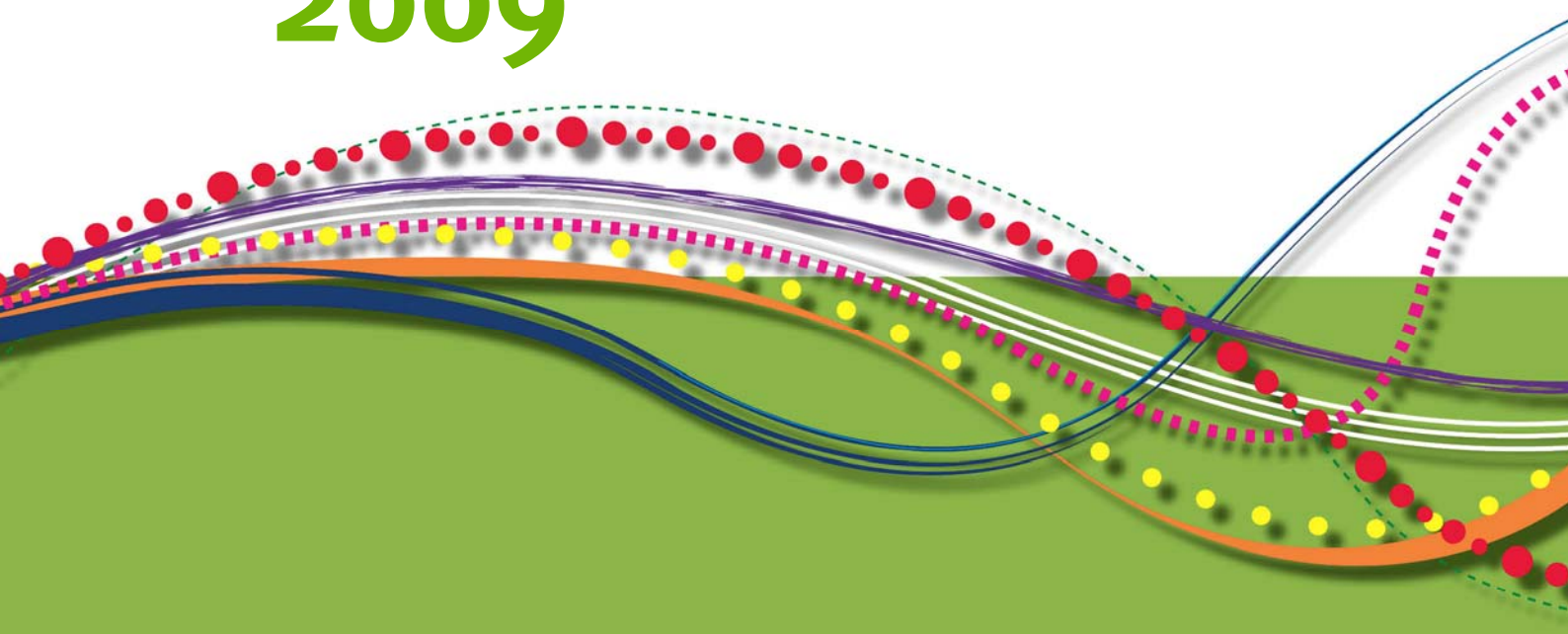
Queensland Health

The health of Queensland's Samoan population 2009



Tomorrow's Queensland:
strong, green, smart, healthy and fair

Queensland Government

The health of Queensland's Samoan population 2009

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

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Executive summary

This document profiles the health of Samoan Queenslanders. Data from a literature review, the Queensland Hospital Admitted Patient Data Collection, Australian Bureau of Statistics and focus groups with Samoan community members and leaders in Queensland are presented.

Quantitative data, particularly on the determinants of health and some health status indicators are not available for the Samoan population. Improved data collection and analysis is required to enable the development of a complete synopsis of the health of Samoan Queenslanders.

At the 2006 Census there were 4863 Queenslanders born in Samoa and 13,536 Queenslanders with Samoan ancestry. The population grew at a rate of 20.4 per cent between 2001 and 2006. The Samoan population speaks mainly Samoan at home and is predominantly Christian. The majority of Samoa-born people arrived in Australia between 1991 and 2000. The population is geographically distributed throughout Queensland. The largest populations live in Brisbane, Logan and Ipswich – with 69.8 per cent of the population living in these three Local Government Areas.

The Queensland Samoan population has Australian and traditional health beliefs and practices. The importance of *Aiga* (family) and *Va* (relational space) to the Samoan world view permeate beliefs about health and illness. Illnesses may be perceived as caused by conflicts with or failed duty towards family, or because of unbalanced social relationships.[1] In Samoan culture, the individual can only be described as having meaning in relation to others, not as an individual. Religion and spirituality are also central to health beliefs and people are viewed as having physical, mental and spiritual needs. The *fonofale* model of Samoan health, developed in New Zealand, has components related to a traditional Samoan meeting house: cultural values (roof); family (floor); and physical, mental, spiritual and other dimensions of wellbeing (four pillars). These traditional health beliefs and the process of acculturation all impact on Samoan health in Queensland.

The Samoa-born population display significant health inequalities with higher mortality rates for all causes and avoidable conditions; and higher hospitalisations for all causes, avoidable conditions, COPD, diabetes and diabetes complications.

Focus groups identified diabetes, coronary heart disease, mental illness, asthma, obesity and cancer as the health priorities in the Samoan community. The main issues raised in the focus groups included lack of culturally tailored health promotion, economic and communication barriers to health, cultural reluctance to seek help and low health literacy. To improve Samoan health in Queensland, all four focus groups recommended culturally tailored health promotion, dedicated Pacific Islander health workers and training, scholarships and up-skilling programs to access health jobs.

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

About the document

Background

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

Document structure

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

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

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

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

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

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

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

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

1 Data sources

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

1.1 Literature review

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

- Health status Samoans
- Health priorities Samoans
- Morbidity Samoans
- Risk factors Samoans
- Pacific Islander health
- Samoa health
- Samoa epidemiology
- Samoa chronic disease
- Samoa mental health
- Social determinants of health
- Health inequity Samoa
- Health disparity Samoa
- Health inequality Samoa
- Samoan health beliefs

Databases searched:

- Medline
- Meditext
- Austhealth

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

Articles were prioritised to include studies on immigrant Samoan populations including those in Australia, New Zealand and the United States.

1.2 Quantitative data sources

1.2.1 Hospital separation data

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

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

adjusted rates, while the end products of indirect standardisation are expected counts and standardised ratios.

1.2.2 Australian Bureau of Statistics

Several data were obtained from the Australian Bureau of Statistics - National Health Survey 2007-08[2], Health Literacy[3], Australian Social Trends[4] and 2006 Census of Population and Housing.[5] 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 Samoan community members and leaders

Four focus groups involving 45 people were held in 2009– six Samoan leaders participated in the leaders' focus group in Brisbane, 24 community members attended two focus groups in Marsden and 15 community members attended a focus group at Deception Bay. The Marsden focus groups were held at a Catholic Church hall and the Deception Bay focus group was held at the office of Pan Pacific Oceania. The first focus group involved nine men and three women; the second nine men and three women; and the third six men and nine women.

The focus groups were co-facilitated by a Samoan facilitator and the Project Officer for this project (himself also Samoan). Focus groups were predominantly in English and also in Samoan. Standard prompting points were used (Attachment 2). The focus group data was analysed by the Project Manager and Project Officer and then checked for cultural accuracy by the Samoan co-facilitator.

1.4 Health service provider survey

A potential sample of health services was developed. Health services in locations where the Samoan population reside comprised the sample. Participants were randomly selected and contacted for a telephone interview. However, as most potential respondents were either not available, or not able to participate due to time constraints, additional participants were selected from the sample or from referrals from the services contacted who could not participate. In total, twelve participants completed the questionnaire (Attachment 5). Three participants had so much information to contribute, that face-to-face appointments were made. The face-to-face interviews recorded the responses of more than one health service provider at a time, as all face-to-face interviewees invited colleagues who also had a lot of information to contribute.

Profile of health service provider interview participants	
Type of health service provider	
Nurse	6
Social worker	2
Community dietician	1
Dietician	1
GP	1
Podiatrist	1
Locations	
Logan	5
Northlakes / Redcliffe region	3
Herston	1
Greenslopes	1
Chermside	1
Inala	1

1.5 Data quality

Data are not available for several sections of this document. 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 Samoa born Queenslanders, or those with Samoan ethnicity.

Improved cultural competency in research, data collection and analysis is required to enable a robust and complete analysis of the health of Queenslanders from a Samoan background.

2 A profile of Queensland's Samoan population

Samoan migration to Australia started during the early part of the 20th century when Samoans came to Australia for commerce, educational and missionary purposes.[6]

During the 1970s the number of Samoans in Australia increased due to Australia-sponsored educational programs. In 2001 there were 13,380 Samoa-born people in Australia and 4040 in Queensland.

2.1 Population size and growth

The minimum core set of indicators defining cultural and linguistic diversity (CALD) are country of birth, main language other than English spoken at home and proficiency in English. Refer to Attachment 6 for the full list of indicators.

The size of the Queensland Samoan population can be estimated from Census data on country of birth and ancestry. According to this data, there were 4863 Queenslanders born in Samoa. Samoa was ranked 27th of all overseas birthplace groups in Queensland. There were 13,536 Queenslanders who identified as having Samoan ancestry.

Table 1 Queensland Samoan population by key CALD indicators, 2006

Queenslanders born in Samoa	4863
Queenslanders who speak Samoan at home	9367
Queenslanders with Samoan ancestry	13,536

The Queensland Samoa-born population grew by 20.4 per cent between 2001 and 2006, while the Australia-born population grew by 7.2 per cent.

2.2 Languages spoken at home

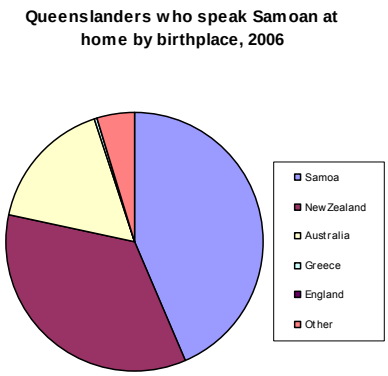
At the most recent Census in 2006, there were 9367 Queenslanders, or 0.3 per cent of the Queensland population, who spoke Samoan at home. This was a 30.1 per cent increase from the 2001 Census. Samoan was ranked ninth of all overseas languages spoken at home in Queensland.[7] Samoan was ranked 26th of all overseas languages spoken in Australia, with 0.1 per cent of the Australian population speaking Samoan at home.

Of those who spoke Samoan at home in Queensland, almost 10 per cent (901 people) indicated they spoke English not well or not at all.

Among those Queenslanders who spoke Samoan at home, 43.6 per cent were born in Samoa, 34.6 per cent in New Zealand and 16.8 per cent in Australia.

Table 2 Queenslanders who spoke Samoan at home by birthplace, 2006

Samoa	4082	43.6
New Zealand	3243	34.6
Australia	1569	16.8
Greece	24	0.3
England	10	0.1
Other	437	4.7
Total	**9365**	**100**



2.3 Ancestry

At the 2006 Census, 13,536 Queenslanders identified their ancestry as Samoan[2]. The largest birthplace groups for Queenslanders with Samoan ancestry were New Zealand, Samoa and Australia.

Table 3 Queenslanders with Samoan ancestry by birthplace, 2006

New Zealand	5130	37.9
Samoa	3932	29.1
Australia	3777	27.9
Fiji	60	0.4
Samoa, American	54	0.4
United States of America	27	0.2
Papua New Guinea	27	0.2
Greece	26	0.2
England	10	0.1
Other	479	3.5
Total	13,522*	100

Queenslanders who identified their ancestry as Samoan lived predominantly in the Brisbane, Logan, Ipswich and Redcliffe to Caboolture areas.

[2] For some demographic and health determinants indicators 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.

Table 4 Queenslanders with Samoan ancestry by top 10 LGAs, 2006

Local Government Area (LGA)	ANC1P Ancestry 1st Response	Sex		
		Male	Female	Persons
Brisbane (C)	Samoan	1329	1269	2598
Logan (C)	Samoan	1137	1193	2330
Ipswich (C)	Samoan	988	965	1953
Caboolture (S)	Samoan	281	328	609
Gold Coast (C)	Samoan	236	186	422
Pine Rivers (S)	Samoan	141	165	306
Redcliffe (C)	Samoan	115	106	221
Cairns (C)	Samoan	79	92	171
Redland (S)	Samoan	69	59	128
Beaudesert (S)	Samoan	26	31	57

2.4 Religious affiliation

At the 2006 Census, Queenslanders born in Samoa identified their religious affiliation predominantly with Christian religions including Church of Christ of LDS (Mormon), Seventh Day Adventist, Assemblies of God and Wesleyan Methodist.

