

The experiences of Queensland *Maori, Pasifika* families and Child Health Service providers in child health service delivery: An exploration of why the lack of uptake of services

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*A Samoan proverb that springs to mind: “E so’o le fau ile fau- each thread derives its’ strength from being interwoven with others to create a strong fine mat” (Winnie Laban, NZ first Pacific woman MP). Metaphorically speaking it is compelling to appreciate in awe of each thread of strengths woven together to construct a mat (platform) for Queensland Maori Pacific Island Families as they sit and talanoa about relevant and culturally safe health service delivery*

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**Talanoa or Getting people to open up**

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## Abstract

A Queensland Health report identified Maori and Pacific Island groups in Queensland as vulnerable groups due to social disadvantage. The application of a contextual framework to analyse literature was undertaken, and one key identified deficit and inequity among Maori and Pacific Island communities in Queensland is disengagement from child and family health services. Qualitative research was undertaken to explore this issue drawing on a theoretical lens which combined Decolonization and Cultural Safety methodologies and *Talanoa* methods for data collection. Embracing a de-colonial lens, *talanoa* methods underpinned interviews that were conducted with twenty-nine Maori and Pacific Island Families in Townsville and eight Child Health Service Providers in Brisbane and Townsville.

The theoretical tool of Charmaz's constructivist grounded theory underpinned data analysis. During data collection and analysis, evolving understanding of theory is constructed through reflection and critical inquiry. Charmaz work on constructivist grounded theory thus aligned with *Talanoa* methods as the mechanism for data generation and analysis whereby data is interpreted and constructs knowledge because of meaningful interactions during *talanoa* with study participants.

Key categories pertaining to power and cultural dynamics, positionality and health inequities, identity versus cultural differences, deficit discourse and cultural disconnection depicted health service delivery to Queensland Maori and Pacific Island Families. The theoretical framework of cultural safety and decolonisation methodologies embraced a model on partnership and shifted the focus from service users (Maori and Pacific) to examine child health service providers' experiences in their work with Maori Pacific Island families. Data interpretation revealed misconceptions and a predisposition to assume that health care delivery that engaged a transcultural approach was culturally safe.



## Dedications

Most importantly I dedicate this thesis to my parents: my father, the late Punapa Erika (Erick) Veseaga, and my mother, the late Wani Erika (Erick) (nee Hoyte) Veseaga. They both passed away in 2009. Dad, I remembered your words as I wrote, sometimes late into the night.

### Fanau/Whanau



*“tagi e haaku a loto, he manatu e tau kupu haau ma Pa”.*

My tears are rolling when I remembered your words Pa.

*“tao e umu ke moho, ko ia ne fakamao ka moua e monuina”.*

In symbolic terms “when you bake food in oven, do it so it will cook properly”, meaning, when you do something, do it to the best of your ability towards completion and blessings.

*Monu Monu Tagaloo.*

*Hake ke pu he lagi likoliko*

*Hifo ke pu he lalo fonua*

*Tukulua siiiooohhhoooe*

*As I called out (tui-kalanga) the above chant of my ancestors (it is a Niuean cultural protocol), at a beginning of a journey to introduce oneself to other Maori and Pacific Island people; this is to provide information about one’s genealogical position, to make a link on cultural, spiritual, social and political grounds thereby relationships are developed.*

## Acknowledgement

Firstly, I give credit to our heavenly Father for his blessings, guidance, and strengths which had made it possible for me to complete this thesis.

Secondly, I would like to acknowledge the traditional custodians of the land in which this thesis was borne, developed, and originated, the Bindal and Wulgurukaba Clan in

Townsville. And we are not forgetting the help of original members of the Community

Reference Group (CRG) in this research, especially “Syd”, a Townsville-based Maori elder (*kaumatua*) who died in the third year of this research. I remembered Syd’s words of encouragement and belief in this research and that is to ensure that this research is completed so that Maori Pacific Island people in Townsville may “have a voice”. In addition, we are not forgetting to say *kia ora* and thank you to an ex-work colleague Kaye Hussey who acted as an intermediary person and initiated several appointments for interviews with Child Health Service Providers in Townsville.

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laid out in the university endorsed national 'Guidelines for editing research theses'.

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To all *fanau* (families/participants) that gave up your precious time to *talanoa* (talk) with me, I am forever indebted to your participation and your willingness to support this research. We hope that self-determination through relevant and culturally safe service provision to Maori Pacific Island people is not only possible but a necessity here in Australia. To each study participant from child health service providers in Townsville and Brisbane who despite being busy with work commitments but had voluntarily offered your time to speak (*talanoa*) with me; *Fakaue lahi*. I am grateful.

To my immediate family Theresa, Francesca, Antonio, Jonathan and Lemalu Salesio, thank you for your patience, understanding and support, as I juggled along in my journey to complete this work.

## **Key terms**

Child health, Decolonisation methodology, Cultural Safety, Talanoa methods, Researcher positionality, Trans-culturalism, Constructivist Grounded Theorist, Service delivery

## **Preface**

This thesis is an original, unpublished, and independent (*gahua*) work completed by the researcher.

Queensland University Technology Research Ethics Approval Number:  
1300000821

**Table 1: Acronyms**

AMS	Aboriginal Medical Services
CALD	Culturally and Linguistically Diverse
CHSP	Child Health Service Providers
CRG	Community Reference Group
GMSBML	Greater Metro South Brisbane Medicare Local
GIA	Grant in Aid
HELP	Higher Education Loan Program
HPV	Human Papilloma Virus
MPIF	Maori Pacific Island Families
MPI	Maori Pacific Island
NHMRC	National Health and Medical Research Council
NZ	New Zealand
PAR	Participatory Action Research
QUT	Queensland University Technology
RN	Registered Nurse
SGV	Special Category Visa
WHO	World Health Organization

**Table 2: Maori and Pacific Island Terms**

Tohunga	Blessed Maori carved necklace made from a greenstone
Fanau	Niuean family
Fakalilifuaga	Respect
Fa'afetai lava	Samoan Thank you
Fenoga	Journey
Fifine	Woman
Gahua	Work
Fakaotiaga he Fenoga	Arrival to destination of a Journey
Kehekehe-anga	Differences
Kau-fakalataha	Collaborative-ness
Hinengaro	Maori mental wellbeing



Hui	Maori meeting
Kaumatua	Maori Elder
Hekeaga he Fenoga	Actual travel of a Journey
Kaupapa Maori	Maori collaborative epistemological model
Siale Tafa	Niuean common pacific island flower
Tangata Whenua	Indigenous people of the land

Talanoa	Talking
Tatai- Oti	Common ground ideals
Tikanga	Maori protocol diligent to respect
Tao e umu ke moho	Niuean proverb “bake in oven to cook well”
Tinana	Maori is to achieve physical wellbeing

Tua-anga	Positionality
Tutala-aga	To tell a story
Wairua	Maori is to achieve spiritual wellbeing
Whanau ora	Maori is to develop and grow well
Tino Rangatiratanga	Maori is to achieve Sovereignty/ self determination
Hake ke pu he lagi	Reach out to the sky
Hifo ke pu he lalo fonua	Reach down to the earth
Tukulua Siiioohoe	Final Call to the Earth and to ancestors
Tino Rangatiratanga	Maori Sovereignty/ self determination
Faka-akoaga	Knowledge achieved through education
Faka-aoga	utilization
Takaalo	Drifter with no sense of belonging

Potu Laufa Lalaga/Kato lalaga	Woven Pandanus Mat/woven basket
Mamatua	Niuean Elders

Magafaoa	Niuean extended family
Maama-anga	Knowledge and expectations
Oue Tulou/tui- kalanga	Calling out in respect
Mahani fakatokolalo	respect
Kawawhakaruruhau	Maori Cultural Safety model
Kamataaga he Fenoga	Beginning of a journey
Ko ia ne fakamao	Niuean those that persist
Lagomatai	Help
Koha	Maori gift
Laumalie	Tongan in essence
Liogi	Niuean Prayer
Manatu e kupu he tau matua	Niuean remembering words of your ancestors
Mana	Maori Respect

Moui Olaola	Niuean Develop and grow well
Monu Tagaloa	Niuean Glory be to God
Monuina	Niuean Blessings
Koe tala fakatu	Poem
Fakalofa atu	To say hullo in Niuean
Mokopuna	Maori for grandchild
Kia ora	greetings in Maori

# CHAPTER ONE Introduction

## Beginning of and preparation for the journey: Koe Kamataaga he Fenoga

In recent years, the Maori Pacific Island population has increased significantly in Queensland,

Australia (Australia Bureau Statistics, 2012, 2016; Batley, 2017; Bedford, Ho & Hugo, 2012; Queensland Health, 2013). Evidence has identified a need for higher level of healthcare and a lack of uptake of health services by Maori and Pacific Island Families in Queensland (Stanley & Kearney, 2017; Sheridan, 2015; Krauss, Angus, Bor & Crichton, 2014; Queensland Health Needs Assessment, 2011a). The Queensland government was concerned with the lack of access to health services (Queensland Health Needs Assessment Report, 2011a) and called for strategic measures to reverse the deficit discourse or disadvantage. To explore the current state of this phenomenon, this research applied decolonisation and cultural safety methodologies, as the overarching theoretical framework, to disrupt the paradigm of the underlying deficit discourse that has long positioned the research methodologies and evidence pertaining to health status of Queensland Maori Pasifika families.

This chapter provides background information on the research population and articulates the research problem, aims and significance of research. An overview of contextual information on Maori and Pacific Islander social, historical, and political position in Queensland, is first presented. In aiming to conceptualise the theoretical tools (cultural safety and decolonisation) which underpin the key concepts of the study, the cultural safety and decolonisation methodologies are then explored. Third is a brief prologue of researcher positionality and finally a summary of the seven chapters that constitute the thesis is provided.

The following engages with the historical association of colonisation, migration, and resettlement in a new country for Maori and Pacific Island Families.

### ***Queensland Maori Pasifika Population***

Maori and Pacific Island people are considered Polynesian migrants to Australia and yet Australia is part of the Pacific Ocean and is part of the Polynesian triangle (Craig, 2011). The geographical boundaries that form the Polynesian triangle extend from Hawaii in the north to New Zealand in the southwest, and link to Easter Islands in the southeast back to Hawaii (Craig, 2011). Maori Pacific Island people like their ancestors have migrated all over the world, and to countries such as Australia, New Zealand and the United States of America

(Statistics New Zealand and Ministry of Pacific Island Affairs, 2011). However, since the early 1970s, a combination of limited opportunities for paid work and low wages in New Zealand and Pacific Islands triggered a high influx of Maori Pacific Island people to Australia to settle permanently. This group has subsequently been labelled as “economic migrants” (George and Rodriguez, 2009; Horton, 2014). Other incentives such as family reunions, accessible government visas for seasonal work such as “fruit picking”, affordable healthcare and social factors have also led to the migration of Maori Pacific Island Families to Australia on a permanent basis (Rodriguez, 2007; Rodriguez, et al., 2014; Ravulo, 2015 & Batley, 2017).

Rodriguez (et al., 2014) discussed how the impact of migration and social disadvantage on Maori and Pacific Island people’s health in Australia reflects the social determinants of health in New Zealand. These determinants include colonial and neo-colonial dislocation and social issues such as household overcrowding, childbearing statistics and related practices based around the *whanau* (extended family). For example, in New Zealand childhood respiratory and ear infections have been identified as the most common preventable illnesses among Pacific Island families due to low-socio economic risk factors such as living in overcrowded accommodation (Paterson, Percival, Schulter, Sundborn, Abbott & Carter, 2008; Tukuitonga, 2012; NZ Ministry of Health, 2018). Although it is important to note the above socio-health indicators, which show disparity between Pacific peoples and the general population, more recent data had shown signs of improvement regarding Maori Pacific Island health in New Zealand, (NZ Ministry of Health, 2018). Of significance to this research methodologies, is a feasibility study undertaken by Maori health scholars based in New Zealand who reviewed studies focussed on addressing determinants of health inequities to ensure a health care system that provides equitable and culturally safe service provision (Curtis, Jones, TipeneLeach, Walker, Loring, Paine & Papaarangi, 2019). The study recommended service delivery that translates a fairer equitable health service delivery towards better and equitable health outcomes.

Similarly, evidence of poor health status among the Maori and Pacific Island population in Queensland was identified by Queensland Health in response to their Maori and Pacific Island Needs Assessment (Queensland Health, 2011a; Metro South Health, 2016). There is a growing need for addressing the significance of health service provision which proposes safe and equitable care. One example is a mixed method study undertaken by a lawyer and his steering committee members in Melbourne which identified health inequities and looked

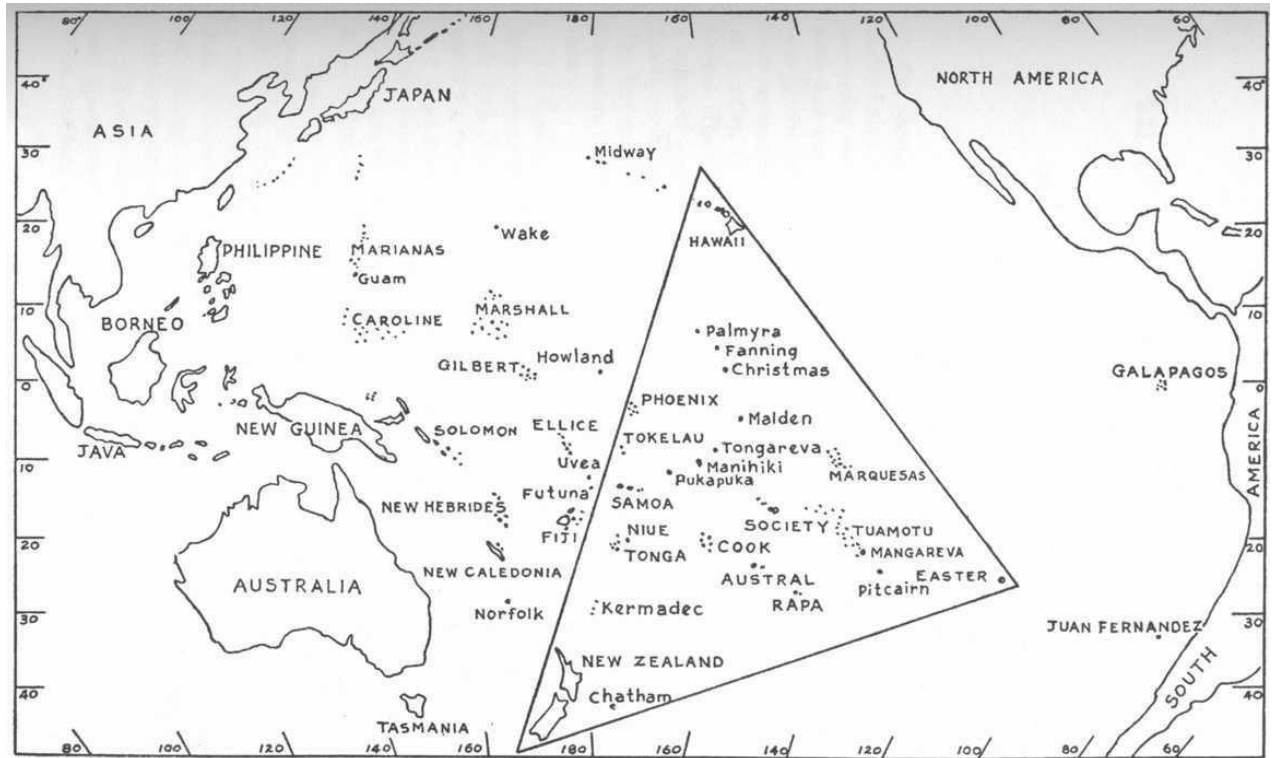
at alternative ways at supporting the Pasifika Community in Western Suburbs of Melbourne. They identified and recommended government and communities to work together towards achieving sustainable goals and increased access to socio-economic, health and educational services for Maori Pasifika population in Melbourne (Razi, 2020). The recommendations stated in the study recommended a need for ongoing engagement as a pathway to increase access to education and health services between government services and Maori Pasifika communities living in Melbourne (Razi, 2020).

