<p>Queensland data relating to mental health and mental health service usage by country of birth were not available at the time of the 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 July 2008 Samoa-born consumers were ranked 19th of birthplace groups using mental health services in Queensland. Samoa was ranked 27th of all birthplace groups in Queensland in the 2006 Census. This could indicate a higher use of mental health services than what</p>	<ul style="list-style-type: none"> Mental illness, social and personal wellbeing, and violence were discussed in all of the focus groups. In particular, participants spoke openly about depression, stress and violence. Psychological and mental health issues were of serious concern to most participants including the Samoan community leaders. Depression and stress were the most common issues discussed. Suicide was not mentioned as a common occurrence in the Samoan community. All of the focus groups did however discuss the high levels 	<p>The PNG and Māori participants in particular discussed the serious difficulties people experience after migration, and also in subsequent years, as they cope to adjust to a life without as much extended family and village support. Suicide was discussed in the PNG (Cairns) focus groups as being a problem among young people but the PNG</p>

Health behaviour	Community	Literature review	Australian quantitative data	Qualitative data	Analysis
		preceding 12 months compared with 20.7 per cent ⁹⁴	would be expected, based on population size.	<p>of stress in Samoan families, particularly due to intergenerational conflict</p> <ul style="list-style-type: none"> • Four health service providers had observed mental illness 'often' among their Samoan clients; five 'sometimes'; and three 'never'. 	community in South-East Queensland only discussed the impact of depression on the community. In contrast, the Māori focus groups described suicide as a problem in the community and that it affects both young and old.
	Papua New Guinean	There is little mental health data in PNG. PNG has one psychiatrist per one million people and one registered psychiatric nurse per 70,000 people. The majority of mental health care is provided by general health workers in various community settings ⁹⁵ .	Queensland data relating to mental health by country of birth are not available. However, 'snap-shot' data (July 2008) shows PNG-born as the fourth largest group of overseas-born of consumers. This fourth ranking is disproportionate from population size, with the PNG-born population ranked 12 th in population size among overseas born populations. This could indicate a higher use of mental health services than what would be expected, based on population size ranking.	<ul style="list-style-type: none"> • In Cairns, mental illness was identified by all three groups. Suicide (mainly young people); poor mental health literacy; social isolation; and gambling addiction were particularly discussed. Participants described family and financial stresses in relation to gambling and the impact on children. • Similarly, in all of the South-East Queensland focus groups, depression, gambling addiction, social isolation, and disconnection from the community were discussed as priority issues • Health service providers were not specifically asked about mental health issues 	
	Fijian and Fiji Indian	Fiji has a high suicide rate with a rate of 15 per 100,000 population for males and 11 for females ⁹⁶ . There are considerable differences between ethnic groups with the rate for Fijians being four and for Fiji Indians 24 per 100,000. An unusually high rate for young Fiji Indian females has been reported ⁹² .	Queensland mental health service snap-shot data (July 2008) shows Fiji-born as the ninth largest group of overseas-born consumers. This ninth ranking is disproportionate from population size, with the Fiji-born population ranked 17 th in population size among overseas born populations. This could indicate a higher use of mental health services than what would be expected, based on population size.	<ul style="list-style-type: none"> • Mental health issues including stress, dementia, depression and suicide were discussed in the Fijian community focus groups. Suicide was perceived to be a growing problem in Fiji, but not in Australia. • Family stressors including intergenerational conflict, family breakdown, acculturative stress and cultural conflict featured in the Fiji Indian focus groups. All of the focus groups discussed the impact of migration with high levels of stress, loneliness and homesickness most 	

Health behaviour	Community	Literature review	Australian quantitative data	Qualitative data	Analysis
				common. The stressors associated with living in a family in cultural transition were particularly highlighted by both young and old.	