2.5 Year of arrival

The majority of Samoa-born Queenslanders arrived in Australia between 1991 and 2000.

Table 5 Samoa-born Queenslanders by year of arrival, 2006

Before 1971	1971-1980	1981-1990	1991-2000	2001-2005	2006	Not stated	Total
42	116	838	2404	1027	132	279	4839

2.6 Participation in voluntary activities

At the time of the 2006 Census, 20 per cent of the Samoa-born population in Queensland had participated in voluntary activities in the preceding 12 months. Samoa-born Queenslanders were ranked eighth among country of birth groups with 20 per cent of people participating in voluntary activities. Australia-born people were ranked fifth with 20.3 per cent of people participating in voluntary activities in the preceding 12 months. Participation in voluntary activities is considered an important indication of social inclusion.[8,9]

2.7 Age and sex distribution

Among the total population of Samoa-born Queenslanders, there were 2628 women (53.22 per cent) and 2310 men (46.78 per cent) in 2006. The sex ratio was 87.9 males per 100 females for Queensland. The sex ratio for the whole Queensland population in 2006 was 99.7 males per 100 females.

In 2006, the median age of the Samoa-born Queensland population was 41.6 years, compared with 37.1 years for the total Australian population and 36.0 for the Queensland population. The age distribution

showed 6 per cent were aged 0-14 years, 9.9 per cent were 15-24 years, 42 per cent were 25-44 years, 35 per cent were 45-64 years and 6.6 per cent were 65 and over [10].

2.8 Geographic distribution

In 2006, more than half of the Queensland Samoa-born population (69.8 per cent) lived in South-East Queensland. Samoa-born people lived predominantly in Brisbane (3783), Logan (3102) and Ipswich (2508).

In 2006, the three Health Service Districts with the largest population of Samoa-born Queenslanders were (4938), Darling Downs-West Moreton (2144) and Metro North (1794).

2.9 Summary of the Samoan population profile

The size of the Samoan population in Queensland can be measured from 2006 Census ancestry data (13,536 people) and country of birth data (4863). It is more likely to reflect the bigger figure since 9367 Queenslanders indicated they spoke Samoan at home in the 2006 Census. The Samoan population is largely proficient in English since 10 per cent (or 901 people) indicated they spoke English not well or not at all.

New Zealand is a source country of significant Samoan immigrants to Queensland. It was the largest birthplace group for those who identified Samoan ancestry and the second largest for those who speak Samoan at home.

The majority of Samoa-born people arrived in Australia between 1991 and 2000. However, this figure does not reflect Samoans who were born in New Zealand, a large source country. It therefore may not provide an accurate picture of the length of establishment of the Samoan population in Queensland.

The Samoa-born population is geographically distributed to Metro South, Darling Downs-West Moreton and Metro North Health Service Districts.

The Samoan population had a relatively high participation rate in voluntary activities, similar to the Australia-born population.

3 Samoan health beliefs

> *"issues of health and well-being without regard for a Samoan view of the self, have little meaning."*[1] (p. 1343)

Health and illness are constructs that differ across cultures. Culture significantly shapes perceptions of health and health-related behaviour. The failure to adequately take into account a population's cultural and social constructs can result in barriers to effective health care.[1] This section will briefly outline the fundamental concepts that are integral to the Samoan construction of health and illness.

The Samoan community has a strong tendency to hold on to traditional beliefs and language. The bestowal of chiefly titles on the younger generation born in New Zealand or Australia maintains strong links to cultural traditions and language to honour the title.

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

Aiga and V*a*

In the West, the experience of health and illness is largely individualised. In Samoan culture, the individual can only be described as having meaning in relationship with other people, not as an individual. This individual cannot be separated from *va* (relational space) that occurs between parents, siblings, grandparents, aunts, uncles and other extended family and community members.[1,11] *Aiga* (family) can mean the nuclear family or the extended family, crossing several generations and all living together in one household.[12] For the Samoan family, the extended family is important, and the larger the *aiga*, the more powerful it is.

Illnesses may be perceived as coming about because of conflicts with or failed duty towards family members, or because of unbalanced or unsettled social relations.[1] There is also the perception that illness is the result of irreverence to ancestors or the dead, either while they were alive or dead. There is therefore a strong relationship between a person's relationships with other people and his or her health.

Aiga influences health decision making and treatments given without regard for communities and communal practices, deny the most important source of meaning and life support.[11,12]

Tapu and *Sa*

Tapu means 'that which is forbidden to the ordinary', as expressed in cultural protocols and etiquette. *Sa* has its nearest English equivalent in the word 'sacred'.[11] These concepts underlie Samoan relationships, community structures, language and behaviour.

Language, Samoan etiquette and protocol in protecting the sacred nature of relationships are important to maintaining wellbeing in Samoan society. Mental illness in particular can be understood to be the result of breaches of forbidden or sacred relationships.[11]

Illness may also be perceived to arise from the violation of a community's traditional and natural lifestyle, or by transgression of social, moral or religious rules. In one study, Samoan participants purported that the neglect of *fa'aSamoa* (traditional way of life) could cause cancer (particularly in relation to the consumption of imported foods) and that adherence to *fa'aSamoa* could prevent it (Hubbell, Luce and McMullin, 2005 cited in.[1])

Spirituality and holism

Religion and spirituality are central to Samoan culture and the Samoan understanding of health.[11-13] Religion is an important part of daily life and prayer may be especially important to health and healing. Christianity was introduced in the early 1800s; hence religious beliefs are often a blend of Christian and Indigenous religious beliefs. Despite the change of emphasis from traditional Gods who were embodied in the natural environment, a person's relationship to land, sea, ancestors, their home village and God remain central to the Samoan sense of self.

People are viewed as having physical, mental and spiritual aspects. These elements can not be separated. Samoan people may view sickness and the physical symptoms of a sick body as a sign, not of a physiological problem, but of a sickness of spirit. The appropriate treatment could involve the re-establishment of spiritual wholeness of both the individual and the family.[1] Australian medical treatments may also be sought.

Body image

Traditionally, Samoans believed that having a very large body was a sign of beauty, wealth, royalty, status and prestige.[12,13] Although this is changing, particularly in countries such as Australia, Samoans still do not subscribe entirely to the Western notion of beauty and thinness.[14]

Fonofale model of health

The *fonofale* model of Samoan health was developed in New Zealand and attempts to present cultural beliefs in a in a holistic health model. The model is named after the traditional Samoan meeting house (thus a communal resource): the roof represents cultural values and beliefs that constitute shelter for life; the floor or foundation represents the family; the four pillars or *pou* connect the culture and the family and represent physical wellbeing, spiritual wellbeing, mental wellbeing and 'other' (which includes gender, social class, age and sexual orientation). The house is encapsulated in time, context and environment.

Figure 1 *Fonofale* model of Samoan health
(Source: 2009 Pasifika Health Action Plan New Zealand)

Health beliefs and acculturative stress

The preceding summary of health beliefs should be considered in the context of a population in the process of acculturation. As for any immigrant population, the Samoan population is adjusting to a host culture and a range of experiences referred to as acculturative stressors. These include [15] :

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

Both traditional health beliefs and the process of acculturation play an integral role in the health and wellbeing of Samoan people in Queensland.

4 Wellness and illness, the health status of Samoan Queenslanders

4.1 Self-reported health status and quality of life

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

4.2 Life expectancy

The life expectancy of the Queensland population 2004-06 (including Australian and overseas-born) is 78.5 years for males and 83.4 years for females.[4] The relatively small number of Samoa-born Queenslanders prevents meaningful country of birth specific life expectancy calculations from being made.

In New Zealand, where Samoans comprise almost 50 per cent of Pacific Islander people, Pacific Islander males can expect to live for 71.5 years and Pacific Islander females for 76.7 years, a gender gap of 5.2 years. Pacific males and females have life expectancy at birth lower than the average for New Zealand: 4.8 years lower for males, and 4.4 years lower for females.[16]

4.3 Infant mortality and health

The most recent available Queensland data reporting infant health and infant mortality are for the period 2006-07. During this period, there were 403 infants born to women who recorded Samoa as their country of birth. The number of perinatal deaths (stillbirths and deaths to infants in the first 28 days of life) was seven.[17] There was no difference in the perinatal mortality rate for infants born to Samoa–born mothers (17.4 per 1,000 total births) compared to all Queensland mothers (10.5).

For the same period, of the 403 births recorded to Samoa-born mothers, 20 occurred before 37 weeks gestation and were therefore classified as pre-term births. The rate of pre-term birth was significantly lower for Samoa-born mothers (49.6 per 1000 total births) when compared to all Queensland mothers (88.7 per 1000 births).[17]

4.4 Deaths – avoidable and all causes

Under nationally agreed criteria, almost two-thirds of all deaths of Queenslanders aged less than 75 years in 2004 were considered to have been potentially avoidable[18]. Of the 9598 deaths of people aged less than 75 years in 2004, 6805 (64 per cent) were considered avoidable and 3092 or 36 per cent were considered non avoidable.

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

In 2005 to 2006, Samoa-born Queenslanders recorded a very high standardised mortality rate (SMR) for total avoidable conditions which was double the rate for all Queensland (Figure 2).

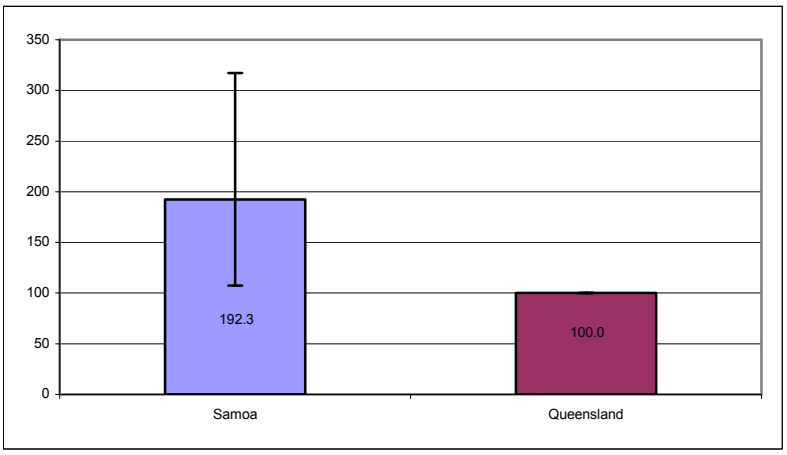


Figure 2 Total avoidable standardised mortality rate, all Queensland and Samoa-born persons 2005 to 2006 (aged up to 74 years)

Similarly, in 2005 to 2006, Samoa-born Queenslanders had a higher SMR for 'all causes' of death (147.8) compared to all Queenslanders(100).

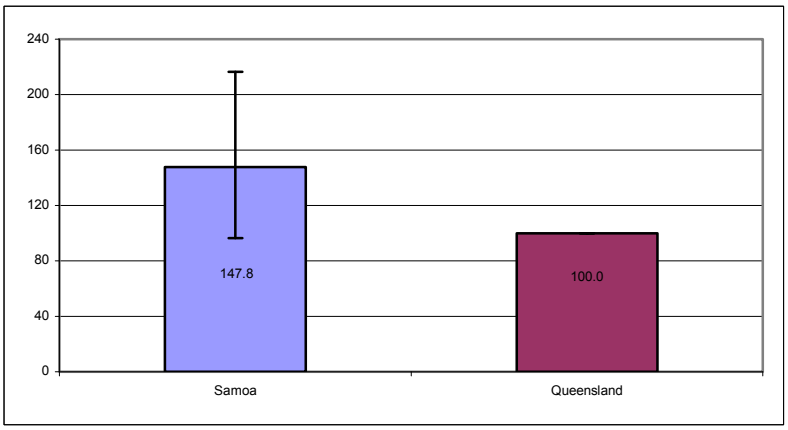


Figure 3 All causes standardised mortality rate, all Queensland and Samoa-born persons 2005 to 2006

4.5 Hospital separations – all causes and avoidable

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

Hospital separation rates and ratios, adjusted for the age of the population, are often used to compare levels of illness in communities. However, they need to be interpreted with caution. Hospital separations also reflect access to hospitals, the need for repeated admission, and current medical practice of treating an illness or injury in hospital, all of which can vary over time and in some cases between geographic areas.[19]

Figure 4 presents the standardised hospital separation ratio for 'all causes' (July 2006 to June 2008) for Samoa-born Queenslanders compared to all Queenslanders. The ratio was double for Samoa-born Queenslanders.