Similarly, in Queensland an exploratory study on Maori Pasifika access to mental health services identified key health inequities. One key indicator was on Maori Pasifika families' desires to work in partnership with government mental health services aiming at increasing access to mental health services (Kingi, Erick, Nosa, Paynter & De Silva, 2021). Another key indicator from the study was to treat and monitor Pasifika and Maori mental health needs on an ongoing basis to enable a capacity to increase engagement with Maori and Pasifika communities in Queensland (Kingi et al., 2021). Another most recent study in Queensland explored Maori Pasifika Youth experiences of their *sense of belonging* while living in Queensland, Australia (Radclyffe, Aia-Faaleava, Avia, Utiku-Roberts, Choon, Tafa & Durham, 2023). Findings showed Maori Pasifika Youth facing insecurities of belonging as part of their daily lives due mainly to their socio-cultural positionalities and cultural differences (Radclyffe et al., 2023).

The above references provide evidence of the need for service delivery desired to be effective and culturally safe to address issues such as lack of uptake of health service by Queensland Maori Pacific Island Families. In this thesis, I describe study participants as Maori and Pacific

Island Families. Pacific Island Families are those that identify as Tongan, Samoan, Fijian, Niuean, Cook Islander, Tokelauan, Tuvaluan, Solomon, Vanuatu, and Papua New Guinean. As visually highlighted in the below map of the Pacific Ocean, Maori and Pacific Island people are not a homogenous group and their diverse geographical and diverse complexities surrounding this population mean that a one- size approach does not apply (Southwick, Keneally & Ryan, 2012).

**Figure 3: Map of the Pacific Ocean: Underlining Polynesian Triangle**



[https://en.wikipedia.org/wiki/Polynesian\\_Triangle](https://en.wikipedia.org/wiki/Polynesian_Triangle), retrieved 01/06/2016

### ***Linguistic considerations***

The study participants in this research, apart from white Australians, were Maori, Samoan, Niuean, Solomon, Papua New Guinean, Aboriginal Australian, and Fijian. In Australia, the latter peoples belong to a few relatively small population groups that share similar neocolonial experiences and common statistics regarding housing, education, child-bearing statistics and health service provision. To consider cultural and language terms for this thesis, I primarily used my spoken native language Niuean, including Maori language words such as *whanau ora* (family well-being) which, in New Zealand, are no longer translated. For a non-Maori Pacific Island readership, these Polynesian words are italicised with English translations in brackets and a glossary is added at the beginning of the document to further explain meanings of these linguistic terms. (Please refer to Table 2 for a further breakdown of these linguistic terms).

### ***Australia Maori and Pacific Island Statistics***

The main pathway for Maori Pasifika people migrating to Australia is via New Zealand, through Australia's skilled migration program (Orton & Edwards, 2020). Based on the ABS



(2016) census, Orton and Edwards (2020) identified a total number of 265, 796 people that holds Pacific Island ancestry had migrated directly from New Zealand and the Pacific Islands. In Australia, there is a growing Maori and Pacific Island community (Rodriguez, 2007 & George & Rodriguez, 2009; Batley, 2017). Over a decade ago, Rodriguez (2007) interviewed Maori and Pacific Island groups and health professionals and found that an increasing number of this population were migrating to Australia on a permanent basis. Rodriguez (2007; 2012) highlighted a much higher birth-rate amongst young migrant Polynesians in Australia compared to their non-migrant counterparts. More recently, the number of Pacific Island people who claimed ancestry increased from 112, 133 in 2006 to 150, 068 in 2011 and to 265, 673 in 2016 (Batley, 2017). According to the Australian Bureau of Statistics (ABS, 2006), approximately 476,000 of Maori Pacific Island people were living in Australia, with 92,911 identified as Maori, a number that had increased to 128,000 by 2011 (ABS, 2011). A combined figure for Pacific Island people is 112, 133 (ABS, 2011). By December 2015, a total number of 634,560 immigrants to Australia were identified as New Zealand citizens (Spinks & Klapdor, 2016).

It is reasonable, however, to assume that the numbers above are an under-estimation since all Maori Pacific Island migrants arriving in Australia come under a generic category on immigration arrival cards identified as “New Zealanders” (Hamer, 2009; Cuthill & Scull, 2011).

In 2011, about 7 % of New Zealand immigrants living in Australia were born in the Pacific (Australia Bureau of Statistics, 2012) and there is an emerging diaspora of Pacific Island migrants in Sydney, Melbourne, and Brisbane (Bedford et al., 2012). Queensland is recognised as having the highest percentage of settlements of migrants from the Pacific Islands (Millichamp & Gallegos, 2011). The age distribution of Maori in Queensland in 2006 was 35% from 0-19 years of age, 36% from 20-39 years of age and 24% from 40-59 years of age (Australia Bureau of Statistics, 2007). In Queensland, relatively high numbers of Maori lived in lower-socio economic suburbs (Queensland Health 2011a). The Maori population, which grew by 44% between 2001 and 2006, is now the largest Pacific Island group in Queensland (Queensland Health, 2011a). Rodriguez (2007; 2012) highlighted a much higher birth-rate among young migrant Polynesians in Australia compared to their non-migrant

counterparts. One in three Maori living in Australia was born in Australia and the number has doubled between 2001 and 2011 (Australia Bureau of Statistics, 2012).

Based on the 2011 census, only 3% of the Queensland Maori population had a bachelor or post-graduate level qualification compared to 18% of the total Queensland population (Queensland Health, 2011a). Surveys by the Australian Bureau Statistics (2007 & 2012) showed that New Zealand- born Maori were significantly less educated than Australian- born Maori with qualifications beyond secondary education at 40 %. The increasing number of young people with no high school certificate, apprenticeship, or tertiary education, was seen to contribute to growing levels of unemployment among Maori and Pacific Island youth in Queensland (Anderson, Latta, Leonard & Stock, 2011). Indeed, many Maori and Pacific students face educational barriers which affect their educational engagement, attainment, and career opportunities.

Furthermore, Scull and Cuthill's (2010) research in Brisbane's western corridor identified key issues affecting Maori and Pacific students' participation in higher education. More recently, access to student loans, such as the Higher Education Loan Program (HELP,) have been introduced to students with New Zealand citizenship who have been living in Australia for the previous ten years (Gartrell, 2015). Indeed, this bill has provided opportunities for Maori Pacific Island people who have made Australia their home and would add value to the economy.

Besnier (2015 in Rodriguez et al., 2017) also noted how hardships for migrants to Australia are sustained due to cultural identity and family cultural expectations. One example is the continuation of financial commitments to family members living back home in the Islands (Stanley & Kearney, 2017). The pressure to send remittances back to families in the Pacific Islands are contributors to a lack of social mobility and prioritisation of one's health needs (Orton and Edwards, 2020). The researcher was cognisant of the fact that reference to the above experiences runs the risk of simplifying and stereotyping the cultural and emigrational complexities embedded within a diverse population such as Maori Pacific Island people. It must be noted, therefore, that there are differences in participation and non-participation levels within the above cultural practices.

In Australia, social disadvantage, obesity, asthma, and diabetes have been evaluated as costing approximately \$2 billion for hospital admissions alone (Pirani, 2007). Carson, Dunbar, Chenhall and Bailie (2007), in their study on Indigenous health in Australia, also

demonstrated the influence between class, social disadvantage and poverty as social determinants of health for Indigenous families. Like other Indigenous peoples, Maori and Pacific people have a history of colonisation resulting in loss of culture and language. For some Maori and Pacific Island families, migration from New Zealand (in search of a better life) is due to these negative experiences (Anderson et al., 2011; Queensland Health, 2011a). As found by Heather (2012), many New Zealand citizens on arrival to Australia are not aware that they are not entitled to many social benefits to assist them with obtaining employment here in Australia although many migrate to Australia in search of 'better wages and lifestyle'. Most important was a recent announcement made by the newly elected Labour (2022) government which offers, as of July 2023, a direct and cheap pathway to Australian citizenship for all Australian- based New Zealand citizens.

As seen in the Queensland Health Report on Maori in Australia (Queensland Health, 2011a), most respondents indicated that they had moved to Australia seeking better employment opportunities and 74% of them had much better employment since migration. Yet, based on the country of birth, there is evidence that Maori Pacific Island youth may be overrepresented in Australian prisons (Shepherd & Ilallo, 2016; Ravulo, 2016). Furthermore, a high number of Maori and Pacific Island migrants to Australia are unprepared for issues of longterm residency (Schwartz, 2012).

It is expected that minor health issues will be the responsibility of the family unit and health services will only be used if emergency care is required (Queensland Health, 2011b; Vaughan, Lilley, Nosa & Fenwick, 2018). Given this situation the following section overviews some major concepts related to health and the involvement of the family unit.

### ***Whanau (Family) and Health***

The concept of family (or *whanau*) is central to Maori and Pacific Island social structures. *Whanau* refers to family and extended family and good health is a balance between mental (*hinogaro*), physical (*tinana*), family/social (*whanau*) and spiritual (*wairua*) dimensions (Queensland Health, 2011b). In New Zealand, the goals of the *Whanau Ora* (Family Wellbeing) framework are to ensure that Pacific families are strong and confident in their Pacific identity and that Pacific families will determine what they need in their lives to be successful (Ministry of Health 2010). *Whanau Ora* framework promotes a whanau-centred holistic approach to quality service delivery which leads to recognition that Pacific

Island families' experiences of health care is influenced by Pacific Island world views, cultural beliefs, and values (Taumoefolau, 2012).

While there is much cultural diversity among Maori and Pacific communities, there are two commonly held Pacific beliefs that need to be accommodated in addressing the goal of improved uptake and access to services for Pacific peoples. The first is that health is a holistic paradigm which includes physical, mental, social, and spiritual wellbeing (PulotuEndemann, Suaali'i, Lui, McNicholas, Milne, & Gibbs, 2007). This concept highlights intersectorial collaboration under a comprehensive primary health care with the need for Government agencies to work collaboratively in a way that recognises the interconnectedness of health, education, housing, justice, spiritual welfare and employment as contributors to Maori and Pacific wellbeing. The second commonly held belief, is that families play a significant role in the health and wellbeing of Maori and Pacific peoples collectively and as individuals (Tiatia & Foliaki 2005). As pointed out by Tait (2009), Pacific people appear to be more connected socially than many other population groups in Aotearoa. And historically, the church plays a pivotal role in most Pacific Island cultures whereby Pacific families are strong participants in church and community activities. As described during a casual *talanoa* (talk) with the researcher, the church in most Pacific families is like a governing body where families get together and hold meetings and *talanoa* (talk) after a spiritual session (Ofa Fukofuka, Queensland Pacific Island State Advocacy Coordinator, personal communication, September 12, 2012).

The number of Maori Pacific Island Families in Australia continues to expand because of birth rates within this group and the movement of relatives to Australia from the Pacific Islands and

New Zealand (Rodriguez and McDonald, 2014). While the economic migrants, as argued by Rodriguez and McDonald (2014), may appear to be fit and willing to work, the manifest incidence of co-morbidity illnesses is significantly high (Rodriguez, 2014; Queensland Needs Health Assessment, 2011a). Possible financial and social burden to both Maori Pacific Island and Australia health services warrants action to ensure effective health service delivery for these peoples.

Maori and Pacific Island health statistics are important to understand for this research. The focus in this study was on health service provision, actions, and issues of communication rather than the ethnicity or the culture of the individual as a patient (Ramsden, 2002).

While several child health services are provided for Maori and Pacific Island families in

regional North Queensland and other parts of Queensland, little attention is paid to the experiences of these services and the specific cultural, social, political and historical context in which these families are positioned.

### ***Research Problem Statement***

The research problem under consideration is poor access and uptake of Child Health services by the Maori and Pacific Islander community in Townsville and Brisbane. The research problem is focused on socio-cultural and socio-economic factors that contribute to low health service uptake in the community under study and is discussed in relation to the cultural, political marginalisation and structural and cultural barriers to health care provision. This research articulates how cultural practices and migrant status interrelate with social disadvantage to impact on access to health service provision.

Queensland is increasingly becoming a permanent home for many Maori and Pacific Island people having resettled from New Zealand or by direct migration from the Pacific Islands (Sheridan, 2015; Rodriguez, 2007, 2012; Batley, 2017). Many Maori Pacific Island Families are not accessing child health and relevant mental health services in the greater Brisbane area for fear of stigma attached to their health conditions and lack of support and culturally safe services identified in health service delivery (Sheridan, 2015). A study in Queensland found that culturally and linguistically diverse (CALD) communities are reluctant to access health services due to perceived racism, cultural differences, and misunderstanding (Henderson &

Kendall, 2011). A report by Queensland Health (2011a & 2011b) on a Maori Pacific Island Health Needs Assessment also reported Maori Pacific Island underutilisation of health services which are accessed mainly in emergency situations (Queensland Health, 2011a; Cruickshank, Lilley, Nosa & Fenwick, 2018). Poor health status and access to health services among Maori Pacific Island Families are a continuing concern. Government reports (Queensland Health, 2011a; Spinks & Klapdor, 2016; Metro South Health, 2016) state that inequality in immigrant populations, including Maori Pacific Island Families, is consistent with international studies of immigrant health in the UK, USA, Canada and New Zealand. Generally speaking, health service provision to populations that identify as diverse and social disadvantage groups in most countries struggle to maintain equitable health care (AsghariFard & Hossain, 2017).