Health behaviour	Community	Literature review	Australian quantitative data	Qualitative data	Analysis
<i>Violence</i>	Māori	<ul style="list-style-type: none"> In New Zealand, Māori are substantially over-represented as both victims and perpetrators of violence in families The lifetime prevalence of interpersonal violence was much higher for Māori women (49per cent) than New Zealand European women (24per cent) 2001). In the Women's Safety Survey 52per cent of Māori women reported experiencing at least one form of interpersonal violence during their current relationship – nearly double the rate among non-Māori. This was not solely violence by Māori men, as many of the women had non-Māori partners. The highest risks were among Māori women with recent partners rather than current ones⁹⁷. 	Not available	<ul style="list-style-type: none"> The focus groups mentioned violence as an issue within the Māori community, but it did not attract further discussion. This could reflect cultural and gender issues within the focus group. The health service providers did not discuss interpersonal violence – they were not asked about it, and did not raise it. 	Interpersonal violence, including domestic violence, family violence, and violence against children, sexual abuse and youth violence was discussed in 11 out of 19 focus groups. It featured most in the Samoan focus groups, followed by the PNG focus groups. Similarly, the health service providers had observed violence in the Samoan and PNG communities.
	Samoan	<ul style="list-style-type: none"> In Samoa 41per cent of ever-partnered women had experienced physical violence from an intimate partner; 20per cent had experienced sexual violence in their lifetime; and the combined prevalence for physical or sexual violence by a partner was 54per cent⁹⁸ A 2002 report by the New Zealand Police identified that 	Not available	<ul style="list-style-type: none"> Previous Queensland research reported multiple and complex cultural and societal issues related to interpersonal and family violence and found high levels of violence¹⁰⁰ Interpersonal violence was identified by three out of four focus groups. Family violence, abuse and breakdown were openly discussed in the focus 	

Health behaviour	Community	Literature review	Australian quantitative data	Qualitative data	Analysis
		Pacific peoples are over represented in violent offending statistics, are at a higher risk of being victims of violent offending than any other ethnic group, including Māori, and are more likely to experience repeat victimisation ⁹⁹ .		<p>groups. The occurrence of sexual and physical abuse appeared to be known to participants, with women and children as the victims.</p> <ul style="list-style-type: none"> • Three health service providers had observed violence 'often', six 'sometimes' and three 'never'. 	
	Papua New Guinean	<ul style="list-style-type: none"> • Violence against women in PNG is widespread, severe and well documented ¹⁰¹⁻¹⁰⁴. • One study reported 60 per cent of men admitted to having participated in <i>lainap</i> (gang rape) ¹⁰². Another study reported a strong link between violence (particularly physical, emotional and sexual) and women's HIV positive status ¹⁰³. 	Not available	<ul style="list-style-type: none"> • Two South-East Queensland focus groups said that violence against women is a problem in the local PNG community. • In Cairns all three focus groups discussed domestic violence and violence among youth in particular. It was agreed that interpersonal violence is particularly prevalent in PNG, but some participants said that the problem is also widespread in the local community. • Five health service providers had observed domestic violence 'sometimes' and five 'never'. Five felt they could not comment. 	
	Fijian and Fiji Indian	<p>National research conducted in Fiji found:</p> <ul style="list-style-type: none"> • 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 ¹⁰⁵. 	Not available	<ul style="list-style-type: none"> • Violence did not feature in the Fiji Indian focus groups. People in one focus group discussed that mental abuse was more common than physical abuse in the community in Australia. • Similarly, in the Fijian focus groups, domestic violence was not identified as an issue of concern. However, participants did acknowledge it occurs in the local community, particularly related to kava and alcohol abuse. 	

Attachment 3 - Summary table of findings on dietary behaviours for Pacific Islander and Māori communities in Queensland

All of the focus groups in each community identified poor dietary habits, poor nutritional understanding and a lack of culturally tailored health promotion as the major issues. Community specific issues identified were:

Community	Issues identified
Māori	<ul style="list-style-type: none"> - large portions - preference for butter, fat, cream - low nutritional knowledge - reliance on fast foods
PNG	<ul style="list-style-type: none"> - traditional diet healthy but deteriorates with time in Australia - traditional diet low in meat and high in vegetables; this is reversed in Australia - low nutritional knowledge
Fiji Indian	<ul style="list-style-type: none"> - low nutritional knowledge - inability to read labels for hidden fats and sugars (language barrier) - lack of knowledge to adapt traditional ways of eating for healthier options
Samoan	<ul style="list-style-type: none"> - food is very important culturally and food is central to socialising - large portions - reliance on fast foods - lack of knowledge to adapt traditional ways of eating for healthier options - low nutritional knowledge
Fijian	<ul style="list-style-type: none"> - better financial resources linked to dietary changes - food is very important culturally and food is central to socialising - large portions
PNG (Cairns)	<ul style="list-style-type: none"> - traditional diet healthy but deteriorates with time in Australia - reliance on fast foods

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