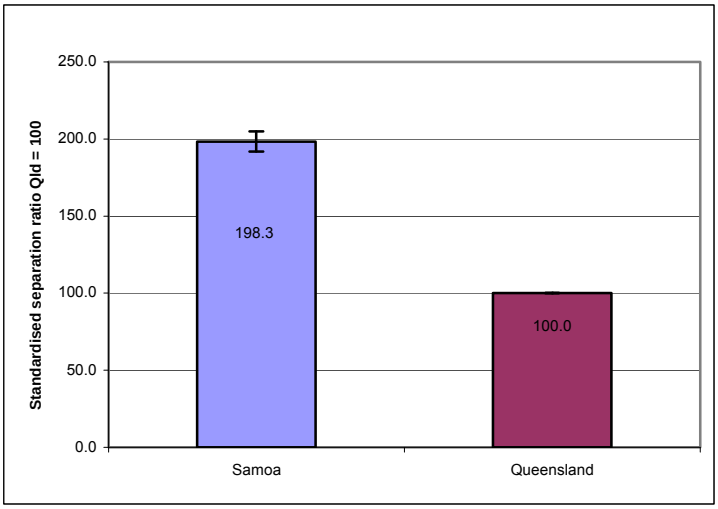


Figure 4 All causes standardised hospital separation ratio all Queensland and Samoa-born persons July 2006 to June 2008

The standardised hospital separation ratio for the same period, for 'total avoidable' separations is presented in Figure 5. Samoa-born Queenslanders had a ratio four and a half times higher than all Queenslanders.

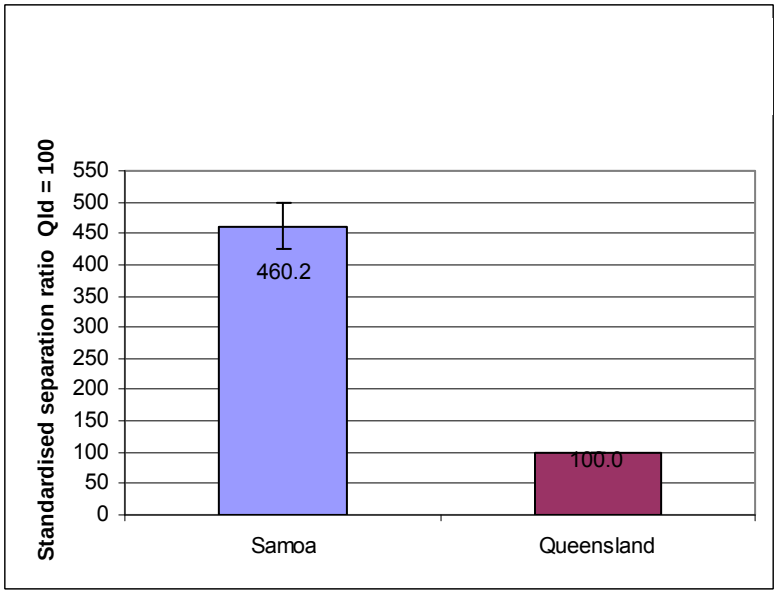


Figure 5 Total avoidable standardised hospital separation ratio all Queensland and Samoa-born persons July 2006 to June 2008

5 Determinants of Samoan health and wellbeing

5.1 About this chapter's data sources

This chapter presents the key determinants of Samoan population health. The chapter presents findings of a literature review, focus groups with the Samoan community and a survey of health service providers.

Each section is reported in the following structure:

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

A summary of findings from focus groups with the Samoan community is presented in Attachment 4. The major points of discussion will be documented in this chapter.

A summary of findings from the health service provider survey is presented in Attachment 5. Relevant findings will also be documented in full in this chapter.

5.2 Determinants of health

Determinants of health refer to the factors that influence the health status of populations and individuals.[20] These factors act in various combinations; that is, health is multi-causal.[21] These determinants or factors include societal factors such as culture, resources and systems; socioeconomic factors such as education, employment and income; health behaviours such as tobacco use, physical activity and alcohol consumptions; and biomedical factors such as blood pressure, blood cholesterol and body weight. These factors are often categorised as either risk factors or protective factors.

The determinants of health are particularly important for explaining and predicting trends in health, and can provide explanations as to why some populations have better or worse health than others. They are at the heart of disease prevention and health promotion.[21]

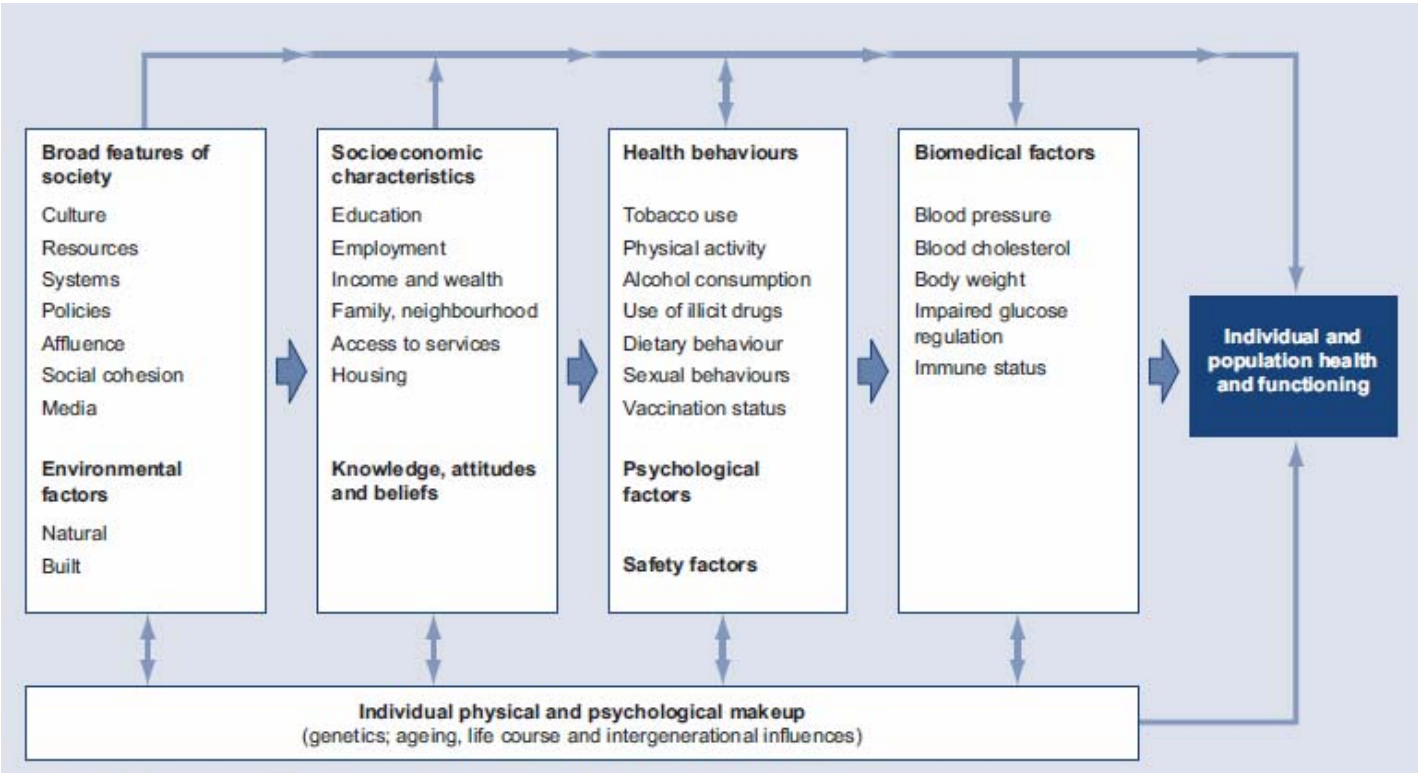


Figure 6 Conceptual framework for the determinants of health
(Source: Australian Institute of Health and Welfare [21])

This chapter documents the determinants of health and wellbeing.

5.3 Broad features of society

The Samoan population in Queensland, like other Pacific Islander populations, is in cultural transition. People from Samoa are immigrants from a country where, as the Indigenous peoples, they had cultural, social and spiritual ties to their land. Like many other Pacific Islander communities, Samoan people do not identify themselves as 'ethnic migrants', and rather see themselves as Indigenous people of the Pacific region.

5.4 Health behaviours

5.4.1 Tobacco use

Tobacco smoking is a leading risk factor in Queensland. It is known to contribute strongly to lung and related cancers, cardiovascular disease and diabetes regardless of country of birth.[19]

International literature reports high prevalence of smoking among Samoan men in particular, in Samoa and in countries where Samoans have migrated. The World Health Organisation reports high prevalence of smoking in Samoa – 40 per cent of the total population are smokers (56.3 per cent of males and 21.8 per cent of females).[22]

In a study of 650 Pacific Islander New Zealanders, Samoan men had a smoking prevalence of 46 per cent while women had 24 per cent.[23] Similarly, the most recent New Zealand National Health Survey found that 34.8 per cent of Pacific men reported daily smoking compared to 21.3 per cent of European/other men and 24 per cent of all men. For women the figures were 31.6 per cent of Pacific women; 19.9 per cent of

European/other women; and 22.9 per cent of all women reported daily smoking[24]. (Samoans comprise more than 50 per cent of those in the 'Pacific' category.)

In a prevalence study in the US involving 1834 Samoans, 31.4 per cent of men and 22.5 per cent of women were current daily smokers. The predictors of smoking included being younger, male, married, less educated, with lower income and more acculturated[25]. This US study concluded that if Samoans were to reach tobacco and health goals and targets, there was a need to: develop tailored tobacco awareness and cessation programs; understand the complex interactions between social, cultural and psychological determinants of smoking and cessation behaviours; and develop policies to limit availability of tobacco, environmental exposure from tobacco, and increase cessation efforts.

In Australia, the National Drug Strategy Household Survey (NDSHS) collects information relating to tobacco, alcohol and illicit drug use across Australia. In 2007, 23,356 participants completed the survey. Overall, 16.6 per cent of participants reported being daily smokers. Data on Samoa-born participants are not available. However, 23.3 per cent of those born in 'other Pacific countries' reported being a daily smoker. This category excludes Fiji and Papua New Guinea. This is significantly higher than the total population rate, and is consistent with New Zealand data.

The National Health Survey 2007-08 asked participants about a number of risk factors including smoking. Of those people born in Australia, 19.9 per cent reported being a daily smoker. Of those people born in Oceania, 22.2 per cent reported being a daily smoker[2].

Smoking was identified as a concern by Samoan community members in only one out of four focus groups with community members. It was not identified as a concern by health service providers in the survey.

5.4.2 Alcohol consumption

Alcohol is the most commonly used drug in Australian society. There is evidence that, from middle-age onwards, relatively low levels of alcohol have some health benefits.[26] However, drinking regularly and drinking at levels higher than the recommended National Health and Medical Research Council (NHMRC) guidelines increases the risk of acute and chronic health and social impacts, and premature death.

The World Health Organisation reported that from a national health survey, alcohol consumption placed 37.6 per cent of Samoan males and 19.6 per cent of Samoan females at moderate to high risk of developing a non-communicable disease.[22] In the New Zealand National Health Survey, 27.1 per cent of all New Zealander males reported hazardous alcohol consumption, while 30.8 per cent of Pacific males reported hazardous drinking. For females the prevalence was 11.4 per cent for all females and 7.6 per cent for Pacific females.[24]

In the National Health Survey 2007-08, participants were asked about a number of risk factors including high risk alcohol consumption. Of those people born in Australia, 14 per cent reported consuming alcohol considered high risk. Of those people born in Oceania, 16 per cent reported consuming alcohol considered high risk.[2]

Four focus groups were run with leaders and community members. Hazardous alcohol consumption was discussed in two focus groups. The major theme related to alcohol was 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 among young Samoan people, particularly girls. Interpersonal violence among Samoan girls (high school students) was also a serious concern, which was linked to hazardous alcohol consumption.