## ***Significance of Research***

A needs analysis survey trialled on the mental health issues of Samoan and Tongan youth in Queensland showed higher rates of Samoan and Tongan youth exhibiting symptoms of mental health issues in comparison to local population (Krauss, Angus, Bor, & Crichton, 2014). This led to organisations such as the Greater Metro South Brisbane Medicare Local (GMSBML) through its Partners in Recovery program, to support a 2015 forum on Maori and Pacific Mental Health. The aim of the forum was to raise awareness of mental health needs in these communities and to identify what needs to be done to promote good mental health for Maori Pacific Island Families in Brisbane (GMSBML News, 2015). Social disadvantages such as living in overcrowded accommodation, being less likely to have a post-school qualification, living in poor neighbourhoods, poor access to mental health services and being socially excluded were some of the identified issues (Sheridan, 2015; Stanley & Kearney, 2017). More recently, employment data in Australia showed a significantly higher number of the younger male Maori Pacific Island population working predominantly in lower skilled and casual-based occupations (Orton & Edwards, 2020). A question that comes to mind is how Covid19 pandemic and its impact is affecting incomes among Pacific Maori families in Australia. Clearly Maori Pacific Island families are employed in sectors that may be heavily affected by Covid19 which means many households may have lesser disposable incomes nor entitled to financial assistance (Orton & Edwards, 2020).

The importance of addressing these issues relates to the ways in which state and federal governments design policies relevant to needs of any marginalised groups including Maori Pacific Island Families in Queensland (Qld Health Needs Assessment, 2011a; Rodriguez, 2012). Furthermore, proponents of cultural safety have been questioning and challenging the nature of power and its influences particularly in understanding how social disadvantage and colonial and neo-colonial experiences impact access to health and illness (Ramsden, 2002; Brown and Smye, 2002; Willis, Smye & Rameka, 2006; DeSouza, 2012; Cox & Taua, 2016; Curtis et al., 2019).

The significance of this research is also justified given that the limited reporting and needs assessments undertaken, and mainly by Queensland Health and academic studies, that link the significance of poverty, unemployment and poor access to social and health services to Maori and Pacific Island Families in Queensland. The current research employs an alternative approach that could usefully inform and influence policy and culturally safe practice in health

service provision to Maori and Pacific Island people in Queensland. The unique process of asking both service users and service providers of their experiences of service delivery is a principle pertaining to the decolonisation methodology.

As pointed out by Smith (1999), the colonial system introduced in New Zealand (1774) has continued to impact on the capacity of Indigenous Maori to fulfill good health and self-determination. Eckermann et al., (2010) argue that decisions are influenced by people's principles, values and philosophies including their ways of knowing and doing.

Furthermore,

Eckermann et al., (2010) discuss how conflict occurs when one group (usually powerful) tries to impose their systems, beliefs, and values on the less powerful. As such, it is envisaged that the research outcomes will serve as a useful and relevant resource in the development of policies and strategies to help generate and sustain informed decisions and debate around health care for Maori Pacific Island Families.

## ***Aims***

The aims of the research were to:

- explore and document how members of the Maori and Pacific Island population in Townsville and Brisbane experienced access to child health services; and
- explore and document experiences of child health service providers when working with Maori and Pacific Island Families in Townsville and Brisbane

The overarching objective was to understand the experiences of Maori Pasifika Families when accessing health services and to understand the experiences of Child Health Service Providers in their work with Maori and Pacific Island families. The aim was to contribute to the development of culturally safe healthcare and to promote access to child health service delivery by Maori and Pacific Island families in Townsville and Brisbane.

This research did not aim to present policies nor address the health problems that confront Maori and Pacific Island people in Queensland. A further goal was not to imply criticism of the significant work undertaken by Child Health Service Providers who work in complex and challenging situations here in Queensland (Queensland Health Needs Assessment, 2011b).

For further clarity I turn now to an initial consideration of the key concepts of cultural safety and decolonisation as they inform Maori Pasifika (including researcher positionality) experiences of health service delivery. The concepts are conceptualised to build a coherent overall argument that acts as the thread throughout the research.

## ***Key Concepts***

### **Culture and its influences**

There are several ways to define culture and the focus of this research is the concept of culture understood as non-material elements that include language, beliefs, ideas, rules, customs, myths and skills in relation to health service provision (Macpherson & Macpherson, 1990). Yet, as argued by Cox and Taua (2013, p. 40), “there is considerable variation in how culture is defined and approached and terms such as race, ethnicity, cultural competence, cultural diversity, and cultural inclusion add to the complexity and confusion”. Thus, while we can reasonably assume that culture influences how we see, understand and respond to physical and social experiences (Cooney, 1994), it is worth noting that the use of the term culture in this thesis assumes a historically and politically informed dynamic and fluid process, not a fixed or pre-determined canon of beliefs, values or practices (Cox & Taua, 2013; 2016) and as encompassing age, gender, ethnicity, class and ability (Ramsden, 2002). The following conceptualises cultural safety as a theoretical perspective that considers power relationships, being aware of differences and decolonisation methodologies namely *Talanoa* methods as applied in this research to collect data from study participants.

### **Cultural Safety and What Constitutes Culturally Safe Service Provision**

Cultural safety in an Indigenous-led model of care involves increasing awareness of the need for uptake of health care services, particularly in Australia, New Zealand and Canada (Lavery, McDermott & Calma, 2017; Cox & Best, 2019). Cultural safety, according to Ramsden (1992), proposes that partnership, protection, and participation are the three main principles integral to the relationship between the consumer and the service provider.

The concept of cultural safety (*Kawa-Whakaruruhau*) was introduced in New Zealand in the early 1990s when it was used to highlight a more focussed response to power imbalances between health professionals and the recipients of healthcare and particularly the Maori recipients (Woods 2010; Ramsden 1992; 2002). The current research applied a



culturally safe approach to examine the institutional dynamics of the healthcare system and the health care professionals within it, specifically in child health service provision for Maori and Pacific Island people in Townsville and Brisbane. To this end cultural safety asks if child health services provided in Townsville and Brisbane demonstrates the interpersonal and reciprocal skills necessary to establish relationships based on respect and mutual understanding. Considering Maori and Pacific people, it also asks if health service providers acknowledge that Maori and Pacific Island health status is related to historical, cultural, and political influences (Wilson, 2008).

There is a growing body of literature on culturally safe service delivery which suggests both the need and opportunity for service providers to develop culturally safe models of care (Cox & Best, 2019; Carey, 2018; Cox & Taua, 2013, 2016; Edwards, Smith & Elston, 2007; Kildea, 2006; Kildea, Kruske & Sherwood, 2010; Kildea, Stapleton, Murphy, Low & Gibbons, 2012; Kruske, Kildea & Barclay, 2006; McClelland, 2011; Ramsden, 2002; Smith, 2007; Wepa, 2005; West, 2010; Wilson & Neville 2009; Woods, 2010).

There is a concern among Maori and Pacific Island communities about their young people who are over-represented in youth detention centres and in suicide incidents and yet Maori and Pacific Island families do not appear to access child mental health support services or community juvenile services (Krauss, Bor, Angus & Crichton, 2014). Bese (2014), in her presentation at a Pasifika youth justice community forum in Queensland, also highlighted a significant number of Pasifika youth at risk with trends suggesting a need for action. A national concern identified in a study by Ravulo (2016) noted that despite constituting 1.3 percent of the Australian population, an over-representation of Maori Pacific Island youths in juvenile centres was reported to be a result of a lack of uptake of preventative community juvenile services.

A further study shows that South Sea Islanders and Pacific Island communities in North Queensland are not accessing services despite experiencing issues with homelessness, domestic violence, mental illness, and unemployment (Dawes & Gopalkrishnan, 2014). A report recently published by Sheridan (2015) concluded that Queensland Maori and Pacific Islanders in Brisbane delay access or avoid mental health service delivery due to the lack of respect of service providers associated with community and cultural stigmatisation following diagnosis with a mental health condition. More recently, findings from a Maori and Pasifika Women and Newborn Health Forum held in April 2016, in Brisbane (Cruickshank, Lilley, Nosa

& Fenwick, 2018; Metro South Health, 2016) summarised experiences of Maori Pacific Island pregnant women who were not accessing relevant midwifery services until birthing.

There appears, however, to be little research on whether health service delivery for Maori and Pacific Island families in Australia is reported or recognised as effective or culturally safe. Currently, practices underpinning principles of cultural safety challenges current orthodox teaching and learning (DeSouza, 2012). International evidence (DeSouza, 2008, 2012; Johnstone & Kanitsaki, 2007) showed that although there is a growing phenomenon of cultural safety, little is known about its practice in health service provision and how well cultural safety is put into use or readily understood by others except for proponents of cultural safety. Cultural Safety acknowledges the influence of the community, the service provider, and the social context in which the individual is positioned (Dudgeon & Walker, 2015). The application of the concepts cultural safety and decolonisation focused on service provider practice and its impact on clinical outcomes and thus on the culture of the health system rather than the culture of the service user.

### **Decolonisation as an overarching framework**

The research aims were explored through an application of a decolonisation framework that upholds the experiences of Maori and Pacific Island people of child health services. Selfdetermination is all about learning and sharing information rather than an assertion of power. I also felt strongly that my research should have some practical and sustainable outcomes for the participants. To further these goals, the research is positioned from a standpoint of *kaufakalatahaaga* (collaborative-ness) in support of social justice, advocacy, self-determination and respectful and meaningful research (Creswell & Plano- Clark, 2011; Rodriguez, George & McDonald, 2017). The power dynamics are crucial in health service provision and the lens of decolonisation demonstrates that nursing interventions and practices become problematic because the outcomes contribute to marginalising non-western knowledge, such as Maori and Pacific, by perpetuating the privileges of mainstream ways of being and knowing (Smith, 1999; Puzan, 2003; Kenney, 2011). As an example, Kenney (2011, p. 128) stated that: "The perceived support for or lack of challenge to Euro-centric midwifery in Aotearoa has reinforced the circulation of colonising discourses within the profession, which perpetuates the marginalisation of Maori world views". Smith (1999, p. 35) also noted "that much of what I have read has said that we do not exist, that we are no good and that what we think is not valid". These ideas can be related to the work of

Foucault (1982) who argues that power relations permeate every part of life and whoever controls the discourse controls power. As described in Gaventa (1993, 2006) Foucault went on to distinguish and elaborate on the role of institutions in establishing and dominate power relations. According to Gaventa and Cornwall (2001), Foucault's discourse on power and knowledge is concerned with human expressions often in the form of knowledge and social relations and is fundamental towards understanding Maori Pacific Island Families versus Child Health Service Providers behaviours and relationships in their interaction during service delivery. Alongside Smith's decolonisation methodology, Cultural Safety as the theoretical tool underpins Foucault's discourse on power and knowledge (1982). Indeed, on reflection, the discourse of power as described in this research was challenged by asking service providers to describe and elaborate on their realities, beliefs and attitudes when working with Maori and Pacific Island families.

Furthermore, a refocus on a decolonisation and governance viewpoint is associated with an introduction of the notion of equity into health care systems, an example of which is based on the equality and equity concepts. One example is bulk billing of health services through the Medicare health system currently based on the concept of equality. The Medicare system is designed to ensure that everyone has the same access to a health service provider regardless of an ability to pay. But it only goes as far as promoting fairness and does not look at other factors such as language barriers, socio-economic barriers, gender, place of residence that act as barriers to healthcare. Maori Pacific Island Families in Queensland (Queensland Health Needs Assessment, 2011a; Spinks & Klapdor, 2016) post migration have high unemployment rates, and many lived in poverty and require extra help to offset the impact of poorer living conditions. A further definition of equity as it applies to health care is stated by Braverman and Guskin (2003, p1) as "an ethical concept grounded in the principle of distributive justice".

Decolonisation of child health service provision is justifiably significant when equity for Maori Pacific Island Families is achieved through equitable and accessible healthcare to assist in maintaining healthier living standards. This research has significance at many levels and contributes to a small but growing body of knowledge on Maori and Pacific Island groups in Queensland. Additionally, culturally safe-based research relates to power and control, which are issues critical to this thesis. The approach assumes the right to self-determination for Maori and Pacific Island peoples in Queensland, not only from a political or socio-economic point of view, but also with respect to being acknowledged as owners of research

outcomes (Smith, 1999). As such, Smith (1999) argues that any research project must be thoroughly considered in respect of Indigenous peoples' interests and needs. In the below paragraph a brief overview of researcher positionality is addressed in articulating the key concepts as realised throughout the study.

### ***A prologue***

Below I tell something of my story as a Pacific Island woman (*fifine*), feminist researcher, and the experiences that have led me to undertake doctoral research with the intention of informing culturally safe service provision for immigrant Maori and Pacific Island families in Queensland including the strengths and challenges it faces in relation to low uptake of health service delivery.

Storytelling being a Pacific Island Woman and researcher is essential. The purpose in provision of personal details in my journey is to declare my genealogy, my heritage, cultural identity and to claim my position as a researcher and author. Storytelling also encourages explication and self-realisation of one's personal journey and is a fundamental principle of what Cultural Safety stands for. Cultural Safety evolves in a circular manner and acknowledges one as being a possessor of culture.

In the early days of resettlement in Townsville, the goal posts around the settlement were continually shifting as were the questions we had about how to make it work for us. Where do, recent immigrants go to seek help when looking for a job, looking for accommodation, resettling children into school or to link with people from the same background? The social isolation was dismal and yet my husband and I have had to continue because there were three other people dependent on us to make the move a "successful" migration.

However, it was not until halfway into the time of resettlement that I recognised the significance of culture and how it was becoming central to my life in two aspects. Firstly, as a low-income migrant and a woman the experience of poverty encompassed cultural alienation, loss of family connection and low social status. Secondly, my work with Indigenous people within the community revealed the cultural dominance of economically powerful groups and the relative powerlessness of Indigenous people to assert important cultural values and beliefs when accessing healthcare (Puzan 2003; Davies & Papadopoulos 2006; Azzopardi & Gray 2010; West, Usher and Foster, 2010). Sadly, the health status for "Australian Indigenous people is an example of how a marginalised and dislocated group is

powerless to historical and social factors such as unemployment, threats to cultural identity and social disadvantage” (Azzopardi & Gray, 2010, p. 105).

I was ill-equipped for the inadequate and unacceptable health care service experiences verbalised by patients and for witnessing such experiences myself. It was an unsettling experience for me to realise that providing culturally safe care or even considering culturally safe care did not seem to be a priority for some of the health professionals in Queensland. In my work in North Queensland within a large healthcare institution, I saw patients from minority ethnic groups and immigrant groups unmistakably marginalised. Open expressions of denigration were often an experience for me whereby my colleagues would initially assume that I was an Aboriginal health worker being hired to “help out”. Often tasks allocated to a health worker would be allocated to be undertaken by me despite being aware that I was an RN (Registered Nurse) and not “a health worker”. On presentation to start each shift in a hospital, it is not unusual for staff members to mistake me for an AIN (Nurse Aid), an EN (Enrolled Nurse) or, due to my name, a male nurse. My experiences as an immigrant woman reflected those of Indigenous Australians who experienced low social status and whose cultural needs or professional statuses are ignored or denigrated (Barclay and Kent 1998; Seaton 2010).

There has been an ongoing concern with a high number of disengagements of child health services demonstrated among Indigenous youth in Townsville and asking why, was one key question influential to my Masters’ degree studies. My master’s study focused on community engagement of young Pacific Island people, in relation to increasing rates for vaccination of the Human Papilloma Virus (HPV) vaccine (Gardasil) that was recently being introduced in New Zealand and Australia. From the outset in Townsville, there was a low uptake of Human

Papilloma Virus (HPV) vaccination among Aboriginal and Torres Strait Islander (ATSI) youth. While working as a research coordinator and child health nurse specialist and vaccinator at the time, I was to promote an uptake of HPV vaccination to this young Indigenous population through holding meetings and workshops with relevant stakeholders. Including in this work is to follow up and vaccinate a high number who had commenced the HPV vaccination program but unfortunately were not returning for their second and/or third dose. To obtain full immunity, completion of the six months HPV vaccination program is needed to be administered within the six-month period after administration of the first dose. There was an immense amount of frustration in which questions were asked. Why are youth not

engaging with services? I had assumed that opportunities to participate in a new trial would be accepted quite readily.

These are some of the experiences that had led to my undertaking this research as such regrettable realisations caused much questioning, thinking and personal challenge on my part.

Thus, this research project is important to me as a person and as a health professional. And with due respect a notation is called for in acknowledgement of New Zealand, Pasifika, and Australia *tangata whenua* (people of the land) for allowing me to recall and to record *your* lived experiences:

*Monu...Monu Tagaloa*

*Hake ke pu he lagi likoliko*

### ***Structure of Thesis and Document Overview***

Chapters 1, 2, and 3 provide overviews of the (*Kamataaga he Fenoga*) *Beginning and Preparatory Stage* of the journey of this research. In exemplifying the decolonisation methodology, a depiction of a three- stage (*fenoga*) journey is used as a metaphor for development of each chapter in this thesis. Because for many Maori Pacific Island Families and as discussed in the background information, health is based on a holistic and spiritual living continuum or portrayed as a journey underpinning cultural protocols, epistemology and ontology, and therefore cannot be separated from their physical desire to achieve *moui olaola/whanau ora* (well-being).

Chapter 1 defined Maori and Pacific epistemology and discussed the concept of *whanau* (family) and what *whanau* means for Maori and Pacific Island people regarding their health including social, cultural and political influences as they access health services. Included also is a discussion on key concepts such as culture, researcher positionality, cultural safety and what constitutes a culturally safe and decolonisation methodology for research on health service provision for this population.

Chapter 2 consists of a contextual review of the existing literature or prior knowledge on the health of Immigrant Maori and Pacific Families and Elders in Australia and New Zealand health service provision in (Australia, New Zealand and internationally), and research evidence on the application of cultural safety, cultural diversity, and health provision. The review encompasses an exploration of contributing factors that influence choice in accessing health service provision. An overview of inter-related issues from disciplines including health sociology, cultural studies and ethnography are embedded in the review. Socio-economic understanding of health and well-being includes and considers the Queensland Health Policy on service provision for Maori and Pacific people in Queensland. An example of collaborative service provision between an Aboriginal and Islanders Medical Service (AMS) and a large tertiary public hospital based in Brisbane is offered as an example of what culturally safe service provision may look like.

Chapter 3 provides a rationale for the tenets underpinning the theoretical framework as it was applied in this research project. The chapter discusses the relevance of decolonisation and cultural safety methodology and justifies its application in this research. The principles of cultural safety aim to reflect critically upon one's own culture, values, beliefs, assumptions. In this research Child Health Service Providers may recognise that these values, beliefs and culture, when imposed on service users, may act as a hindrance when accessing health services. Decolonisation methodology exposes colonial and neo-colonial imperialism and how it impacts the health-seeking behaviour of Maori Pacific Island Families as they access health services.

Chapters 4, 5 and 6 explore the (*Fakaholoaga he Fenoga*) *Actual Journey* of this research. Chapter 4 describes in detail the methods used for recruitment of study participants and data generation through to data analysis methods and ethical considerations. Through the lens of decolonisation methodology, the Indigenous dialogical method of *Talanoa* is explained as the research data generation method. Data analysis was underpinned by Charmaz's (2006; 2014; 2017) stance on constructivist grounded theory to support the Ramsden Cultural Safety Model (2002). Analysis of the language of Child Health Service Providers identified discourses which informed health service provision to Maori Pacific Island Families. Reflexivity as promoted by Charmaz (2017) was a significant factor whereby perceptions of Child Health Service Providers including the researcher regarding

service delivery were reflected upon and questioned based on a platform underpinned by principles of cultural safety.

Chapters 5 and 6 present the outcomes of interpretations of the perspectives of Maori Pacific Island Families and Child Health Service providers. Chapter 5 highlights the socioeconomic impact and positionality of Maori Pacific Island Families in Queensland which are fundamental to an appreciation of participants' perspectives and literacy levels when accessing health service provision. In summary, an interpretative analysis of transcultural healthcare approach which underpins service delivery to Maori Pacific Island families is discussed. Chapter 6 moves on to explore a further three key interpretations namely Power Dynamics, Deficit Discourse and Cultural Disconnection generated from the analysis.

Finally, Chapter 7 locates the Cultural Safety Model and Decolonisation Methodologies as a framework that identifies interrelationships between key categories. Rather than locating the individual in terms of their health-seeking behaviours it was necessary to bring the Cultural Safety Model to the analysis to enable a broader interpretation that reflects knowledge, individual, organisational, historical and political factors. Chapter 7 contextualises the interrelationships between key categories underpinned by the Cultural Safety Model in response to the question of whether Cultural Safety, or a lack thereof, is the overriding premise contributing to experiences of low uptake of health service delivery among Maori and Pasifika Families in Townsville. Chapter 7 provides concluding arguments, limitations of the research and recommendations, which pertain to the (*Koe Fakaotiaga he Fenoga*) *Arrival of Journey of this research*.

Suggestions for further exploratory studies is recommended post acknowledgement of limitations of the research. A discussion of overarching implications of findings recommends ways to address identified issues through working in partnership with Maori Pacific Island Families in Queensland within the Australian health context. Relevant and sustainable health services to occur must involve a process of collaborative-ness, where mainstream and Maori Pasifika Indigenous ways of doing are combined in mutual understanding to create and maintain relevant and culturally safe access to health services. Hence, a construction of the *Lalaga/Talanga Model for Service Delivery* (t based on partnership) Model is presented.



The following chapter reviews evidence-based knowledge and information with a view to better understand the status of knowledge around the health experiences of child health service delivery. The review literature was purposively chosen based on currency, relevance, and articulation.

# CHAPTER TWO Literature Review

## *Introduction*

The contextual literature review on child health and health service provision for Maori and Pacific Island populations within the Australian and New Zealand contexts was ongoing. Overall, the contextual review explores the intersections of Indigenous populations' experiences in New Zealand, Australia, and Canada but with limited literature on child health service provision for Maori Pacific Island Families in Queensland. The literature review also explores power and privilege and the intersections of peoples' experiences in relation to marginalisation, oppression, and dominance.

The review of literature encapsulates broad themes surrounding decolonisation and culturally safe practices relevant to Indigenous –based and Maori Pacific Island healthcare programmes and studies in Australia, New Zealand and overseas. The inductive (exploratory approach) of the contextual review facilitated an understanding of the concepts of culture and cultural safety and the issues of diversity and health inequality in health service provision for Maori and Pacific families. The review also summarises Queensland Health Policy in relation to service provision for Maori and Pacific Island people in Queensland such as an example of collaborative service provision between an Aboriginal and Islanders Medical Service (AMS) and a large tertiary public hospital based in Brisbane, Queensland. I have also included literature informed by the works of pioneers such as Ramsden (1992, 2003) and Smith (1999) who laid the foundation for understanding culturally safe healthcare practices based on decolonisation as a research framework.

## *Literature review methods*

The databases of ProQuest, QUT E Prints, Medline, Inform It and Google Scholar were searched, using key concepts, for relevant Maori and Pacific Island studies in health, health service provision for Maori and Pacific Island people in Queensland and overseas, and for research focused on cultural safety, Maori and Pacific Island health (NZ and Australia). The review includes several internet sites connected to government organisations such as Queensland Health, New Zealand Ministry of Health and University sites and were explored with an aim to understand access to health service delivery for Maori Pacific Island families. The researcher became a member of a scholarly website, Research-gate and Pacific Scholars,

from which numerous relevant academic articles were accessed. Relevant literature pertaining to Maori and Pacific Island child health and research programs particularly in Australia however was limited.

Queensland Health was one of the major contributors of publications in the area and mainly because of funding and reporting requirements in Maori and Pacific Island health in Queensland (Queensland Metro South Health 2006; Queensland Health 2011a; Queensland Health 2011b). The publications identified Maori and Pacific Island people in Queensland as a priority population due to social disadvantage. Rodriguez and others (2007; 2012; 2013; 2017) published research findings which revealed health and socio-related issues that Maori and Pacific Island people faced on migration to Australia. More recently, work by Ravulo (2016) has focussed on the plight of New South Wales Maori Pacific Island Youth affected within the juvenile system. Ravulo (2016) endeavoured to provide greater understanding and awareness of Pacific Island communities with a focus on engagement with mainstream service providers who were working with Maori Pacific Island communities in an Australian juvenile context.

Since her passing in 2003, the cultural safety work of Ramsden has been extended with publications authored by academics in Canada, New Zealand and Australia who favour the concept due to its relevance for their work with Indigenous populations. Selected publications from 1992 to 2023 were chosen using search terms such as cultural safety, immigrants, and child health service provision and access for Maori Pacific Island Families in Queensland and New Zealand were categorised under themes as highlighted below.

### ***Studies Focusing on Health in Maori and Pacific Islander Families***

The Pacific Islands Families Study in New Zealand (Paterson et al., 2008) noted that Pacific peoples are over-represented in many adverse health and social statistics indicating high rates of hospitalisation and death. Yet, there is limited information available for efficacious public health interventions for this population (Paterson et al., 2008). The Pacific Island Families Study (2008), a birth cohort study, was developed through a process of collaboration with the

Pacific community, researchers, and relevant service providers. One of the key findings was that although generally poor, most Pacific families living in New Zealand were sending home (to families living in the Pacific Islands) financial gifts and have financial church commitments. These commitments frequently made household financial situations even

more difficult (Paterson et al., 2008). Similarly, and based on studies on Maori and Pacific Island social disadvantage in Australia, Rodriguez (2007; 2012; 2013) found that these communities demonstrate a different attitude to money and family responsibilities than Anglo-New Zealanders or Australians.

Rodriguez (2007) interviewed Maori and Pacific Island family groups and individuals and key informants who were Maori and Pacific Island nurses and health workers and had trained and worked in the Australia health care system during the previous five-years. The study concluded that not only do the income-providers provide for more people in a household there was also a high cultural expectation that financial stipends would be sent back to the Islands (Singh, 2005; Rodriguez, 2007; Stanley & Kearney, 2017). Money sent back home to the Islands (mainly from New Zealand and Australia) is much needed and comprises an estimated third of Gross Domestic Product (GDP) for Samoa, Tonga, and Cook Islands (Singh, 2005). More recently, while global growth recovered in 2021, actual GDP in the Pacific Islands declined by an average 2.0 percent caused heavily by Covid19 outbreaks and lockdowns (Pacific Islands Monitor 2022).

Studies have also reported that Pacific Island families, who regard eating as a central part of family life and cultural practice, present with major health issues related to the type and quantities of food eaten (Rodriguez, 2007; 2012; 2013; Akbar, Radclyffe, Santos, Mopio & Gallegos, 2022). Findings of one study indicated that Maori and Pacific Island families, as a result of cultural practices around generosity with food, regard obesity as “normal” which has significant health implications (Rodriguez, 2012).

Overall, Maori and Pacific Island people have the world’s highest incidence of diabetes (Akbar et al., 2022; Ministry of Maori Development 2000; New Zealand Health Survey 2008) and approximately 150 of all Maori deaths each year in New Zealand is due to diabetes, representing one of the highest death rates from diabetes in the world (Maloney-Moni and North, 2003; Qld Health, 2011; Akbar, Windsor, Gallegos, Manu-Sione & Anderson, 2021).

Maloney-Moni and North (2003) did an evaluation (study) of Maori Health status in New Zealand. Using case notes and drawing from community health theory, the study described the scope and strategy for practice in client’s home settings. Findings of their study indicated that cardio-vascular diseases made the largest contribution to health loss in Maori populations and that smoking, hypertension and high blood cholesterol all ranked highly as contributors to the burden of disease (Maloney-Moni and North, 2003). No official directive

behind the trend has been published but there is a possibility statistically that the initiative is a success for Maori health outcomes, since anecdotally the service has a success in uptake (Maloney-Moni & North, 2003). Akbar in her research identified a high number of Maori Pasifika people experiencing higher burden of mortality and morbidity caused by Type 2 diabetes (et al., 2021).