5.4.3 Dietary behaviour

Nutrition is an important determinant of health and wellbeing. Good nutrition is essential for the normal growth and the physical and cognitive development of infants and children, healthy weight, enhanced resilience and quality of life, good physical and mental health throughout life, resistance to infection, and protection against chronic disease and premature death.[27]

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

The National Health Survey 2007-08 also found that adults born in Oceania were more likely to be overweight/obese (63.1 per cent) compared to adults born in Australia (55 per cent).[28] The second-highest proportion of overweight/ obesity was recorded for men born in Oceania (68 per cent). The largest proportion of overweight and obese women were those born in the Oceania region and Southern and Eastern Europe (both with 56 per cent).The National Preventative Health Taskforce identified school boys of Middle Eastern and European background and boys and girls from Pacific Islander backgrounds to be more likely to be obese.[20]

The World Health Organisation reported that 35.6 per cent of the population in Samoa ate no fruit or less than one serving of fruit per day.[22] In the New Zealand National Health Survey, 63.3 per cent of all New Zealander men and 71.1 per cent of women reported adequate vegetable consumption, compared to 42.9 per cent of Pacific New Zealand men and 39.4 per cent of women. The same survey reported 43.3 per cent of all New Zealand men and 63.6 per cent of women as having adequate fruit intake, compared to 53.5 per cent of Pacific New Zealand men and 57.5 of women.[24]

Poor nutrition was discussed as a major health problem in the Samoan community in all of the focus groups with community members and leaders. 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. The importance of food in Samoan culture was discussed and people described the importance of food to Samoan people's social life. 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. At the leaders' focus group one Samoan leader said:

> *"… we have a big dinner at night. Breakfast is the left overs from the night before. That food covers dinner and breakfast. We don't eat cereals and those things"*

One participant at a community focus group summed up a sharing feeling across all focus groups:

> *"We are stuck with our way of eating, we eat the same food. If we can understand a better version of our food without compromising quality and taste.. We need this training, improved recipes…"*- Samoan female

The need for culturally tailored health promotion, using a variety of methods, was called for by all focus group participants. Some of the topics for community education included healthy lifestyles, adaptation of Samoan food, the prevention of illnesses and understanding the health system.

Some of the methods suggested:

- health workshops
- ongoing sessions
- information dissemination through churches, radio, schools, sporting clubs
- education of the pastors and ministers and engagement with churches as vehicles for community education
- seminars
- sessions in Samoan – 'our language, our issues'.

Focus group participants discussed many educational and promotional needs and believed the best way to deliver this was through culturally tailored programs by Pacific workers. The following comment was typical:

> *"There should be a lot of education. We need to be taught…Need forums, community education… Community organisations can do that, delivered in our own language. Need a Samoan or Pacific Islander worker to do this… Need a Samoan worker to link."* – Samoan female

The health worker survey indicated that 10 workers had observed obesity 'often' among Samoan clients; 1 observed it 'sometimes'; and 1 had never observed it. Two respondents who work with young people had observed that young people frequently have not been provided with breakfast or lunch and that the main meal of the day is in the evening and this meal is large. A reliance on fast foods was also observed. One dietician interviewed mentioned the importance of culturally tailoring interventions and the importance of engaging leaders and working in the community, rather than the community coming in to Queensland Health services. Another respondent, a nurse, discussed the importance of health promotion conducted by professionals from a Samoan background. Some health service providers expressed frustration at not being able to effectively engage and work with their Samoan clients on dietary and lifestyle factors.

Breastfeeding

Infants and children depend on good nutrition for normal growth and development. Breastfeeding is associated with a reduction in the incidence and impact of childhood infections, allergic disease, diabetes, obesity, some childhood cancers and Sudden Infant Death Syndrome. Breastfeeding is also associated with reduced risk of cardiovascular disease in adulthood.[27]

During 2006, 193 infants were born to Samoa-born mothers in Queensland hospitals and of these, 150 infants (78 per cent) were being exclusively breastfed at discharge following birth. This is lower than exclusive breastfeeding rates by Australian-born mothers (83.3 per cent). No breastfeeding data are available at six months of age by mothers' country of birth; however, all Queensland rates at 2006 were known to be 57 per cent, which fell well below the national objective of 80 per cent.

5.4.4 Physical activity

Physical activity is essential for maintaining good physical and mental health and general wellbeing of adults and children. Regular physical activity reduces the risks of many chronic diseases, particularly cardiovascular disease and Type 2 diabetes. Half the adult population in Queensland is not sufficiently active and there is great potential to improve physical activity.[27]

Data relating to levels of physical activity for Queenslanders by country of birth is not available. The National Health Survey 2007-08 found that adults born in Oceania had slightly lower sedentary levels compared to adults born in Australia.[28]

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) and women (27.3 per cent) are more likely to be inactive than men (14.8 per cent). It was also reported that the national prevalence of obesity in Samoa is 57.0 per cent (48.4 per cent in males and 67.4 per cent in females) and increasing with age. Obesity is more common in urban areas in Samoa.[22]

In the New Zealand National Health Survey the following data was collected on physical activity and body size:

Table 6New Zealand prevalence (per cent) risk and protective factors in adult males and females by ethnic group (age-standardised) 2006/07

Factor	Pacific males	All males	Pacific females	All females
Physically active	74.8 (66.9-82.7)	78.4 (76.6-80.2)	61.2 (53.5-68.8)	69.9 (67.9-71.9)

Regularly physically active	51.7 (43.6-59.8)	56.7 (54.5-58.9)	44.0 (35.9-52.1)	48.6 (46.5-50.6)
Sedentary	10.9 (5.4-16.5)	10.9 (9.5-12.3)	23.9 (17.1-30.6)	13.6 (12.2-15.1)
Overweight	43.9 (37.2-50.6)	40.5 (38.3-42.8)	34.8 (27.1-42.6)	27.5 (25.8-29.2)
Obese	38.0 (31.1-44.8)	19.2 (17.7-20.6)	47.8 (39.8-55.9)	21.0 (19.5-22.5)
Overweight or obese	81.8 (75.8-87.8)	59.7 (57.5-61.9)	82.6 (76.6-88.6)	48.5 (46.4-50.5)
Abdominal obesity	52.2 (44.8-59.6)	26.2 (24.5-27.9)	76.6 (68.6-84.6)	34.6 (32.7-36.4)

An international literature review found a connection between Westernisation and obesity in Asian migrant populations and Pacific Islanders. It was found that the body mass index (BMI) of immigrants from Polynesia are generally higher in Westernised countries than those of their counterparts in their countries of origin [29].

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. The following comment was typical:

> *"We eat good food but we don't exercise!"* – Samoan female

It was also recommended by community members and leaders that culturally tailored programs that promote a balance between physical activity and food consumption be implemented.

The health service provider survey did not specifically ask about physical activity. However, one health service provider had successfully implemented a culturally tailored physical activity program in a school setting through the establishment of a Pacific Islands community garden. The project had a high level of support from Pacific Islander students and achieved a high level of engagement.

5.4.5 Sexual behaviours

Safe sexual behaviour is another factor affecting health and wellbeing [30]. Unsafe sex, unplanned pregnancies, sexually transmitted infections, HIV infection and unwanted sex are some of the issues related to sexual behaviour.

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

New Zealand reports national data on sexual health[16]:

- the incidence of Chlamydia at sexual clinics among Pacific young people (15-24 years) was 18.5 per cent for males and 10.2 per cent for females; and 10.4 per cent for all New Zealand males and 5.5 per cent females 1999-2002
- the incidence of gonorrhoea at sexual clinics among Pacific young people (15-24 years) was 6.5 per cent for males and 2.7 per cent for females; and 1.7 per cent for all New Zealand males and 0.7 per cent for females 1999-2002
- Pacific teenagers had higher pregnancy (65 per 1000 compared to 37 per 1000) and birth rates (41 per 1000 compared to 19 per 1000) than the all New Zealand average but a similar abortion rate (15 per 1000 compared to 13 per 1000)

A health needs assessment by Counties Manukau District Health Board in New Zealand also found that the rate per 1,000 for teenage deliveries (aged 15-19 years) was 37.9 for Samoan teenagers compared to 30.3 per 1,000 for the rest of New Zealand (2003-2005) [31].

In a World Health Organisation survey of sexually transmitted infections and HIV prevalence in Samoa, it was found that the prevalence of low- to moderate-risk pregnant women was high. In particular, the prevalence rates of chlamydial and trichomonal infections were of concern [32].

Sexual health issues were discussed at some length in two focus groups, despite sexual health issues being considered relatively taboo topics for public discussion. Unplanned pregnancy, teenage pregnancy, the 'shame factor', abortion and sexually transmitted infections were all mentioned. Participants generally discussed the pressure to conform to the community's behavioural codes and that bringing shame to the family was highly undesirable. One participant described that even if the immediate family was supportive of an unplanned pregnancy, pressure could even come from outside the family:

> *"...should add abortion to the list. People don't like to discuss – the shame factor. There's family pride – you don't want other families to know about this. Shame is a very big issue – the fear of bringing shame to your family ... Even outside the family – they cause the trouble – even if your family accepts your pregnancy"* – Samoan female

Participants in one focus group particularly discussed the shame and secrecy prevalent in the Samoan community around sexual issues.

The survey with health service providers found that 1 had encountered sexually transmitted infections among Samoan consumers 'often', 2 'sometimes' and 9 'never'. This could largely reflect the type of services these workers are employed in. Two health service providers who specifically worked with high numbers of Samoan young people observed many sexual health issues including unwanted sex, unwanted pregnancies, sexual abuse and sexually transmitted infections. One health service provider stressed her concern at the increasing number of Polynesian girls reaching puberty as early as eight years old. This health service provider wished to highlight the link between obesity and early puberty.

5.4.6 Vaccination status

Queensland data is not available to provide vaccination rates by specific country of birth. A Logan study[33] on immunisation for children from Samoan, Tongan, Cook Islands and Māori backgrounds reported lower immunisation coverage (77 per cent) in four Logan suburbs and an overrepresentation of children from these backgrounds among those in prep/year one who were overdue for immunisation. Barriers to immunisation were identified as previous immunisation experiences, cultural norms, family structure, language barriers, low health literacy and enablers were having knowledge of immunisation and the health system, the ability to read and speak English, an understanding of incentive programs, having support family networks and maintaining a record of past immunisations.

5.5 Psychosocial factors

5.5.1 Psychological and mental health

There are no data available on the prevalence of mental illness in the Samoan population in Queensland. Mental health service use by members of the Samoan community is reported in section 6.4.

International literature on mental illness among Samoans is dominated by suicide data. Samoa had one of the highest rates of suicide in the world during the 1990s which has since declined (article requested).[34] In 2008 the World Health Organisation reported that the number of suicide attempts was again increasing in Samoa, however the proportion resulting in death was only 47.6 per cent in 2003/04 compared with 60.5 per cent in 1999/2000 [22]. There is no data available on suicide among Samoans in Australia.

Mental illness prevalence data is available from New Zealand. The most recent New Zealand Mental Health Survey found[35]:

- 46.5 per cent of Pacific people had experienced a DSM-IV CIDI 3.0 mental disorder at some stage during their lifetime compared with 39.5 per cent of the overall New Zealand population
- during the preceding 12 months 25.0 per cent of Pacific people experienced a disorder compared with 20.7 per cent of the total New Zealand population
- the most commonly reported lifetime disorders were anxiety disorders (27.7 per cent),followed by mood disorders (19.0 per cent) and substance use disorders (17.7 per cent). Eating disorders among Pacific people were much less common over the lifetime (4.4 per cent).

Samoan people comprised 50 per cent of the Pacific respondents in this survey and therefore the results should be interpreted with caution.

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 in the focus groups, including the Samoan community leaders. Depression and stress were the most common issues discussed. One participant discussed the common perception that mental health issues only affect Western people:

> *"Depression – people that deal with stress, it can happen with anyone, part of self esteem. I didn't think island people were affected by depression, thought it was a 'palangi' disease. But I've learned more and it affects everyone at any age. Some people die of that, it can lead to suicide. Stress is also part of that."*– Samoan male

Suicide was not mentioned as a common occurrence in the Samoan community. All of the focus groups did however discuss the high levels of stress in Samoan families. In particular, intergenerational conflict was widely discussed. Four health service providers had observed mental illness 'often' among their Samoan clients; five 'sometimes'; and three 'never'.