In New Zealand, the Respiratory Health Impact Report 2013 reported asthma deaths were six times higher for Pacific Peoples and five times higher for Maori compared to New Zealand European (Asthma Foundation, 2014). Furthermore, the report highlighted Maori children had a higher incidence of asthma compared to non-Maori children, tended to have more severe symptoms, required hospitalisation for asthma three times as often, and required more time off school because of asthma (Asthma Foundation, 2014).

To consider the above phenomenon within a broader socio-economic context the findings highlighted that inequalities in health by socio-economic deprivation were linked. For example, those in the most deprived quantile were more likely to be hospitalised with a respiratory condition.

A further research project completed in New Zealand on mental health issues of Pacific Island people by Vaka (2014), reports Pacific Island children aged 18 and over born in the Pacific Islands had lower rates of mental health issues than Pacific Island children born in New Zealand. Vaka posed the question of why there was an increase of Tongan Pacific Island people being born in New Zealand diagnosed with mental illness in comparison to Tongan Pacific Island people born in Tonga and migrating to New Zealand. As indicated, several studies on Pacific peoples' mental illness have focused primarily on rates, acuity and prevalence (Ape-Esera, Nosa & Goodyear-Smith, 2009; Foliaki, Kokaua, Schaaf, & Tukuitonga, 2006; Simpson, Brinded, Fairley, Laidlaw & Malcolm, 2003). The study showed that there is a lack of research focussed on experiences and what mental illness means for Pacific Island people and this limits the ability to effectively address the mental health issues for Pacific Island people in New Zealand especially for those born in New Zealand (Vaka, 2014).

A needs analysis survey on the mental health of young Pacific Island Samoans and Tongans in Queensland reported rates of mental health problems of Samoan and Tongan youths who migrated to Queensland were greater than for the local population (Krauss, Angus, Bor, & Crichton, 2014). There were two major contributing stressors: firstly, these youths were

struggling to adapt to an Australian way of life and secondly, they struggled daily with financial pressures caused by socio-economic disadvantage (Krauss, Angus, Bor & Crichton, 2014). According to Krauss et al. (2014) there are distinct differences in mental health concepts between Pacific Island people and Western society. These distinct differences as previously mentioned by Pulotu-Endemann et al., (2007) are Maori Pacific Island people understanding of mental illness is not seen as a separate entity but is considered an overall well-being of the physical, mental and spiritual in relation to the social harmony of the community.

Individual misconduct and misbehaviour causing disharmony to the community is often conceived as mental illness. Furthermore, there was a concern identified in a case study by Kearney, Fletcher & Dobrenov-Major (2011) of Samoan families in a high school in Brisbane. The study showed a strong cultural discontinuity (differences) between the high school and Samoan parents and no systemic effort had been made to address these differences resulting in greater challenges and a threat to proper education and well-being of a child (Kearney, et al., 2011). In the following section examples of overseas studies that consider socio, political and cultural positions of people accessing health services are reviewed.

### ***Health Service Provision***

According to the philosophy and practice of cultural safety it is the patient, not the health professional, who decides whether services rendered are effective for them as an individual (Ramsden, 2002). Health service provision does not occur in isolation and for this reason the healthcare system within which health professionals are positioned is important.

On an individual level, Richardson et al., (2009, p. 27) in their study on nurses' perception of cultural safety within an acute service provision setting discussed "inherent difficulties in questioning patients about the quality of their care from a cultural safety perspective".

Richardson et al., (2009) and Curtis et al., (2019), recommend that service providers (nurses) need to undergo a process of self-reflection to gain awareness of their practice. Without reflection and critical thinking, situation of risk is readily missed and not seen, thereby runs the risk of providing care that is demeaned and culturally unsafe.

Health care service provision takes place against "a background of social, political, economic and ideological systems that influence interactions within these settings "(Browne & Syme,

2002, p.28). Browne and Smye (2002) and Willis, Smye and Rameka (2006) used a cultural safety model to analyse health policy affecting Aboriginal people in Canada and Maori in New Zealand. Brown and Smye (2002) applied Ramsden's model as guide to "postcolonial scholarship" and argued that "cultural safety is a useful guide by which we can better critique issues of institutional racism and discrimination" (p. 54). Brown and Smye (2002) claimed that then current system and its policies had been set up to mask the way that people are disadvantaged based on culture. These authors and other colleagues (Browne et al. 2009, p. 167) were drawn to using cultural safety "because of its compatibility with critical theoretical perspectives that foster a focus on power imbalances and inequitable social relationships in healthcare". The conclusion by Browne and Smye (2002) was that cultural safety provided a discourse within which to ask questions about the "rightness" of policy.

Using a dichotomy of power and knowledge to reflect upon Maori Pasifika families lack of access to child health service providers, can be related to a study in New Zealand by Wilson and Neville (2008) who explored previous studies and the nature of nurses' practices when working with elderly people with delirium. Wilson and Neville (2008) used a critical gerontological methodology informed by a way of thinking about culture, philosophy and Foucault understanding of discourse on power. According to Wilson and Neville (2008), Foucault (in Reason & Bradbury, 2007) also argued that to maintain power is inherently related to knowledge and discourse. According to Cockerham, Foucault proposes that knowledge is a social construction, and that truth-claims are equal to power plays (Cockerham, 2007). In brief, postmodernism sees reality as what individuals and social groups make it to be (Cockerham, 2007). Likewise, Reason and Bradbury write that for Foucault power "works through (discourses), power exists through action and is immanent in all spheres, rather than being exerted by one individual" (Reason and Bradbury, 2007, p. 72). Gaventa and Cornwall (2001) also describe Foucault's view of power as an underlying force that emerges as a force that made people do things against their wishes. The implication of the theoretical lens of the research is plausible given the role each participant unknowingly creates as reflexive actors during service delivery.

Using cultural safety and decolonisation methodology as key concepts are fundamental towards provision of health services that are accessible, welcoming, and responsive to clients' needs and are fundamental in reducing the burden of preventable childhood diseases seen among Pacific Island children (Finau, 1996). Finau, had completed numerous feasibility and access studies in New Zealand regarding Pacific Island Families. Although

parenting is difficult in a rapidly changing environment, effective approaches to change can be developed through strengthening of the family unit, improved communication and access and the encouragement of community participation in economic development and social issues (Finau, 1996; Coxon et al., 2002; Tukuitonga & Finau 1997). Tukuitonga (2012), Pacific Island advisory chair for New Zealand Ministry of Health (2012-2014) and Director General to the South Pacific Health Commission from 2014 to 2019 reports that poor health outcomes impacting on Maori Pacific Island Families are related to social determinants, such as income, employment, housing quality and education.

In Australia, Leone et al., (2012) explored at Aboriginal women's experiences of services during pregnancy, childbirth and postnatal in South Australia. These authors conducted research between 2007 and 2008 with the Aboriginal Health Council in South Australia and Murdoch Children's Research Institute. They found that although most families of young children are well supported socially and make good use of services, some do not. Children from families that have poor social support and make limited, or no use of early childhood and family services are at increased risk of poor health and developmental outcomes. This research confirms what many professionals working with children and families already knows; that the families most in need are the least likely to access support (Leone, Mason & Metcalfe 2012).

Also, Browne and Fiske (2001), in their study report on First Nation women from a reserve community in north-western Canada drawing on aspects of critical medical anthropology from a theoretical orientation of s cultural safety. Ethnographic interviews were conducted with 10 First Nations women using critical and feminist perspectives. It was found that the social elements of cultural safety, such as potential solutions to critical imbalances of power, offered an alternative perspective on cultural diversity. The historical effects of colonisation and ongoing social structures were set up to disadvantage Indigenous people (Browne & Fiske, 2001; Brascoupe & Waters 2009).

Furthermore, studies are more focused on their effectiveness for those that use these services (Katz, LaPlaca & Hunter, 2007). A further example is a six-year longitudinal mixed methods study in the United States that analysed 2005 service use administrative data for 531 mothers and conducted in-depth interviews and observations with 40 families. The study focussed on low-income parents of young children and their characteristics and needs (Spielberger et al., 2009). During the study parents described how their contact and



experience with service providers in the past had left them feeling judged and under surveillance. Winkworth et al., (2010a) noted that service provider's relational barriers included insensitive and judgemental behaviours adding to parental stress.

Health professionals and policy makers today have access to much evidence on the causes of lifelong harm to children. This evidence highlights the need to reduce parental stress during the significant developmental period of the child (Newman, 2008; Winkworth et al., 2010a; Winkworth et al., 2010b) and part of that story is providing culturally safe services.

There has also been a significant change in how vulnerable parents are viewed and hence how they can be best supported. Such families have often been looked at as "hard to reach" (Brackertz, 2007). The assumption was that the problem existed in the families themselves rather than in the services provided (Brackertz, 2007; Katz et al., 2007) and hence it was more likely that these families could be seen as ones failing to make the most of the services (Brackertz, 2007).

Indeed, accessing a culturally safe health service is dependent on the active participation of clients in service provision (Wilson & Neville 2008; Wilson, 2008; Bishop, 2003). Failure to identify and understand key practices influencing service provision risks providing irrelevant healthcare and compromises its efficacy (Bishop, 2003).

All citizens may expect and demand the right to accessible, affordable, and appropriate health care (Stewart, 2006). In practical terms, however, such ideals are not quite as easy to understand, implement or achieve (Kanitsaki & Johnstone, 2007). Stewart (2006), in her report on multiculturalism in Australia regarding access to healthcare, defined social justice as the foundation of multiculturalism which includes cross-cultural respect. The implication of these ideas for healthcare provision is a requirement for equity in service access. Kanitsaki et al., (2007) did a study in response to the marginalisation of ethnic minority groups in Australia when accessing health service care and concluded that Australia's health care system, including nursing, is not as responsive as it needs to be in accommodating the cultural diversity of the population it serves. This assertion is supported by other studies that claim that Indigenous community and Australians from minority groups still face "barriers to equal access to health care" (Bryant, Foley & Percival, 2008, p.10; also, see Kanitsaki & Johnstone 2004; 2007; 2009). Considering the increasing rate by 57% of overseas migration to Australia as of March 2012, concerns have been raised regarding the quality of Australia's health care services provided to the minority cultural care groups (Kanitsaki et al., 2007;

Australian Bureau of Statistics, 2012). Kanistaki et al., (2007) found that disparities among the minority groups have become prominent and support the need for responsive action from the Australian healthcare system including calls for a cultural safety approach in healthcare delivery to redress the status quo.

A report recently published by Milroy (2020) highlighted how access to health services for Indigenous Australians living in remote communities are further limited due to current restrictions imposed by the pandemic Covid19. The report exposed many health challenges that coincided with the pandemic period and health issues including mental health issues, anticipated to worsen over time. Most mobile health services were forced to stay away as most remote communities remained closed. One of the concerns listed by Milroy (2020) was whether Indigenous Australians during the pandemic would receive equitable and culturally safe care called for in the Aboriginal Ethical Position Statement.

### ***Studies on Service Delivery for Maori Pasifika***

In New Zealand, Wilson conducted and reported on a study to explore the nature of nurses' practices when working with vulnerable populations through interviews with 38 Maori women aged between 24 to 65 years of age. When services are delivered in a manner that addresses individual cultural diversity and needs, such services are received and utilised in a more effective manner (Wilson, 2008). The study used Glaserian grounded theory informed by Maori-centred philosophies. Wilson (2008) found that when interventions and positive outcomes were not achieved, it was common for clients to be labelled "non-compliant", a phenomenon being experienced by many Maori women similarly to other Indigenous women in countries where they are subject to colonisation. Another study in New Zealand by Kenney (2011), found that when non-Maoris act for and describe Maori women's experiences Maori women are discouraged and prevented from becoming experts themselves. Kenney (2011) looked at the practices of midwives in relation to Maori women and their families using a biculturalism framework. The outcomes suggested subordination where colonizing discourses and practices are simply constructing Maori "ways of knowing" as inferior to their European counterparts (Kenney, 2011; Smith, 1999).

A further study in New Zealand by DeSouza (2012) on eight Plunket Nurses (Well-child Health Nurses) on their perceptions of caring for migrant women questioned the model used within the Royal New Zealand Plunket Society regarding service provision. Findings of this study showed that "Plunket nurses deploy culturist discourses to account for the differences

between migrant mothers and the unmarked implicit norm of the dominant maternal subject” (DeSouza, 2012, p.7). DeSouza is saying that care provided to a migrant mother is based on racial, ethnic, and assumed physical characteristics held in relation to assigned labels held by service providers. This means a migrant mother will be labelled in terms of her cultural group which is assumed to be static and homogenous (DeSouza, 2012; Vertovec, 2011). In review of DeSouza’s work, health professionals continue to fail to register the “institutional, historical, social and structural contingencies that shape the life of this migrant mother” (DeSouza, 2012, p.8). Such findings will have implications to Maori and Pacific Island people given that they are significant group of migrants in Australia and given their socio, cultural and historical context.

Elder et al. (2009) reported on a study conducted in New Zealand which aimed to identify aspects of planning needed to develop a sustainable specialist Maori mental health service. They used a Maori methodology, *tikanga* (Maori protocol and practises), in a 2-day facilitated *Hui* (meeting) and workshop with key stakeholders to identify key goals and values that may be useful in the development of services for this population. Key stakeholders involved comprised carers of Maori patients with mental health issues, team staff members and service providers who provide mental health services to Maori population in South Auckland New Zealand. Several aspects of *tikanga* (Maori protocol and practices) were identified as essential to the positive outcomes of future for the service provision to Maori with mental health issues. *Tikanga* Maori (Maori protocol and practices) could be beneficial in settings such as Townsville, the original site of my proposed research, where planning for sustainable Maori responsive service might need to be undertaken.

In New Zealand, Kirk, Barnett and Clayden (2002) conducted a study using a before and after design to evaluate the effectiveness of the global budget as a model of funding primary health care services with a focus on access for services for Maori and Pacific population. The following excerpt outlines many issues in relation to access to and delivery of healthcare for Pacific communities. As quoted in Kirk et al., (2002, p.73), “there are a lot of families not attending their family and general practitioner clinics because of their limited English, they have immigration, money, family issues and when accessing healthcare some do not understand what a health professional requires of them”.

Although the above quote focuses on barriers to access to service provision, it has implications for developing health policies that recognise social disadvantage and

inequalities in the health sector for Pacific peoples (Kirk et al., 2002). The study identified that access to services is a core theme and a concept aligned with public health which impacts on the health status of the population as well as individuals where inequality exists.

Mila-Schaaf and Hudson (2009, p.117), in New Zealand, examined the concept of “negotiated space” which has relevance to this study’s focus on Maori and Pacific Island families facing issues of access to health services. The concept was developed by Smith (cited in Schaaf et al., 2009) to describe the over-lap of different worldviews between Maori and Western scientific contexts (i.e., health care provision). Schaaf et al., (2009, p. 116) argued that this concept could provide the opportunity for “conceptual understanding of the principles of equation, balance and alignment” in relation to developing a partnership through dialogue and suggested that “negotiated space” is where intercultural negotiation and permission can take place.

Fundamental to the purpose of this research and reiterated by these commentators that, “there has been limited research on why most vulnerable families fail to use or disengage from services and little is known about the merits of different strategies to engage vulnerable families” (Leone et al., 2012, p. 2; Queensland Health Maori Pacific Island Women’s and Neonatal Health, 2016; Sheridan, 2015; Dawes & Gopalkrishnan, 2014; Krauss, Angus, Bor & Crichton, 2014; Queensland Health Needs Assessment, 2011a). For example, structural factors such as the lack of appropriate support for parents including culturally safe services was one of the challenges identified by Anderson et al., (2011).

Wilson and Neville (2008, p. 174) found that a “problem focused approach to health care service delivery is offered and that the social context relevant to people’s lives outside of the healthcare system claimed by health providers, that of holism, is merely a rhetorical construct”. What Wilson and Neville are saying is that despite claims for “social and holistic care”, health care service provision experienced by service users was irrelevant and “holistic care” being implied does not exist. Furthermore, this argument needs to be fully recognised and embraced by existing service providers who, with their strong focus on “economic rationalism” (Wilson & Neville 2008, p.174) currently attach more importance to cost effectiveness than service effectiveness.

Southwick (2001) in her study on Pacific women and Southwick, Keneally and Ryan, (2012) in their study on Pacific Island families’ experiences with health service provision in New

Zealand, reports that health care providers will need to genuinely believe in their ability to understand and to contribute to care regarding their attitudes about healthcare provision. It is thus considered crucial that mainstream providers develop awareness about their own cultural assumptions in positing normalisation when looking after “others” accessing their services (DeSouza, 2012).

### ***Diversity, Health Inequality and Health Service Provision***

The issues of health inequality, cultural diversity and health service provision are discussed in studies by Davies and Bath (2001), Bulman and McCourt (2002), Braverman and Gruskin (2003) and Davies and Papadopoulos (2006). Overall, these studies suggest that mothers from “other” cultural backgrounds, for example, refugees and migrants, experience poor access to appropriate information and that their movement through a system is problematic with tensions between professional involvement and family involvement (DeSouza, 2012).

Davies and Bath (2001) explored the experiences of Somali women when accessing maternity services in the UK. Focus groups and semi-structured interviews were held among English and non-English-speaking Somalian women in the UK and the analysis found that poor communication among non-English speaking Somalian women and health professionals was a barrier to these women seeking healthcare services. For instance, a study in Tennessee, USA, on health-seeking behaviours of white people versus black people, called for a greater understanding of the social and environmental factors that impact on health-seeking behaviours in addressing lack of uptake of child health services (Thurston et al., 2018).

A study on the birth experiences of more socially disadvantaged or minority women showed (with quality and access to care) that 11% of participants stated midwives did not treat them with respect (Bulman & McCourt 2002). Similar findings were highlighted by Davies and Papadoulos (2006) in their study with Ethiopian asylum seekers and refugees in the UK in which participants felt their social and healthcare needs were not met.

For healthcare professionals, it is significant to understand that culture is dynamic, not fixed but fluid (Cox & Taua, 2009; 2013). It varies between and within groups and changes in response to time and societal changes (Wilson, 2008). For example, studies on Pacific families as highlighted earlier by Tiatia (2012) are problematic because no one group is homogenous and as argued by Ramsden (1990) the reality of gathering culturally specific

knowledge about groups is problematic due to the variability that is present among and within groups. To explain this variability further, as found by Tiatia (2012), younger generation Samoans who partly identify with the majority norms are obliged to maintain cultural family values for fear of disrupting these values. However, they distanced themselves from their families which may lead to disastrous behaviours (suicidal ideation) stemmed from perceived ruptures and isolation to family unity (Tiatia, 2012; Tiatia-Seath, Lay-Yee & Von Randow, 2017). Understandably, the above study by Tiatia is reviewed to underline a principle of cultural safety and that is to work in partnership with the actual individual that seeks help rather than to assume that 'all' Maori Pacific Island Families have the same needs and values and to impose these values onto a Maori Pacific Island service user when accessing health care.

Similarly, an exploratory study by Radclyffe et al., (2023) on *sense of belonging* of Maori Pasifika Youth in Queensland, found that Maori Pasifika Youth face insecurities of belonging as a daily part of life. Contributing mitigating factors are due to socio-economic circumstances, cultural differences, and cultural identity.

Further, in New Zealand, a taskforce was established to respond to a report (Carroll et al., 2011) on childhood development. Led by the New Zealand Prime Minister's Chief Scientist Advisor, Gluckman (2011), the taskforce report argued that while it is the environmental context which matters in childhood development, culturally relevant solutions are strongly indicated. In Aotearoa (NZ), there have been assertions by Maori and Pacific advocates, that to address these issues requires an understanding of culturally specific and safe practices by health service providers (Gluckman, 2011). However, this is problematic because this is asking health service providers to learn and understand Maori and Pacific families' 'culture' which reinforces the very perception that health service providers can know what is 'best' based on problematic cultural recipes. In such a model assumptions and attitudes are made based on preconceived knowledge and ideas about Maori and Pacific Island families. The Prime Minister's taskforce emphasised that the recommendations in the report are not intended to be ethnically specific but rather are context specific. That is, some children from low socioeconomic backgrounds who experience multiple risk factors including poverty, family violence, abuse and neglect are more at risk of negative outcomes during adolescence than are children who do not experience these risk factors (Gluckman, 2011).

The key issue identified in the above report is that Maori and Pacific children are being red flagged and labelled as those developing negative outcomes because they identify as Maori and Pacific. Exhibiting cultural differences can be problematic because there are also implications of being labelled and or targeted when you exhibit behaviours that are different from the mainstream. One such implication is addressed by Ravulo (2016) in his studies with Pacific Island youth who are involved in the Australian youth justice system. Ravulo found that the judicial system in Australia is quite critical and *being indifferent* to behaviours of Pacific Island youth.

### ***Policies in relation to service delivery for Maori Pacific Island communities***

In 2011, Queensland Health developed an organisational cultural competency policy in response to issues of service delivery for culturally and linguistically diverse (CALD) communities identified by the Ethnic Community Council in Queensland (ECCQ) and Queensland Government Multicultural Policy 2011 (Queensland Health 2011b). Maori and Pacific Island families in Queensland were grouped under an umbrella as a culturally and linguistically diverse (CALD) community. Issues such as lack of interpreters and health professionals in need of skilled development in cultural development were identified (Queensland Health, 2011b). A project was completed by Queensland Health based on an extensive consultation with Maori and Pacific Island communities and stakeholders. The project was undertaken in 2011 as part of the Maori and Pacific Islander Health Needs Assessment and Policy which led to an establishment of the Good Start Program (Queensland Health, 2011b).

In terms of policy for Maori and Pacific Island communities, Maori Pacific Island people are classed and categorised as culturally and linguistically diverse (CALD) population here in Queensland (Krauss et al., 2014). Policies designed in relation to anyone who differs from the mainstream population, including Maori Pacific Island population in Queensland, are thus being delivered whether relevant or not. This is shown in a case study on Pacific Island Samoan children's transition between home and school here in Queensland. While the study reported concern with Samoan parents and teachers being aware of cultural differences between the family and schools, no systemic efforts were made to accommodate this nonalignment (Kearney, Fletcher & Dobrenov-Major, 2011).

The Good Start Program was designed in response to needs identified in the Maori and Pacific Needs Assessment report aimed at developing well-being for Maori and Pacific Island people in Queensland but is only funded for five years with funding due to end June 2015 (recently extended to another 3-4 years). Maori and Pacific Island health workers were hired on a parttime basis on a temporary contract to run programs aimed at developing good health. Again, this transcultural approach to service delivery depicts dependency rather than allow for selfdetermination to occur whereby Maori and Pacific Island people are asked nor encouraged to be involved with planning and governing of delivery of services pertaining to their wellbeing and healthcare. Likewise, another review reported in Queensland for culturally and linguistically diverse (CALD) communities suggests that the use of bi-lingual and culturally specific health workers may promote greater uptake of chronic disease prevention strategies (Henderson, Kendall & Se'e 2010).

Using cultural brokers who belong to the same language community as the target population can be of significant benefit in enhancing service uptake and access and can sit well with models based on cultural safety. However, in general, transcultural approaches are reductionist, whereby cultures are seen as and accepted as static and simplistic in nature thereby negating diversity and individualism. Transcultural approaches promote a checklist approach and are accepted by service providers deemed as appropriate (Nursing Council of New Zealand, 2009). Furthermore, in contradiction to the cultural safety model the Queensland Health Transcultural Mental Health Centre, in their final report of the Promoting Stronger Samoan Families Project (Queensland Health, 2006), outlined how information needs to be communicated in certain ways and places so that people will be more receptive. This transcultural approach could be perceived as many Pacific Island people as possible to be highly religious and the most efficient way to do things is to approach an issue through church leaders. As can be readily seen, however, this approach would leave out those who may not be participating in church activities and has the underlying assumption that all those who do have the same cultural needs or perspectives. There are Pasifika-based programs in Brisbane and including Queensland Health-based health programs that offer ethno- educational programs to health service providers that work with Queensland-based Maori Pacific Island Families such as Queensland Health Good Start Program & Mana Mentoring (Queensland Metro South Health, 2016). Such programs emphasised a transcultural approach where Health Service Providers are



educated and advised about Maori and Pacific Island Culture and their ways of doing, so to engage with Maori and Pacific Island people.

### ***Social Justice for health service access of Maori Pacific Island Families in Queensland***

The Queensland Maori and Pacific Island Health Needs Assessment & Policy (2011b) found low rates of service access among all Maori and Pacific Island communities here in Brisbane, Queensland. The needs analysis report concluded that exploration was needed into current workforce models to improve health service access in the context of the Queensland health sector by hiring Pacific Island staff and liaison officers. The Queensland Health Workforce Development Unit had taken the lead and one of the strategies was to increase service access to Maori and Pacific Island people by exploring Maori and Pacific Island identified workforce roles required to facilitate improved health service access (Queensland Health Needs Assessment, 2011b).

In summary, the report indicated that Maori and Pacific Island communities experience higher health inequalities than the total Queensland population. Except for a strategy of hiring Pacific and Maori staff, peer workers and liaison officers, there were no systems identified that strategically addressed the inequalities experienced by the Maori and Pacific Island communities and little coordinated efforts across departments on actions to effectively address the needs of Maori Pacific Island people in Queensland (Kearney et al., 2011; Krauss et al., 2014).

As previously found, studies discussed how mainstream mental health services in Brisbane were perceived by Maori and Pacific Island community members as providing services that exclude Maori and Pacific Island cultural realities and input, (Krauss et al., 2014; Sheridan, 2015; Kingi, Erick, Nosa, Paynter & De Silva, 2021). Hence the need to draw on key concepts of decolonisation and cultural safety to lay out the theoretical constructs central to the research question and aims in the research.

### ***Research on the Application of Cultural Safety in Australia***

In Australia, those involved with Indigenous health have also shown interest in cultural safety as a useful theory (Eckermann et al., 2010; Cox & Taua 2013, 2016; Best & Fredericks 2014). Options for access to equitable and relevant health care here in Queensland could be seen

among some of the Aboriginal Community Controlled Health Services established in the early 1970s in response to Indigenous people's difficulty in accessing mainstream health services and to address dissatisfaction with existing services and their service delivery (Kildea, Kruske & Sherwood 2010; Kildea et al., 2012). Aboriginal Medical Services (AMSs) were established in areas as community- controlled health services and many AMSs were significant in providing relevant and culturally safe healthcare by working in partnership with women, families, communities, and other service providers.

In 2004, the Murri clinic based at Mater public hospital was established to offer an option for collaborative service provision and is an Indigenous antenatal health (Murri) clinic for Aboriginal and Torres Strait Island women located within certain geographical areas in Brisbane (Kildea, Kruske & Sherwood ,2010; Kildea et al., 2012). Most of the families that accessed this service provider were clients of the Aboriginal Medical Services (AMS) based in Brisbane and were given a choice to enlist the services of Murri (antenatal) clinic rather than antenatal services offered within mainstream services. Prior to the opening of the Murri clinic a community-based consultation with community elders and families was undertaken regarding how and what service delivery should be (Kildea, Kruske & Sherwood, 2010). Surveys with those who had attended the Murri clinic were undertaken after 2 years from the start of the of the clinic had found that services offered to users and external stakeholders were highly valued. Most service users (92%) perceived that their needs were understood and respected at the Murri (antenatal) clinic (Kildea et al., 2010; Kildea et al., 2012). Furthermore, Aboriginal and Torres Strait Island health workers and liaison officers were integral to the clinic's success and Kildea et al (2010) noted, had impacted on an increase in uptake of the Murri Clinic services.

A further study in Queensland found that 28% of the Australia population with culturally and linguistically diverse backgrounds were reluctant to use mainstream health services due to cultural differences and language barriers (Henderson & Kendall, 2011). Analysis of data from Pacific Island, Sudanese and Afghani communities in Logan, Brisbane, showed that most participants expressed long-term difficulties in their experiences when accessing health services. Language difficulties and socio-economic factors impeded communication with service providers who were reluctant to use interpreters. In conclusion, the study argued for health service provision that identified a clear role for community-based navigators to address concerns about the health system to improve accessibility to health services (Henderson & Kendall, 2011). Community-based navigators were used in the above

research on health service provision for disadvantaged people since it challenges the traditional role of health service providers as fully competent practitioners. On the contrary, the approach encourages practitioners to practice from a starting point of reflexivity which, in turn, implies the practitioner makes visible their actions and their effects on service provision (Charmaz, 2017). Furthermore, as noted below, there are several alternative options available to determine whether service delivery is sustainable through using research methods deemed effective.