5.5.2 Interpersonal violence

Abuse and steep power hierarchy within a community are recognised as risk factors to health and wellbeing.[21,30] Queensland and Australian data on the prevalence of interpersonal and domestic violence in the Samoan population are not available. National surveys such as the Personal Safety Survey (2005) are not reported by country of birth.

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

International data on interpersonal violence in Samoa are available from the World Health Organisation. The WHO Multi-country Study on Women's Health and Domestic Violence Against Women [36] interviewed a nationwide representative sample of 1640 women aged between 15 and 49 years. The main findings were:

- 41 per cent of ever-partnered women had experienced physical violence from an intimate partner
- 20 per cent had experienced sexual violence in their lifetime
- the combined prevalence for physical or sexual violence by a partner was 54 per cent. Violence was less common for women living in urban areas and with higher income levels.

Studies in New Zealand indicate that violence occurs at higher rates in the Pacific communities living there. A 2002 report by the New Zealand Police identified that 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 [37].

A Queensland report on a Samoan family violence project [38] reported multiple and complex cultural and societal issues related to interpersonal and family violence in the Queensland Samoan population. The key issues found were:

- Samoan perspective of domestic violence – domestic/family violence was perceived as mainly physical abuse while psychological, emotional, financial, social and sexual abuse were accepted as normal practices

- Samoan perspective of the law – the law was considered '*palagi*' (Western) by many whereas the Samoan spiritual and cultural values were considered the true laws to keep unity and peace in the community
- Migration and acculturation – the stressors and unrealistic expectations following migration were contributing to instability and uncertainty within families. Changes in family roles, financial pressures, lifestyle changes and other acculturative stress was a factor in arguments, fights and violence
- Help seeking in the Samoan community – the Samoan reluctance and fear to seek help was reported to be exacerbated by the fear to not lose face when needing help from a service provider. The main fear is rumours that may bring shame on an individual, family and community
- Background of harsh discipline in families and the community – there was a tradition of harsh discipline and punishment administered by chiefs, elders, teaches and parents. This background has influenced current practices and behaviours in the community.

Interpersonal violence was identified by three out of four focus groups with Samoan community members and leaders. Family violence, abuse and breakdown were openly discussed in the focus groups. The occurrence of sexual and physical abuse appeared to be known to participants, with women and children as the victims of this violence. One participant at a community focus group made the following comment, which the group agreed with:

> *"Sexual and physical abuse – should be added to the list. It is very common…mainly children and women. Samoans can take it for granted that this abuse is normal. It is neither normal nor acceptable. We don't talk about it…."* – Samoan female

These focus group findings are consistent with findings and observations in the earlier Queensland Health report on family violence in the community [38]. Three health service providers had observed violence 'often', six 'sometimes' and three 'never'.

5.6 Socioeconomic characteristics

5.6.1 Access to health services

The health system itself is a fundamental determinant of health.[39] The World Health Organisation has identified that in most countries the health care system is inequitably distributed. This is pronounced in low- and middle-income countries, but inequity is also prevalent in high income countries such as Australia. There is evidence that people from ethnic minorities and Indigenous peoples are less likely to receive recommended health services and treatments that the wider population can expect to receive[39]. Access to culturally appropriate health services is an important protective factor.[30]

Lack of culturally tailored health promotion

In focus groups with Samoan leaders and community members, many issues arose about access to the health system in Queensland. A strong theme throughout all of the focus groups was the lack of culturally tailored health promotion targeting the Samoan community. This was described as a lack of 'community education', lack of 'translated health resources' and lack of 'community awareness' of health campaigns.

Many further suggestions were provided for health promotion programs that the Samoan community has a need for:
- healthy eating
- interpersonal violence and sexual abuse
- consequences of alcohol and gambling
- mental health
- caring for sick relatives
- communication and importance of keeping appointments

Participants discussed the importance of incorporating cultural issues within community education programs, for example, food and its role in Samoan culture would have to be incorporated into a healthy eating program. This reflects people's personal experiences with programs that are not culturally competent and therefore experienced as inaccessible. This is congruent with the National Health and Medical Research Council's recommendations for more culturally competent health promotion.[40]

Lack of communication and engagement

The need for communication and engagement from Queensland Health was expressed particularly in relation to nutrition and interpersonal violence. There was also a strong sentiment that Queensland Health should promote services available to the Samoan community as many people were not aware of the services available. One participant at a community focus group who is a community leader discussed the language barriers many older Samoan Australians face:

> *"There's a free program for a hearing check and hearing aid. Does the Samoan community know about this? No, probably not. You meet a lot of older people and they shout because they can't hear you. They may not know about it…Three weeks ago there was a brochure in the mail box saying I could have a hearing check. I went today. Other elderly won't understand because the brochure was in English."* – Samoan male

The reluctance by the community to engage with health was also discussed by the community focus groups. Participants discussed many people's strong reliance on their church and the need to develop skills and confidence within families to take action on a wide range of health issues. It was perceived that engagement with health services, in addition to the church would be important for the Samoan community.

Communication barriers were also discussed in the focus groups. The need for more Samoan interpreters and the availability of on-site interpreters in particular were discussed.

Lack of dedicated Pacific Islander programs, services and staff

The unavailability of dedicated Pacific Islander services and programs featured in all the community focus groups. The need for dedicated services was particularly highlighted for issues related to social and personal wellbeing. Intergenerational conflict, violence, sexual abuse, family breakdown, polygamy, child safety and suicide were discussed in this context. It was felt that counselling would not work in the Samoan cultural context, but that community education, community engagement, culturally appropriate emotional support and a public dialogue in the community to 'air' and 'expose' these issues would all improve the current situation that people were concerned about. These would have to be conducted in the Samoan language and within a Samoan cultural setting.

Another strong theme was the lack of culturally appropriate health services and lack of dedicated Pacific health workers. The importance of being able to relate to a health or support worker was discussed, as well as the service being culturally relevant and appropriate. One focus group discussed the lack of a community controlled health service while another the lack of a connection point, a linking point, where Samoans could go for help, information and referral. All of the focus groups expressed the notion of '*for Samoan by Samoan*'.

There was widespread agreement across the focus groups that a culturally specific service was required. One participant summed it up:

> *"Need a connection point – a linking point – where you can go to get some help. Doesn't matter what it is – education or some other help. Just a place to go for help. One place is not sufficient for a whole community. There should be a lot of education. We need to be taught. We need that knowledge what mental health is for example. Need forums, community education. Community organisations can do that - delivered in our own language. Need a Samoan or PI worker to do this. Need a Samoan worker to link."* – Samoan female

However, in one community focus group there was also a debate about the Samoan strong preference for services from other Samoans. One participant challenged the group by stating:

"For some people their worse barrier is themselves, because they refuse to change. We came here to be educated and have a better life, but should we be asking for Samoan workers here, Samoan workers there. How would that be received by government?" - Samoan female

Lack of cultural competency in health services

Three focus groups discussed the lack of cultural competency in health services they had experienced. This ranged from the need to develop a policy on having visitors, training staff on Samoan health and cultural issues and training for front office staff. One focus group discussed the need for front counter/reception staff to have this training to reduce the amount of racial discrimination experienced by Samoans. The experience of racial discrimination is another risk to health and wellbeing [30]. The main effect of front end social discrimination is that Samoans may become reluctant to access services and thereby put their health at risk. Other effects include the lack of trust and confidence in the system and its workers.

The survey with health service providers also identified a range of barriers to access – most are congruent with the community and leader focus group results. Health service providers identified, in descending order, lack of engagement between health services and the Samoan community, the marginalisation and isolation of the community, the lack of Samoan health workers, lack of cultural competency, lack of dedicated Samoan services, economic barriers and reliance on the church. More than three-quarters of health service providers also observed language barriers, literacy barriers and non-attendance or drop-out within their respective services.

There is overall consistency in the barriers to access identified by the Samoan community members and leaders, and health service providers.

5.6.2 Income, employment and education

Poverty and low social status are risk factors to health and wellbeing while supportive economic and social conditions, income, wealth, employment and education are protective factors [21,30].

At the time of the 2006 Census, the median individual weekly income for the Samoa-born in Australia aged 15 years and over was $450, compared with $431 for all overseas-born and $488 for all Australia-born [6]. Although the weekly income difference did not appear to be considerable, it should be noted that Samoan family composition is more likely to comprise of a couple with children or a single adult with children than the wider population. For example, in Victoria 18.7 per cent of the population lives in a family with no children, while only 10.2 per cent of Samoa-born live in such a family. Similarly, 64.1 per cent of Samoa-born lived in a family with children compared to 47.9 per cent of the total Victorian population.

Samoa-born people in Queensland were highly represented in the middle to lower income brackets, and poorly represented in the high income brackets in the 2006 Census.

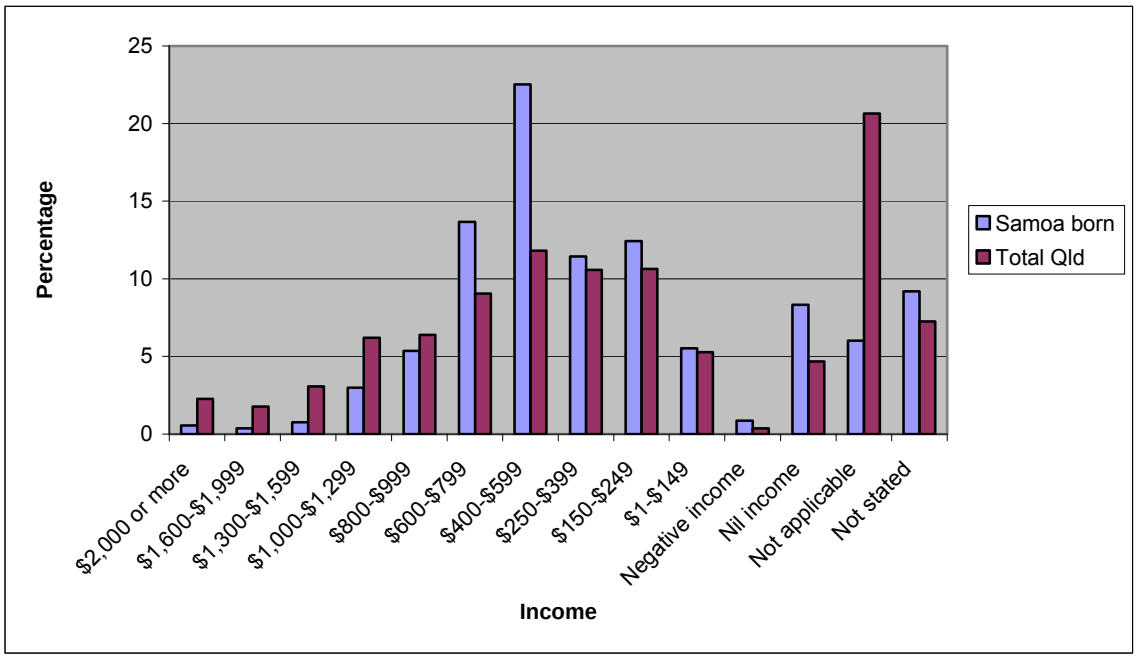


Figure 7 Individual weekly income all Queensland and Samoa-born persons, 2006

The 2006 Census also found that Samoa-born in Australia had a lower level of educational qualifications than the whole population. For example, 35.2 per cent of the Samoa-born aged 15 years and over had some form of higher non school qualifications compared to 52.5 per cent of the Australian population. Among the Samoa-born, 7.7 per cent had Diploma level or higher qualifications and 11.1 per cent had Certificate level qualifications. From the Samoa-born, 9020 had no higher non school qualification, of which 6.4 per cent were still attending an educational institution.

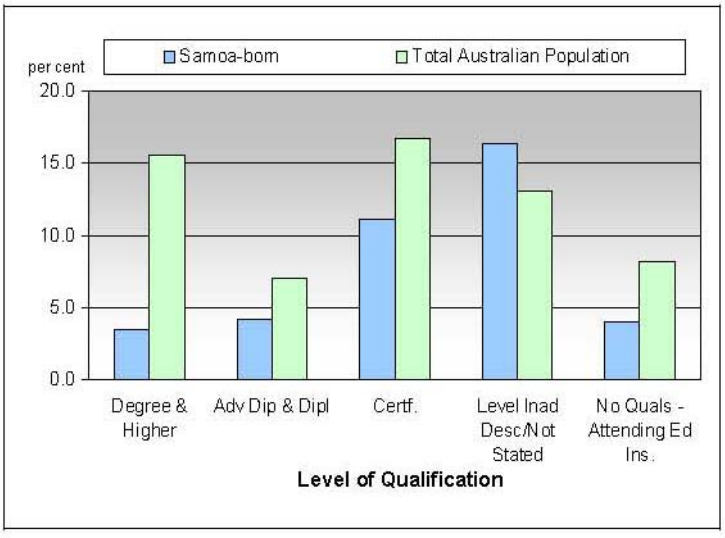


Figure 8 Level of qualification all Australia and Samoa-born, 2006 [6]

Among Samoa-born people in Australia aged 15 years and over, the participation rate in the labour force was 63.6 per cent and the unemployment rate was 9.4 per cent. The corresponding rates in the total Australian population were 64.6 and 5.2 per cent respectively.