## ***Conclusion***

To date, there is limited literature or evidence that explains why there is a low uptake of health services occurring among Maori Pacific Island Families in Queensland (Queensland Health Maori Pacific Island Women's and Neonatal Health, 2016; Sheridan, 2015; Dawes & Gopalkrishnan, 2014; Krauss et al., 2014; Queensland Health Needs Assessment, 2011a, Cruickshank et al., 2018). There is strong research evidence of the importance for providing relevant and culturally safe health service provision. Too often, health service providers, as found within the literature both here in Queensland and in New Zealand, are limited by their inability to analyse their assumptions, their service provision and their own actions as they are too focussed on understanding the "other", thereby resulting in stereotypical assumptions being made and health service provision experiences that marginalised health care for Maori and Pacific Island people. In addition, the researcher envisions development of new knowledge particularly in adding to limited literature pertaining to Maori and Pacific Island health service experiences here in Queensland.

As we have seen from the above review there is an urgent need for effective responses and health providers to facilitate positive outcomes for Maori Pacific Island families in Queensland. The proposed research asks service providers to consider and examine their own realities and attitudes they bring to each person they encounter in their practice. Further they need to evaluate the impact that historical, political, and social influences on the health of Maori Pacific Island Families in terms of research or service delivery. The following chapter discusses the methodologies that will be used to further these goals.

## ***CHAPTER THREE Theoretical Framework***

### ***Introduction***

This chapter addresses the concepts of Cultural Safety and Decolonisation and how they underpin processes of culturally safe service provision by considering the socio-economic and cultural position of Maori Pacific Island Families in the research context. The chapter justifies the use of the theoretical framework to analyse and interpret the research data. The starting assumption is that contextual and environmental factors are essential in understanding Maori Pasifika families and their health seeking behaviours in accessing service delivery.

### ***Why decolonisation, cultural safety and talanoa methods***

In this research the use of critical indigenous pedagogy such as cultural safety and decolonisation encouraged the researcher to expose key concepts connected to creation of meaning of science and knowledge integral to Maori Pacific Island well-being (Smith, 1999). Also, of significance was that the theoretical approach privileged social and local knowledge through engaging in *talanoa* while acknowledging conventional knowledge in health and health service delivery.

The following section begins with an overview of historical and colonial experiences as they shaped and influenced current experiences and the positionality of Maori Pacific Island people in Queensland as they accessed health service delivery. The use of decolonisation methodology in this research addresses the significance for Maori Pacific Island Families to be viewed in a holistic context, from the past, the present and the future.

### **Colonisation**

The development of European capitalism, from the 1500s onwards, introduced systems whereby control over land, law, language, education, health, and family structures passed from Indigenous peoples to the colonisers (Nairn, 1997). Because of its origins, colonisation is deeply intertwined with European worldviews. Colonial viewpoints have continued to persist through the lens of Western ways of thinking despite significant gains that have been made to resist colonialist assumptions within the academy world (Hunt, 2013). An explanation by McGibbon et al., (2014) highlighted how colonisation in its subtle ways sets

the foundation of nursing theory with its intention to civilize the world. McGibbon et al., (2014) critically analysed the effects of politics and power in influencing the synthesis of the nursing profession. The above authors continue to contribute in their discussion towards decolonising the nursing profession. Key viewpoints indicated in their work were the ongoing colonisation of nursing's intellectual development through examining white privilege and racism that sustain colonising action and thinking in nursing services.

The effects of colonisation in influencing nursing service delivery can be found amongst indigenous populations in which there has been poor health, social disruption, low educational level and suppression of culture, language, and spirit (Dudgeon & Walker 2015; Dudgeon & Pickett 2000; Smith 1999; Hunt, 2013). According to a World Health Report (2010), one key indicator of the impact of inequities in health status globally is the continuation of poor health status among Indigenous populations of their Lands and in their countries (Pulver et al., 2010).

The WHO's global health outcomes clearly identify the need to increase social justice, followed by equal distribution of health, responsibility, implementation and knowledge (Pulver et al., 2010). The current reality is that factors that drive health inequity are systemic and many of these factors relate physical health, socio-economic status, and political, cultural, historical and environmental issues (Mauri Ora Kite Ao, 2009; Tukuitonga, 2012; Curtis et al., 2019). In Australia and New Zealand colonisation has had a debilitating and chronic impact on well-being of their Indigenous populations (Dudgeon and Walker, 2015; Curtis et al., 2019).

In New Zealand, work has been undertaken to expose the links between colonisation, land and language loss, security in identity, social disadvantage, and health for Maori Pacific Island people (Tukuitonga, 2012; Curtis et al., 2019). As found in New Zealand, inauspicious social conditions are greater determinants of health in Maori Pacific Island communities than lack of uptake of health services (Southwick et al., 2012). Issues for Maori Pacific Island people are further magnified on migration to a country such as Australia, where Maori Pacific Island people make up a small minority within a larger population group and are isolated from their culture, values and families (Rodriguez, 2007).

Solutions for Maori and Pacific people in Townsville and Brisbane may not be straightforward. Evidently, Seaton (2010) in her study reported previous work undertaken by the government in Australia to assist access and equity to health care have had variable

outcomes in which there appears to be a disconnect and a lack of participation mainly by marginalised groups. Moreover, Kearney et al., (2011) and Stanley and Kearney (2017) identified a non-aligned world of home and school between second generation Australian Samoan students, their parents and their schools. And children being born to Maori Pacific Island parents living in Australia are faced with secondary challenges of creating an identity informed by their parents and yet different.

### ***Decolonisation Methodology***

Decolonisation methodology, like cultural safety, is concerned with and aims to achieve collective change; it is a developing framework that seeks to deconstruct existing relations and conditions of power (Clark et al., 2010; Baker 1997). Smith's (1999 p. 23) work on decolonisation methodology "stressed the need to revisit research methodologies used to impose the authority of western science on knowledge production and thus to deconstruct the effect of colonialist scientific objectivity which perpetuates marginality".

Anderson (2001) further argued that the aim of decolonising nursing research is to give voice to participants who have been silenced and thus allow critical examination of how politics and social history have variously shaped knowledge, lives and opportunities. There had been studies written from a reductive perspective whereby service providers were not accountable for their attitudes and cultural realities and their impact on relationships between themselves and service users (Wilson 2008; Eckermann, et al., 2010). The framework in this research project allows Maori Pacific Island Families to be part of research planning, feel safe in research processes and have the right to voice, determine, participate, and shape their own destinies.

A decolonisation theoretical framework is necessary within any Indigenous research given the current social inequities that Indigenous peoples continue to experience (Kovach, 2010). Decolonisation methodology is significant because it focuses on and seeks to interrogate the powerful social relationships that marginalise Indigenous peoples (Kovach, 2010). Indigenous Canadian and Indigenous Australian scholars (Alfred, 2008; Martin, 2003) have supported and promoted decolonisation methodology regarding research with Indigenous Aboriginal people. Alfred (2008) and Martin (2003) described decolonisation as a method to exemplify Indigenous Aboriginal current health conditions as they rise to restore their place and not become lost in the colonisation rhetoric.

A decolonisation methodology examines and aims to deconstruct politics and history that have invariably positioned lives and integrates the knowledge and strengths of participants who are vulnerable and marginalised within a system, thus providing the lens to examine how politics and history have positioned lives, knowledge, opportunities and choices (Kovach 2010; Nabobo-Baba 2008; Anderson 2000; Smith 1999). For example, Linda Tuhiwai Smith (1999) commenced writing from her own position as a Maori researcher in social sciences in addressing her Indigenous Maori colleagues and in developing research methodologies which better reflect the interests of Indigenous peoples. Smith (1999) argued that history, writing and theory must be decolonised so that these stories no longer reflect the stories and ideas of the powerful but the interests and understandings of the Indigenous (for Maori) people who have been dominated. Smith (1999) and Nabobo-Baba (2008) both assert that Indigenous researchers must not only be self-reflexive, critical, and ethical but be humble and honest in their work with people.

### ***Cultural Safety Model***

In the late 1980s, Ramsden (1990) developed a concept referred to as “Negotiated and Equal Partnership” in response to perceived detrimental and enduring social effects of colonisation on the health status of Indigenous Maori. Ramsden’s work was a significant force in shaping the development of the concept of cultural safety for use by nurses. Furthermore, and as seen overseas, cultural safety as a model was used to extend discussion on the development of increased recognition and responses to personal nursing and health prejudices in service delivery (Woods 2010; Browne & Smye 2002; Willis, Smye & Rameka, 2006; Lavery, McDermott & Calma, 2017). Brown and Smye (2002, p. 49) claimed that “cultural safety alerts us to examine not only current inequities but also the long histories of economic, social and political subordination” that are the causes of current health and social issues impacting Aboriginal people, and, by extension Maori and Pacific Islander families.

Cultural safety is a philosophy and practice that provides a theoretical framework that enables effective relationships based on the understanding that the patient may have a worldview and lifeworld that differs from that of a health professional (Ramsden, 2002). Cultural safety requires health professionals to explore and to reflect on their own practice and the potential impact of their beliefs and practices with people they work with (Nursing Council of New Zealand 2009; McClelland 2011). Similarly, Charmaz (2017) argues her

constructivist grounded theory is underpinned by researchers' conceptualisation of data and is dependent on their interpretations of data.

Ramsden (2002), in articulating her Cultural Safety Model (Kawa-Whakaruruhau), pointed to the need for service consumers and service providers to work in partnership and to remain focused and respectful of each other's cultures. Importantly, Ramsden (2002, p.112) stated that service providers "do not need to understand the cultural dimensions of any culture other than their own". The above means service providers in Townsville do not have to learn about Maori Pacific Island Families and their ways of doing things to provide culturally safe care. Rather, the onus is to be put back to Maori Pacific Island Families because they are the ones to decide whether the services provided for them are culturally safe or not. Smith (1999) refers to this reversal of competency in terms of decolonisation methodology where Maori Pacific Island Families can articulate and discuss how and what service provision should be for Maori Pacific Island Families. In reflecting on Maori and Pacific Island poor health status in Queensland it is important to understand and contextualise Maori and Pacific Island people within their social, political, and cultural backgrounds. Thus, the importance of Maori and Pasifika family's perspectives in determining effective and appropriate care provision.

Hence self-reflection is paramount to consider whether professional practice is culturally unsafe by including "any action which demeans and diminishes or disempowers the cultural identity and wellbeing of this individual" (Cox & Taua 2013, p. 40). In sum, cultural safety is concerned with social justice and is "about nurses, communication, power, prejudices, and attitudes rather than ethnicity or a patient's culture" (Ramsden, 2002, p. 5). Child health service providers need to understand and to acknowledge that their services and health systems are embedded in a culture with an emphasis on colonised subjectivities in terms of existing policies.

### ***Cultural safety and Decolonisation methodology in relation to research with Maori Pacific Island Families***

Wilson and Neville (2009, p.69) discussed culturally safe research processes, methodologies and argued "that mutually aligned research endeavours are a fundamental right for vulnerable populations". A framework based on partnership, participation, protection, and power was presented and can be used to underpin the planning and development of any research processes involving vulnerable populations (Wilson & Neville 2009). Indeed, this



will be a welcoming aspect for Maori Pacific Island Families participants in this research because it will recognise their skills, knowledge, and experiences, thus enabling culturally safe principles. Thus, cultural safety, also aimed at decolonisation, sits well in the theoretical framework.

In the case of this research, which is underpinned by cultural safety and decolonisation methodologies, Maori and Pacific Island family perceptions of experiences of child health services were explored through the use of an Indigenous Pacific conceptual framework (*Talanoa*). Ramsden's thesis on cultural safety redirects the gaze from solely on service users to focus on service providers and their reflections on their own beliefs and practices. For example, Charmaz (2017) in articulating her constructivist grounded theory to pursue critical qualitative inquiry, argues that researchers and service providers develop a deeply reflexive stance on self-consciousness as an outcome of their interpretations of participant stories. In turn, several strategies such as self-consciousness supports researchers in interrogating their data and actions as they evolve in their research (Charmaz, 2017). Interchangeable to cultural safety as a model, Mills, Bonner & Francis (2006) described Charmaz in her writings as being explicit in her potential to communicate how participants constructs their world.

The methodologies ensured that ethical dimensions, such as power dynamics, informed consent and cultural considerations, were the focus of the research guidelines. As highlighted by Smith (1999) and Cram (2009), all research involving Indigenous populations must employ culturally safe approaches which take into consideration the issues that are important for the people being researched. For example, a mentor who was part of a community reference group (CRG) for the research agreed to participate as a support person in relation to potential cultural complexities that arose throughout the research process.

As Cox and Taua (2013) clarified, it is fundamental we understand that diversity exists between and within cultural groups and results in diverse views. The concern is that access to services and service provision is often based on ethnic groupings and problems defined on specific issues idealised by the service provider. This perspective is problematic because cultural fluidity and variation as seen and experienced between and within same groups of people means changes in response to time and societal changes (Cox & Taua 2013; Wilson 2008). In summary, cultural safety as a model in influencing service provision focuses on the actual needs of a human being as a service user rather than on some stereotypical views about the culture of the service user.

## ***Research for Maori Pacific Island Families in Townsville and Brisbane***

The choice of decolonisation methodology and cultural safety model and the associated methods for data collection: to hold a conversation and to tell a story (*Talanoa*), relate to my lifeworld and my cultural assumptions as a member of the target population and are best suited to achieve the outcomes. As an Indigenous Pacific researcher, while exploring an appropriate theoretical framework for this study, I was particularly drawn to the work of an Indigenous academic on Maori heritage. Smith (1999) outlined a goal to equip researchers from Indigenous communities with concepts and worldviews for conducting research from an Indigenous perspective. Throughout the process there is a need to expose, resist and to transform the emerging presence and influence of colonialism.

Within the premise of power and knowledge, Maori Pacific Island Families and Child Health Service Providers come from different cultures and social backgrounds and thereby may construct meanings in different ways, even in relation to the same issue (Crotty, 1998; Lester, 1999). This research ensured that Maori Pacific Island Families perceptions or ways of understanding and doing are explicated in all facets of this research, thus acknowledgment of Maori Pacific Island Families voices are heard in anticipation of self-determination (Smith, 1999).

Through reflexivity service providers are aware of their own position in this relationship with their clients and how easy it can become for the one in a powerful position to impose their values, beliefs and actions onto those deemed less powerful. A partnership can become stronger, productive, and more meaningful if mutual trust and respect are present. This type of relationship is what Ramsden was talking about when she referred to service provision that were deemed culturally safe. The researcher in anticipation will ensure that processes of partnership, protection and respect will be maintained always between the researcher and participants.