An examination of the Samoa-born and total Queensland occupational categories in the 2006 Census indicates that Samoa-born hold less skilled occupations than total Queensland. There is a congregation of Samoa-born in the 'labourers' and 'operators and drivers' categories and an under representation in 'managers' and 'professionals'.

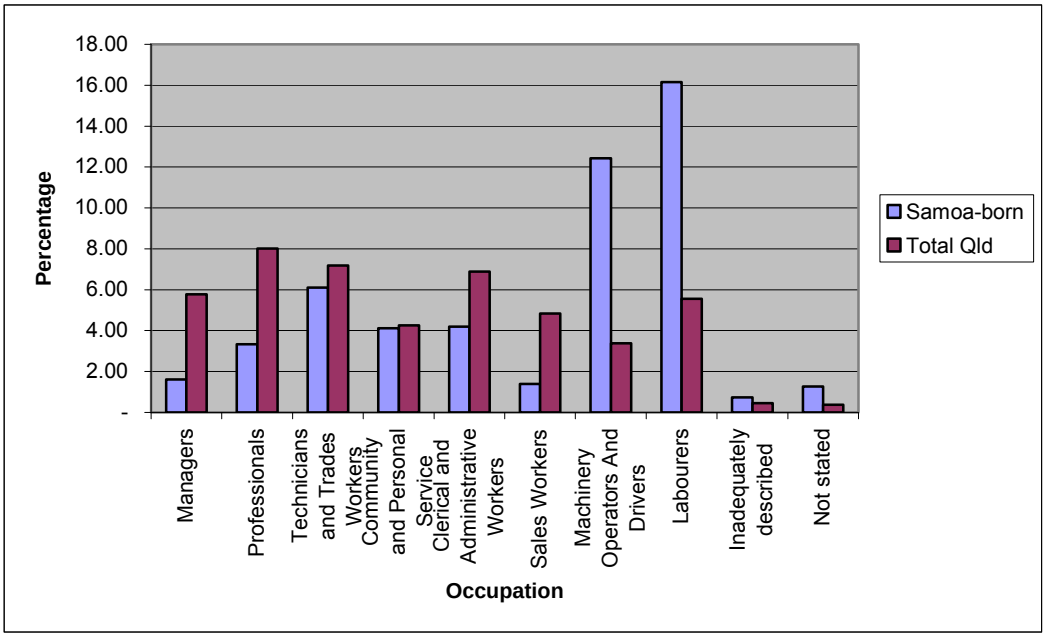


Figure 9 Occupation all Queensland and Samoa-born persons, 2006
Note: the 'not applicable' category has not been included in this figure

All of the focus groups discussed Samoan people's economic barriers to lead healthy lives, work in healthy environments, and access the medications and services they require. Unemployment and under-employment have placed financial hardship on families. It was discussed that young people are often encouraged to enter employment rather than university or higher studies, in order to bring money into the family budget. It is clear from the focus groups that the Samoan community does not have access to large amounts of financial resources. Families often send money to relatives in Samoa and spend money on attending family and community events. These are important cultural practices that promote connection and support.

The economic and educational situation of the Samoan community is exacerbated by ineligibility for the Higher Education Loan Program (HELP) and other forms of income support to those who entered Australia after 2001 from New Zealand. This ineligibility affects the majority of the Samoan community in Queensland.

At two community focus groups it was also discussed that sometimes people feel obliged to donate to their church, beyond their capacity. This brought additional stress and burden. The complex cultural issues related to belonging and support appeared to be related to this over-extension of financial capacity. For example, one participant said:

> *"Sometimes the support system is what is weighing down on you – our various churches. We feel that we have to give – we give beyond our means – it puts financial strains…Church doesn't force us to give – but parents and family tell them to give. Need to educate the people, don't feel forced but give from your heart." -Samoan female*

The finding is validated by a similar finding reported by the Samoan violence prevention project that remittance back to Samoa (or New Zealand),church donations and the cultural obligation to help others has an impact on families and health.[38] Similarly, the health service provider telephone survey revealed that clinicians working with Samoan children in school settings frequently observed children living in poverty without resources for school equipment, shoes, lunch and excursions.

5.6.3 Family and neighbourhood

Family and in particular, marital status is an important protective factor. Married people tend to be healthier and live longer than those who are unmarried. Research also shows that children and young people in lone-parent households have poor health status than those in two-parent households. This appears to be due to material disadvantage, rather than the family structure itself [21].

Queensland Census data indicate that 7.93 per cent of Samoa-born people identified as being a lone parent, compared to 4.21 per cent of the total Queensland population. Similarly, 2006 Victorian data indicates that 17.6 per cent of Samoa-born lived in a one parent family compared to 10.5 per cent of the total population.

Qualitative data indicate that *aiga* or family, community and church are the foundation of Samoan culture in Australia [38]. The church in particular has replaced the village support structure in host countries such as Australia and New Zealand.

In the focus groups many family issues emerged. Young people spoke of growing up with unreasonable expectations, being pressured to perform well, being burdened with too much responsibility at a young age, and having inadequate supports available. They also discussed the paradox of being burdened by their support system – the church and the family. A young woman at a community focus group said:

> *"Sometimes it's the comparison between the kids – why aren't you successful like them? There's pressure and expectations. Even the good things should be acknowledged. We are pushed too hard by parents…pushed beyond capacity. Sometimes you blame yourself, and want to protect the family from shame… Suicide is very complex; we cannot find the correct words to explain it. Within a family we really need to know each other and each other's needs."*

Participants also discussed the intergenerational gap within families, with children and parents having poor communication and understanding of each other's needs. The difficulty of raising children in a different cultural environment with different values dominated discussions among parents and the challenges of living a bicultural life was discussed by young participants. A young participant at a community focus group said:

> *"You grow up in a Samoan family where what dad says is it. Your opinion doesn't matter, you are not asked. It's easy to say you understand but hard to achieve. We need to discuss these things in an open forum like this. Some families can't sit down and talk. There is awkwardness between the parents and kids."* –young Samoan female

Older participants also agreed that the intergenerational gap within most families was a cause for concern. One older participant said:

> *"There's a lack of family connectedness – when children reach out for help it isn't always there, particularly because of selfishness by the fathers…"* - Samoan male

Participants at one community focus group debated the effectiveness of sending 'problem children' back to Samoa to be 'sorted out' by relatives and friends. Some felt this was a successful strategy that provided a cultural and village connection and a break from damaging influences such as drugs, while others felt this was running away from the problem and that parents should take greater responsibility.

Family and community matters were not specifically discussed in the survey with health service providers. However, a number of health service providers had observed young children taking on responsibility for their parents' and other relatives' health issues, such as injecting insulin and organising health appointments. Health service providers working with young people had observed young people's powerlessness and inability to communicate their issues to their parents/carers. They also observed young people needing to hide Western approaches to health care from their parents, who subscribed to traditional methods only. The results from the community focus groups and health service provider survey are congruent indicating an intergenerational and cultural divide between adults and children, high reliance on churches and high levels of familial stress.

There is increasing evidence that neighbourhoods affect health, particularly children's health [20,41]. As a result of lower socioeconomic resources children from ethnic minority populations in particular have limited access to neighbourhoods with opportunities such as good schools and after-school programs, safe streets and play-grounds and positive role models. After taking into account individual-level factors, disadvantaged neighbourhoods are associated with detrimental health outcomes, negative health behaviour, developmental delays, low birth weight, teen parenthood and academic failure for young people and higher rates of mortality, depression, cancer and cardiovascular disease for whole populations [41,42].

In the community and leader focus groups, the neighbourhood environment was not specifically discussed. However, in the health service provider survey, the neighbourhood environment was mentioned. In particular, health service providers working in deprived areas such as Inala-Goodna region and Woodridge discussed their lack of referral options, the lack of community infrastructure and resources, overcrowded housing conditions and the high level of police presence necessary in the neighbourhood and high schools in the area. Three health service providers identified a lack of family support as a major problem to working with Samoan patients.

Transport barriers were only discussed in one focus group and it was recommended that a community transport service be provided to help with access to health services. Australian literature linking social exclusion and transport disadvantage is growing and focussed on socially excluded communities living in the outer urban fringes of cities and in regional and rural areas [43-46]. This is therefore a pertinent issue for the Samoan population, which is concentrated in the outer urban fringes.

A recent Melbourne study[43] found that socially excluded populations living in the outer fringes of Melbourne were more likely to be 'forced car ownership' users rather than 'zero car ownership'. There was evidence of financial stress associated with owning and running cars in 'forced car ownership' households. These households also operated smaller and older cars than other households. There are no Australian data on transport disadvantage in the Samoan population. However, the Samoan population is socially excluded and lives in the outer city areas and therefore may experience the stressors outlined in the Melbourne study.

5.6.4 Housing

Housing conditions are recognised as a factor affecting health and wellbeing.[21] Poor housing and ill health are linked.[47] In particular, there is an increasing body of evidence associating housing quality with infectious diseases, chronic illnesses, injuries, poor nutrition and mental disorders.[48] There is also a relationship between health and whether a family lives in owner-occupied housing, privately rented housing or public housing.[49]

In Victoria, Samoa-born people have lower rates of home ownership and higher rates of renting accommodation than the wider population:

Table 7 Housing tenure all Victoria and Samoa-born persons (Vic), 2006 [50]

Tenure type	*Per cent of all Samoa-born (Vic)*	*Per cent of all Victoria population*
Fully owned	4.3	30.1
Being purchased	33.2	39.8
Rented & rent free	53.5	21.1
Other	0.6	0.5
Not stated	7.4	5.8
Not applicable	1.0	2.7

New Zealand housing data indicate that the Pacific populations have the most crowded housing conditions.[47] Pacific populations are also most likely to live in multi-family households and have the largest household sizes.[51]

Housing issues did not arise in the community focus groups. Only in one community focus group did participants discuss the limitations to being able to set up Samoan gardens due to the majority of Samoans

renting their homes. A community garden was recommended. Housing issues arose as secondary issues in the health service provider survey. It was observed that some Samoan families live in overcrowded housing conditions, sometimes with several families living in one house. This is consistent with New Zealand data. These health service providers had observed skin infections in Samoan children and young people that are commonly seen in developing countries among those who live in overcrowded conditions with poor sanitation and hygiene.

5.7 Knowledge, attitudes and beliefs

5.7.1 Health literacy

The National Preventative Health Taskforce recognises that knowledge, attitudes and beliefs are important factors in the health of individuals and populations.[20] Health literacy refers to the knowledge and skills required to understand and use information relating to health issues such as drugs and alcohol, disease prevention and treatment, safety and accident prevention, first aid, emergencies, and staying healthy [3]. Health literacy is particularly important to understanding the health of immigrant populations, as education and health literacy have an integral relationship with the overall health of a society's population, as well as inequalities within the population.[3]

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

The ALLS found particular factors influenced people's health literacy. These included education, occupation, parental characteristics, and English as a second language. Only 26 per cent of those born in a mainly non-English speaking country achieved Level three or above.

Focus groups with Samoan community members and leaders found very poor health literacy among the Samoan community in Queensland. Leaders and community members provided many anecdotes that described people's low knowledge of health issues and services. One participant at a community focus group despaired about people's lack of knowledge about health and health services and the unnecessary suffering she had observed in her community:

> *"Epilepsy – we are so used to not having any medication for this that people don't necessarily go out to look for medical advice. Because people are cared for by their family and that's all they know."* - Samoan female

Participants at one community focus groups discussed people's lack of understanding of basic mental health issues and denial that such issues affect people in the Samoan community. One participant summed it up in this way:

> *"Mental health – it is a problem but we don't take it seriously. We don't think we are affected by it. We don't understand what it is. The high rate of suicide and depression is being recognised in Samoa. But traditionally we ignore it. We need some form of education. Need qualified people to deal with it. We need some sort of educational program." – Samoan male*

The low levels of knowledge about health and services were related to poor system navigation skills in the community. Many examples were provided of people not knowing how to access services, or even knowing the existence of services. It is clear from these focus groups that the Samoan community is disengaged from the mainstream service sector. Many people are closely engaged with their church and there is a strong reliance on the church for assistance and support. One participant at a community focus group expressed her distress at the level of isolation and suffering that could be prevented:

> *"I recently heard of two Samoan mothers keeping their daughters at home with schizophrenia with no help at all. Only recently it has come out through the GP that there's help available. We need a worker right there to help and connect. We are too shy to ask, we don't ask for help, or know what to ask for. It is hard enough to walk into Centrelink. Our people don't ask. Sometimes it's shyness and sometimes its*

pride too. We need to encourage them to come out. The mother said to me – if only they knew who to turn to for help, or where to go. It is very sad. They didn't know where to go."
– Samoan female

The findings of the focus groups are consistent with the findings of 2006 ALLS and the survey with health service providers.

The survey with health service providers specifically asked clinicians if they had observed barriers for Samoan clients in using their health services such as language barriers, literacy or understanding of hand-outs, pamphlets or instructions. Of the 12 interviewed, 9 had observed both language barriers and barriers in Samoan clients understanding hand-outs, pamphlets or instructions. Only three health service providers had not observed this among Samoan clients. Of the three health service providers who had not observed this, one always used interpreters and observed this reduced the barriers; one had seen such few Samoan clients that these observations were not possible; and the third had not observed this among Samoan clients.

Among those who had observed barriers related to health literacy for their Samoan clients, some of the most pertinent factors were:

- 75 per cent of Samoan clients have literacy problems
- Samoan community is very marginalised
- Lack of dedicated Samoan staff and programs to reduce the barriers
- Low level of understanding, even if resources are translated. Difficult to transfer information as it is difficult to relate to the person (cultural differences)
- Lack of appropriate system navigation – only come in when crisis has occurred
- Lack of insight into importance of health, attending appointments, undergoing tests, importance of catching problems early and not waiting for health crisis.

These findings are consistent with those of the community and leader focus groups.

5.7.2 Help seeking behaviour

Attitudes and belief systems affect health and health choices. Cultural values and world views also influence health and health choices.[52,53]

Internationally it has been 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 Western medicine, especially preventive health services [53]. Minor health issues are often expected to be cared for within the family or social unit and Western medicine only if emergency care if required. Once in the health system though, the health care provider is seen as wise and authoritative. There are differing perspectives of the use of the health care system:

Western health care workers, with their emphasis on prevention, often have difficulty coping effectively with Samoans in a health care setting because of what they may perceive as a lack of regard for preventive health care. However, Samoans tend to regard the authority of a doctor with great respect and do not want their doctor to waiver on treatment decisions. [53]

Internationally it is observed that Samoan people have problematic access to Western medical care, except for emergency care and that there is a general mistrust of the medical system.[53]

The leader and community focus groups also discussed the community's apparent cultural reluctance to seek help, with people waiting until their health situation was very bad before seeking help. It was discussed that Samoans were generally reserved, shy and ashamed to seek assistance and services and this was one of the primary factors in the communication barrier. 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 to most things. Secondly, the cost of medical care and treatment is prohibitive and exacerbates people's reluctance to seek help. 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 deal with appointments alone, once again exacerbating their reluctance to go. One Samoan leader explained the problem:

> *"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

This experience is consistent with overseas experiences indicating that minority ethnic communities require health system navigators to facilitate equal access to the health care system. The health system navigators perform a range of tasks including appointment making, support to attend appointments, follow up and coordination of care, family involvement and communication, arranging paperwork and interpreters and conducting community outreach. These duties help patients overcome numerous structural and cultural barriers, thereby promoting timely and comprehensive screening, diagnosis and treatment.[53]

The health service provider survey also identified people's tendency to come in only during a crisis. It was also observed by half of the health service providers that there is a lack of trust between the community and health services and five had observed the community as very marginalised. This impacts on help seeking behaviour.

6 Health outcomes

6.1 Cancer

Cancer is not just one disease, but a diverse group of diseases. Although there are many types of cancer, they all start because abnormal cells grow out of control. Cancers were the leading cause of the burden of disease and injury in Queensland in 2006, causing 18.9 per cent of the total burden of premature death and disability. Lung, colorectal, breast and prostate cancers caused half the cancer burden (49.2 per cent) .[27]

The standardised hospital separation ratio for all cancers excluding non-melanocytic skin cancers (July 2006 to June 2008) for Samoa-born Queenslanders was lower than that of all Queenslanders (Figure 10).

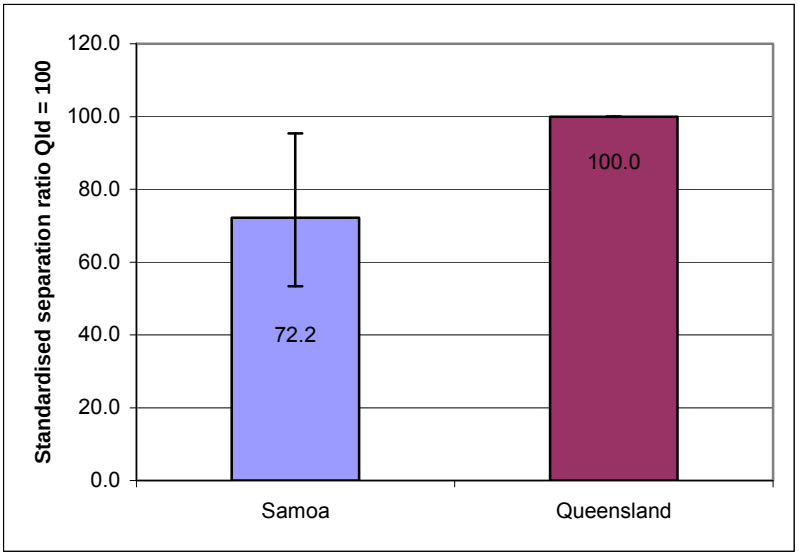


Figure 10 All cancers (excluding non-melanocytic skin cancers) standardised hospital separation ratio all Queensland and Samoa-born persons July 2006 to June 2008

Prevalence and trends in all types of cancer by Australia and Samoa-born Queenslanders are found in Table 9. In the six years from 2000 to 2006, there was an increase in cancer incidence for Australian-born Queenslanders of 22.4 per cent compared to 100 per cent for Samoa-born Queenslanders. However, it should be noted that cancer incidence (the number of new cases in a given period) are very small for Samoa-born Queenslanders and therefore any change in the number of cases has the potential to cause large increases or decreases in 'percentage change' figures. Also, due to the very small number of cases, no conclusions can be made.

Table 8 Cancer incidence by Australia and Samoa country of birth 2000-2006

Country of birth	Year				
	2000	2002	2004	2006	Percentage change 2000-06
Australia	11850	12799	13471	14507	22.4
Samoa	10	19	13	20	100

(Source: Cancer Registry, Queensland)

6.2 Cardiovascular disease

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

Coronary heart disease (heart attack and angina)

There was no difference in the standardised hospital separation ratio for coronary heart disease (July 2006 to June 2008) for Samoa-born Queenslanders (121.5) and total Queenslanders.

This result should however be noted in the context of the significantly higher ratios for diabetes (three times higher) and diabetes complications (seven times higher). As diabetes increases the risk for CHD, this similar ratio for CHD should not be discounted due to statistical insignificance. It is likely to indicate a health inequality.

Stroke

There was no difference in the standardised hospital separation ratio for stroke (150.8) for Samoa-born Queenslanders compared to all Queenslanders (100) for the period July 2006 to June 2008.

6.3 Diabetes

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

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

The standardised hospital separation ratio for diabetes, for Queensland's Samoa-born population compared to all Queenslanders (July 2006 to June 2008), is presented in Figure 11. Samoa-born Queenslanders had a ratio three times higher than the corresponding ratio for all Queenslanders.

The standardised hospital separation ratio for diabetes complications for the same period is presented in Figure 12. Samoa-born Queenslanders had a ratio more than seven times higher than the Queensland ratio (100). This ratio was not the result of frequent hospital visits by a small number of renal dialysis patients.

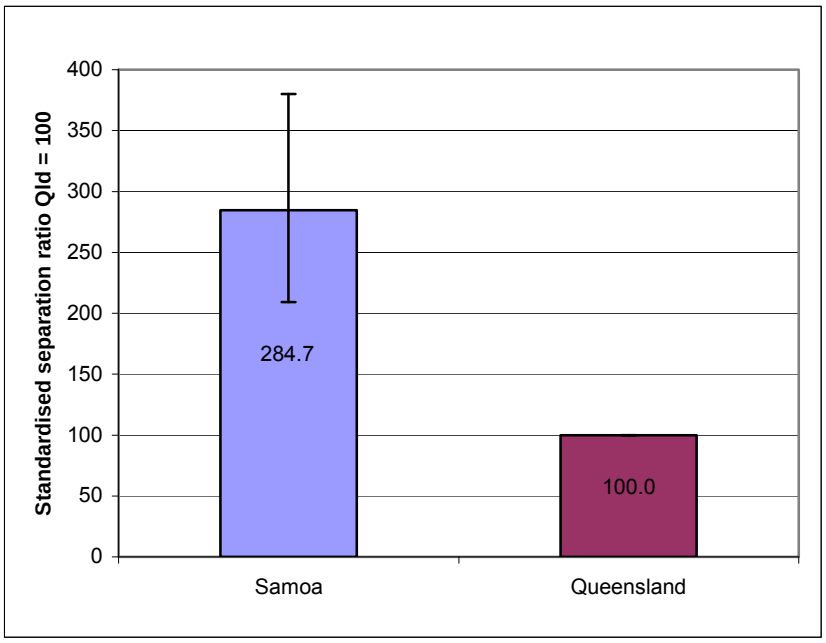


Figure 11 Diabetes standardised hospital separation ratio all Queensland and Samoa-born persons July 2006 to June 2008

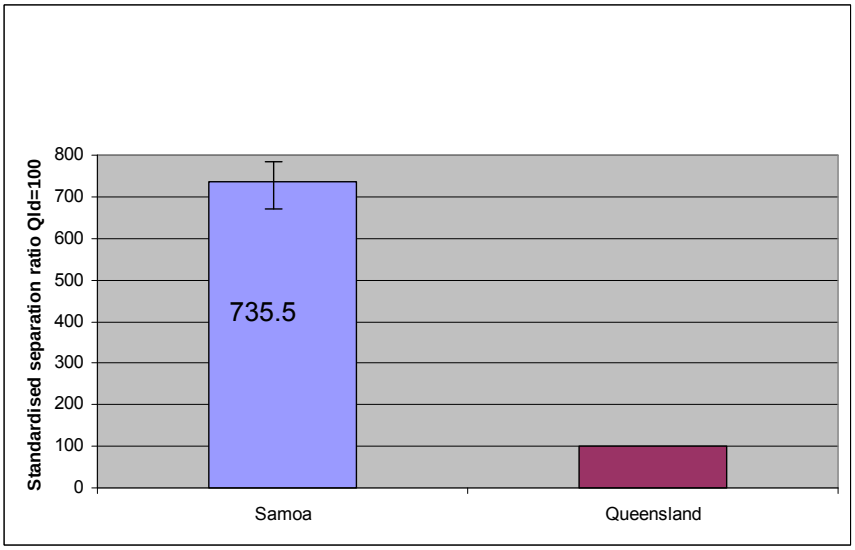


Figure 12 Diabetes standardised hospital separation ratio all Queensland and Samoa-born persons July 2006 to June 2008

6.4 Mental health

Mental health is the ability for people to interact with one another and the environment, in ways that promote subjective wellbeing, optimal development and the use of cognitive, affective and relational abilities. An individual's mental health is derived from their genetic makeup and general life circumstances, including their social, economic and environmental situation. Mental health problems and mental disorders refer to the spectrum of cognitive, emotional and behavioural disorders that interfere with the lives and productivity of people [54].

Queensland Health mental health service data by country of birth were unavailable 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, although caution should be exercised with interpreting this data in isolation. In July 2008 Samoa-born consumers were ranked 19th out of birthplace groups using mental health services in Queensland. Samoa was ranked 27th out of all birthplace groups in Queensland in the 2006 Census. This could indicate a higher use of mental health services than what would be expected, based on population size.

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

The New Zealand Mental Health Survey reports ethnic groups classified as Māori, Pacific and other. Of all Pacific people who took part in the latest survey, 49.2 per cent were Samoan. It was found that Pacific people experienced mental disorders at higher levels than the general population. The prevalence of disorder in any period was found to be higher for Māori and Pacific people than for the 'other' composite ethnic group. For disorder in the past 12 months, prevalence was 29.5 per cent for Māori, 24.4 per cent for Pacific people and 19.3 per cent for others, which indicates that Māori and Pacific people have a greater mental health burden. It was concluded that much of this burden appears to be due to the youthfulness of the Māori and Pacific populations and their relative socioeconomic disadvantage [35]. Although no conclusions can be drawn from a survey in which 50 per cent of respondents were Samoan, in the absence of a Samoan population health survey, it is the best available data.

Higher prevalence of suicide, suicide plans and suicide attempts were also reported for Pacific people compared to 'other'. This is congruent with data from Samoa which indicates Samoa has one of the highest youth suicide rates in the world.[22,34] Australian suicide data by ethnicity are not available.

6.5 Respiratory disease

Asthma

Asthma is a chronic disease characterised by recurrent attacks of breathlessness and wheezing, which vary in severity and frequency from person to person. While the cause of asthma is unknown, there are factors that may increase the risk of developing the condition, including environmental exposures such as tobacco smoke, specific allergens, lack of physical activity and stressful life events[19].

For the period July 2006 to June 2008, there was no difference in the standardised hospital separation ratio for asthma for Samoa-born Queenslanders (117.5) compared to all Queenslanders.

Chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease (COPD) is a specific health condition which affects the lungs. It is characterised by a persistent blockage of airflow from the lung and can be life threatening. The condition cannot be reversed. The main form of COPD is emphysema. The main cause of COPD is tobacco smoking[19].

Figure 14 presents the standardised hospital separation ratio for COPD, for Samoa-born Queenslanders compared to all Queenslanders, during the period July 2006 to June 2008. Samoa-born Queenslanders had a ratio of 229.4 per cent which was more than double the ratio for all Queenslanders.

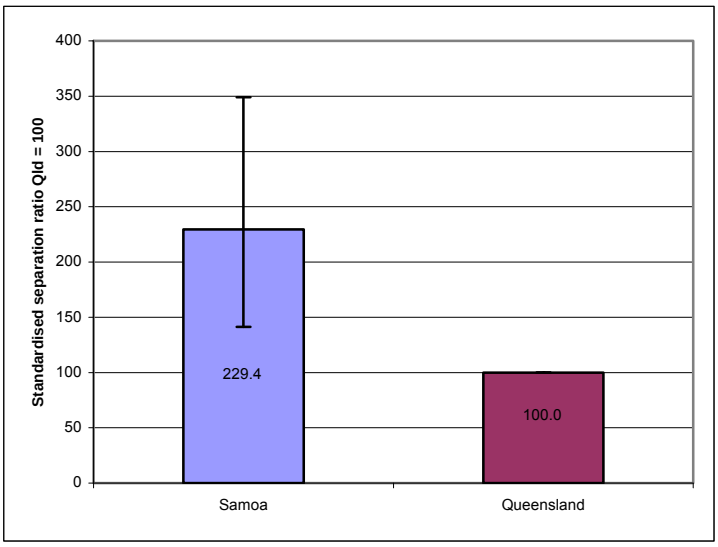


Figure 13 COPD standardised hospital separation ratio all Queensland and Samoa-born persons July 2006 and June 2008

6.6 External causes

Injury resulting from an external cause

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

While deaths from injury have declined, rates of hospitalisation for many injuries have increased over the past decade, in particular, fire, burns and scald injury in young children, and fall related injuries in older people[19].

For the period July 2006 to June 2008, there was no difference in the standardised hospital separation ratio for external causes for Samoa-born Queenslanders (91.9) compared to all Queenslanders.

6.7 Musculoskeletal disease

Musculoskeletal conditions include arthritis and other joint problems, and disorders of the bones, muscles and their attachments to each other. Arthritis and musculoskeletal conditions are the world's most common cause of severe, long term pain and physical disability[19].

For the period July 2006 to June 2008, the standardised hospital separation ratio for musculoskeletal disease for Samoa-born Queenslanders, was lower (72.9) than all Queenslanders (100).

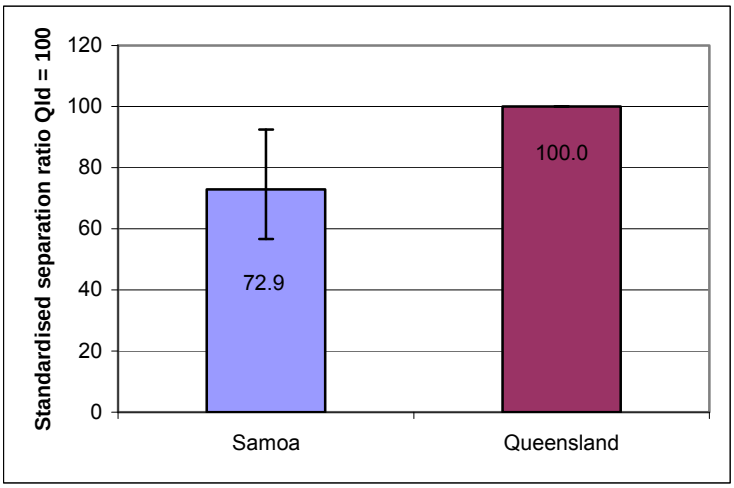


Figure 14 Musculoskeletal disease standardised hospital separation ratio all Queensland and Samoa-born persons July 2006 and June 2008

6.8 Communicable disease

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

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

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

7 The way forward to improve Samoan health

The health experiences and needs of people in the Samoan community in Queensland are largely similar to those of other Pacific Islander communities.

The chronic disease burden is high with higher all cause and avoidable mortality rates. Hospital separation rates were more than seven times the ratio for diabetes complications, almost three times for diabetes and more than double for COPD. Mental health snap-shot data also suggests that the burden of mental illness could be higher among the Samoa-born. This data was supported by four focus groups which identified diabetes, mental illness, asthma and obesity as the health priorities in the Samoan community. The other main issues raised in the focus groups included lack of culturally tailored health promotion, economic and communication barriers to health, cultural reluctance to seek help and low health literacy. To improve Samoan health in Queensland, all four focus groups recommended culturally tailored health promotion, dedicated Pacific Islander health workers and training, scholarships and up-skilling programs to access health jobs.

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

Attachment 1 - Data and methodology

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

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

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

Hospital separation data were derived from the Queensland Hospital Admitted Patient Data Collection, including private and public hospitals. All disease specific hospital separations were derived using the principal diagnosis of inpatient episodes of care. All separations were coded using the International Classification of Diseases version 10 Clinical Modification (ICD-10-CM) using standard code sets.[55]

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

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

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

Attachment 2 – Focus group prompting points (community members)

1. Arrival and refreshments (30 mins)

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

Traditional welcome and Aboriginal and Torres Strait Islander acknowledgement

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

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

Does anyone have any questions before we start?

3. Introductions (15 mins)

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

4. Health priorities from community perspective (20 mins)

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

<u>What are the issues with the health system common in our community?</u>
- what about health promotion campaigns?
- what about community health services?
- what about hospital services?

5. Present literature review (15 mins)

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

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

6. Present leaders' responses (15 mins)

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

<u>What do you think about what your leaders said? Do you agree?</u>

7. Strategies to address health needs (30 mins)

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

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

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

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

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

8. Summing up (15 mins)

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

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

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

9. Finish

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

Attachment 3 – Focus group prompting points (community leaders)

1. Arrival and refreshments (30 mins)

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

Traditional opening and Aboriginal and Torres Strait Islander acknowledgement

Introductions (name and community)

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

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

Does anyone have any questions before we start?

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

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

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

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

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

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

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

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

Please answer the following questions:

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

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

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

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

Please advise us what Queensland Health could do to:

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

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

Please present your small group work. Please tell us:

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

8. Finish

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

Traditional close

Attachment 4 – Summary of focus group results

Four focus groups involving 45 people were held– six Samoan leaders participated in the leaders' focus group in Brisbane, and 39 community members attended three focus groups in Marsden and Deception Bay.

Across all focus groups, the following health conditions were identified as being prevalent in the Samoan community in Queensland.

Identified by all four focus groups	Identified by three focus groups	Identified by two focus groups	Identified by one focus group
Diabetes (type 2) Coronary heart disease Mental illness Asthma Obesity Cancer Gout	Violence and abuse Arthritis Epilepsy	Gambling Sexual health including STIs & abortion Migraine Ulcers Alcohol and drug abuse Ear infection Dental health Gallstones Aged care	Tuberculosis Disability Smoking Muscle tension Snoring Work injuries Skin conditions Glaucoma Spinal injuries Cellulitis Eye infection Lupus Circumcision Pneumonia Menstrual pain Bladder infection Stroke Cramps Iron deficiency Hay fever

The focus groups were also asked to comment on the Queensland health system and the interaction between Samoans and the health system. Many barriers and problems were identified. These are summarised below:

Identified by all four focus groups	Identified by three focus groups	Identified by two focus groups	Identified by one focus group
Lack of culturally tailored health promotion Economic barriers to health Cultural reluctance to seek help Low health literacy Communication barriers	Lack of Pacific dedicated programs and services Lack of community engagement Lack of cultural competency in services	Lack of Pacific health workers General dissatisfaction (waiting times)	Discrimination

Finally, focus group participants were asked to make recommendations or suggest strategies for remedying the problems identified. These are summarised below:

Identified by all four focus groups	Identified by three focus groups	Identified by two focus groups	Identified by one focus group
Culturally tailored health promotion Dedicated Pacific Islander health workers Training, scholarships and upskilling programs	Dedicated Pacific programs and services Pacific Health Centre Interpreter services (need more Samoan interpreters)	Community capacity building	Community engagement Increase cultural competency in services Reduce economic barriers Reduce physical barriers (transport services)

Attachment 5 - Results of survey of health service providers

Health service providers were asked to comment on whether barriers are experienced by Samoan clients in their service; whether they had experienced any difficulties or challenges working with Samoan clients; to rate the frequency they had observed particular health conditions among their Samoan clients (health conditions identified from the literature review); and to suggest the most important health priorities and strategies to improve Samoan health.

The following summary table presents the results of the questionnaire:

Question	response	
	Yes	No
Do you see Samoan patients in your service?	12	0
In your observation, do Samoan patients experience: - language barriers?	9	3
-problems of literacy	9	3
-non-attendance or drop out of using service?	12	0
Do you experience any difficulties or challenges in: -communication?	9	3
-cultural understanding?	10	2
-developing rapport or engagement?	10	2

Please rate the frequency you have observed the following issues:	often	some-times	never
Diabetes	9	1	2
Cardiovascular disease	8	2	2
Obesity	10	1	1
Asthma	0	6	6
Family violence	3	6	3
Sexually transmitted infections	1	2	9
Drug and alcohol abuse	2	9	1
Gambling addiction	0	3	8
Mental illness	4	5	3

Major health priorities and problems identified	Frequency
No trust/ engagement	6
Very marginalised people and community	6
No Pacific Islander workers to work with	3
Nutrition issues	3
No family support	3
Lack mainstream worker understanding	3
No dedicated services – 'forgotten people'	2
Economic disadvantage	2
Domestic violence	2
Influence of church	2
Very poor compliance	2
Diabetes	2
Mental health	2
Child protection & neglect	1
Sexual health	1
Skin disorders	1
Health low priority	1
Cardiovascular disease	1
Obesity	1

Strategies identified by health service providers to address health priorities	Frequency
Pacific Islander workers	6
Need Pacific Islander services in community setting like A&TSI services	5
Culturally appropriate interventions	3
Health promotion/education	2
Family support services	1
Girls support	1
Youth services in economically disadvantages areas	1
Samoan resources	1

Attachment 6 – Standards for Statistics on Cultural and Language Diversity

The Australian Bureau of Statistics Statistical Concepts Library provides authoritative information about the concepts, sources, methods and classifications underlying Australian official statistics. The *Standards for Statistics on Cultural and Language Diversity* [56] identifies three 'minimum core set' items that measure cultural and linguistic diversity (CALD) and an additional eight standard indicators.

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

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

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

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

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