Smith (1999) critically reviewed the impact of western orientated research upon voice and identity in Indigenous communities. Smith argued for a theory of western methodologies research to be carefully evaluated and deconstructed for lack of efficiency in giving justice to Indigenous voice. Smith (1999) asked that when research was conducted by and for Maori people in New Zealand who have historically called for *mana* (respect) and *rangatiratanga* (sovereignty) in research, their participants have the right to express, determine, participate and shape their own identities. Such an approach will add to and strengthen the rigor of

research with Indigenous people (Nakata, Nakata & Chin 2008; Smith 1999). Nakata et al., (2008) further suggests that the challenge for Indigenous research is to draw from and develop an Indigenous own analytic position. In the meantime, Indigenous research will continue to uphold an Indigenous platform to extend and to develop their position, including Maori Pacific Island Families in Queensland. One could argue that cultural safety and decolonisation methodologies was necessary in this research given the existing inequities that Maori and Pacific Island families continue to experience here in Queensland.

## ***Conclusion***

Decolonisation and cultural safety methodologies emphasise needs and challenges as developed by representatives of the Maori and Pacific Island people participating in the research. Thus, decolonisation methodology is an Indigenous research methodology which aims to understand problems locally and construct knowledge that is directly useful to the Maori and Pacific Island community in Townsville and Brisbane. The input of staff contribution from service delivery is significant so this research sought to determine staff experiences of working with Maori Pacific Island Families thereby to critically evaluate their work practices and experiences of working with Maori Pacific Island Families (Seaton, 2010).

While experiencing inequalities in their health experiences and being subjected to enquiring lenses of service providers and their interpretations, this research strives to find better ways of working with Maori and Pacific Island people by reversing the situation by asking service providers to reflect on their service provision particularly when working with Maori and Pacific Island people (Woods, 2010). This implies an assignment to Maori and Pacific Island peoples in Queensland of the right to self-determination, not only from a political or socioeconomical point of view, but also with respect to being acknowledged ownership of research outcomes (Smith, 1999).

Furthermore, Smith (1999) argues that any research project must be thoroughly considered, in respect of Indigenous peoples' interests and needs. Smith (1999) call for decolonising processes to be used to achieve equity within power relations inherent within service delivery. Cultural Safety requires individual health professionals to explore their own assumptions and beliefs so they can be more open to others way of being and doing. Indeed, Ramsden in giving credit to Paulo Freire's work wrote: "And Friere's work in its global

understanding of liberation struggles emphasises that this is the important initial stage of transformation – that historical moment when one begins to think critically about the self and identity in relation to ones’ political circumstances” (Ramsden 2003, p. 42).

Decolonisation of services within Child Health Service Providers begins with the awareness of the circumstances of the self and others. Gaining awareness is often cited as a beginning point for one’s journey to understand marginalisation and oppression of others and in this research, Maori and Pacific Island Families (Nursing Council of New Zealand, 2009). This is the reason why Ramsden referred to the nurse, “as a bearer of her or his own culture and attitudes, and subconsciously or consciously assumes power that may impact on the recipient of care “(Ramsden, 2002, p.109).

There is an implication that health professionals need to demonstrate genuine interest and encourage this form of mutual understanding when working with their clients (Woods 2010; Gibbs 2005). An important factor in understanding cultural safety is to work in partnership with people who are less powerful and to respect and genuinely believe in the partnership process. Furthermore, Eckermann et al., (2010) note how a reductive perspective used in much research, does not “embody” the ethics of cultural safety theory where participants can be part of the research planning, to use their language of choice and contribute to the directions of outcomes.

In summary, decolonisation methodology provided the lens through which to examine the data, language, and concepts and to consider the perspectives of the participants (Maori and Pacific people) in the current research. The theoretical framework underpinning decolonisation and cultural safety in this research is a deliberate and intentional undertaking to enable and celebrate the realization of our full potential as Maori and Pacific people. Hence, in the following chapter an Indigenous Pasifika (Pacific) dialogical method, Talanoa (talk or to tell a story), is chosen as the method to collect data from study participants.

## CHAPTER FOUR Methods

### Actual Journey: Koe Hekeaga he Fenoga

#### *Introduction*

The purpose of this chapter is to contextualise in detail the methods applied in this research. The chapter begins with a discussion of the *Talanoa* process as a conceptual framework which informed data generation with Maori and Pacific Island people in Townsville and Child Health Service Providers both in Townsville and Brisbane. The *Talanoa* in its process, acknowledged how positionality of each study participant shaped their experiences and decisions around access to, and provision of, health services. The chapter moves on to provide a detailed description and justification of the setting and recruitment, data generation and data analysis. The discussion includes consideration of ethical issues relevant to the research.

The application of Charmaz's constructivist paradigm to interpret data was grounded in the assumption that perceptual realities and lived experiences are the underpinning factors that contribute to Maori Pacific Island Families viewpoints on service delivery. Rather than looking specifically at current inequities affecting Maori and Pasifika families as they access service delivery this research explored the role of the health system and health service providers in terms of service delivery for Maori and Pasifika families.

#### **TALANOA**

An explanation of the conceptual framework of (*Talanoa*) is critical in illuminating how its application decolonises research and contributes to the development of empowering policy and relevant services for Maori and Pacific Island Families. *Talanoa* was developed in response to the needs and challenges of the Maori and Pacific Island people who participated in the research. Thus, questions were unravelled in the way they were answered, unfolded and developed over the duration of the project (Fa'avae et.al., 2016; Havea, 2013; Stringer, 1999).

As highlighted by Smith (1999), decolonisation aims to deconstruct power relations within research, and this is seen within the *Talanoa* research method where the focus is on participants' worldviews and their perceptions of their experiences. The origins of the role

of *Talanoa*, is similar to that of Yarning used by Aboriginal peoples and Torres Strait Islanders in Australia which sought to empower people through the construction of their own knowledge in a process of action and reflection (Tsey & Every 2000; Tsey et al., 2002). The *Talanoa* is a dialogical method also used in New Zealand by Pacific Island researchers doing research with Pacific Island communities to promote and allow participants to communicate openly and collectively within a group (Prescott, 2008; Vaiioletti, 2006; Vaka, 2014).

*Talanoa* as a research method for data generation has thus been used in previous studies and reported to be effective for Pacific Island people (Farrelly & Nabobo- Baba, 2012; Latu, 2009; Otsuka, 2006; Otunuku, 2011; Vaka, 2014; Akbar et al., 2021). Those who write about *Talanoa* as a Pacific Island research method describe *Talanoa* as a holistic combination of emotions, beliefs, experiences, aspirations and actions between researcher and participants (Vaiioletti, 2006; Latu, 2009; Prescott, 2008). In addition, Otunuku (2011) described *Talanoa* as having contextual determinants such as social values, language, professionalism, and personality. *Talanoa* requires researchers to develop trust with participants and to ensure that information is shared willingly. Since *Talanoa* is grounded in openness, relationship building accounts for both the participants and researcher's professional and personal experiences (Otunuku, 2011). Moreover, *Talanoa*, when used as a tool for data generation encourages positive and collaborative approach between researcher and participant (Akbar, et al., 2021).

Fa'avae, Jones and Manu'atu (2016) emphasised how the *Talanoa* process shapes and develops relationships between the researcher and participants. As highlighted by Fa'avae et al., (2016) and Vaiioletti (2011), without this relationship building the *Talanoa* remains at a superficial level where the conversation or interview is polite and friendly but not grounded in mutual trust and respect that encourages open dialogue. In this project, the development of a good relationship between the researcher and study participants started with an introduction focussed on our genealogical origins. A shared knowledge of each other's position in life, language and family produced harmony between me, the researcher, and the participants and gave us confidence to communicate openly. For example, an older study participant who had come from the same Pacific Island as myself became much more open and confident with her responses once she recognised that I was able to speak with and respond to with her in her native language. As such, the *Talanoa* process was aligned with culturally safe and respectful research processes (Cox and

Simpson, 2015) through transparency and relationship building between the researcher and participants (Fa'avae et al., 2016).

There is also the potential to situate the *Talanoa* process as a philosophy of life which looks at transforming people to become critical thinking person's thereby empowering their capacity to develop independence and self-determination in society. As argued by Vaiioletti, *Talanoa* can facilitate people to "engage in social conversation which may lead to knowledge creation that allows rich contextual and inter-related information to surface as co-constructed stories" (Vaiioletti, 2006, p.24; also see Savin-Baden & Wimpenny 2007). Havea (2013, p. 200) summarised *Talanoa* as an approach "that refers to three overlapping events: story, telling, and conversation. *Talanoa* is not one or the other, but one in relation to the other two. Story is, in relation to telling and conversation; telling is, in relation to story and conversation; conversation is, in relation to story and telling; *talanoa* is all three at once. *Talanoa* is usually informal, fluid, and flexible".

The *Talanoa* process applied in interviews with Maori Pacific Island Families and Child Health Service Providers in Townsville and Brisbane was dependent on the context of each *talanoa*. One contextual aspect that emerged during *talanoa* or an interview was that the *talanoa* framework was not framed around a deficit discourse but instead allowed for an opportunity to develop an honest and transparent relationship using a strengths-based approach to communication, between the researcher and the participants. For example, prior to each *talanoa*, opportunities were given for both the researcher and the study participant to describe significant factors in their lives that makes them happy and strong people. Hence, the opportunity is optimised for ongoing conversation or dialogue surrounding topics included in this research. It provides the opportunity to develop credibility whereby the researcher steps beyond the known and enters and sees the world from the participant's perspective (Vaiioletti, 2013).

A further contextual aspect of *Talanoa* was that different cultural assumptions emerged between the researcher and Child Health Service Providers, during some of the interviews. An example is of one service provider who described their intervention with Maori Pacific Island families from a bio-medical perspective in terms of symptoms, statistics, and diagnosis. I interpreted the above experience as an underlying barrier for Maori Pacific Island families when accessing a service provider. The ability to create an open and honest

conversation therefore was limited. The researcher on reflection later asked the question: What would a Maori Pacific Island Family person or member do or how will they react in a situation like the above? Although Charmaz, Thornberg and Keane (2017) were not referring to child health service providers in particular, the above example can be compared to their description of how objectivist grounded theorists assumed data as an isolated entity and research participants are hence perceived as a statistic attached to no values. As Ramsden argued, nursing activities, including research, are never value free but rather socio-political activities which engage the values, assumptions and priorities of those involved (Ramsden, 2002; Cox & Simpson, 2015).

Overall, *Talanoa* enabled the research process to be guided by Maori and Pacific Island *tikanga* (protocols). For example, the *Talanoa* process of engagement meant that interviews started with a *liogi* (prayer) if a participant desired. A further factor considered to be a cultural protocol in research for Maori and Pacific Island people is the provision of a *koha* (a gift) in the form of a voucher or money for petrol or the supermarket to reimburse the time participants gave to the research (Wilson, 2008).

Since Maori and Pacific Island people in this research were heterogeneous with diverse views and beliefs some opted not to participate in such practices. However, it is an important factor that each family must feel respected and acknowledged as research participants with a voice rather than as passive agents (Smith, 1999; Nabobo-Baba, 2008). During each *talanoa* session, the researcher spoke with diligence and respect with Maori Pacific Island Families study participants and information about the research was readily made available which is the most favourable approach on which to base relationships with Maori Pacific Island participants (Kirk et al, 2002). Integral to the application of the process of *Talanoa*, there is a confirmed place for the conceptual framework of Maori and Pasifika as critical to the research framework (Martin, 2003). This form of gathering information is a research method frequently used in qualitative research by Pacific Island researchers and provided the participants an opportunity to feel safe to tell their stories, offer their perceptions, feelings and experiences that matches their concept of cultural identity (Prescott, 2008; Vaiolletti, 2006). The following section gives an example of a data collection method used by Indigenous Australians researchers.



## ***Examples of culturally safe research techniques used in other studies.***

Yarning, like *Talanoa*, is a valuable tool because it allows for a relaxed and familiar communication process within a known and culturally safe environment. Research has concluded that the study population, Maori Pacific Island Families, has poor access to relevant health services here in Queensland. The current research through the use of the *Talanoa* dialogical process addressed issues as part of an iterative research cycle that involved ongoing dialogue, probes, challenges and clarifications that saw new information emerge (Fredericks et al., 2011; Kovach, 2010; Bessarab & Nga'andu, 2010; Geia, Hayes & Usher, 2013).

Geia et al., (2013) described Yarning as an Aboriginal term for storytelling. Yarning is a culturally safe process towards understanding an Indigenous perspective and implications for research practice (Geia et., al 2013). Martin, an Australian Indigenous researcher, discussed the application of yarning as a research tool to mediate both the cultural conventions and expectations of Indigenous communities and participants (Martin, 2008). Principles of yarning were applied in a study on Indigenous youth in Queensland (2007) which showed that it is critical to make the project “youth friendly” and ensured that questions asked were relevant and helped to “frame” the topic and scope out relevant issues that could be further explored (Larkins et al., 2007; Tsey & Every ,2000). One of the principles of yarning is a longlead time to allow for consultation with relevant people to give them time to consider the project, build up trust and understand any implications (Grove et al., 2003; Thomas 2004; Crowe 2000). Yarning enables Indigenous people to talk freely about their experiences, thoughts and ideas and encourages the researcher to explore a topic in more depth (Bessarab & Nangdu 2010). A further study in Australia reported on yarning as a participatory action research (PAR) process within an Aboriginal Community Control organisation based on principles of empowerment, inclusivity, and respect (Fredericks et al., 2011).

When conducting Maori and Pacific Island research it is important to consider Maori and Pacific Island knowledge and theoretical frameworks. Vaoletti (2006) argued that methodologies used to solve issues for non- Pacific Island populations are not suitable in searching for solutions for Pacific peoples and recommended more suitable research methods such as the *Talanoa* process be applied to generate data when doing interviews with Pacific Island people. An example in this research and one that comes under the

umbrella of the decolonisation methodology was the establishment of a community reference group (CRG) to contribute community perspectives and to give priority to community consultation in research. I now turn to a discussion of the process of forming the CRG which guided the conduct of the research and ensured that appropriate dialogue took place. I saw this process as central to a decolonisation methodology (McClelland, 2011).

### ***Informing the community and establishing a Community Reference Group (CRG)***

Prior to recruitment of study participants, social researchers usually attend meetings to inform a community about an intended project and to gain an understanding of community perspectives on the project. At this time ethical principles that guide the research process, potential risks and benefits, and an overview of the planned research procedures including informed consent can be addressed (Liamputtong, 2009; Crotty, 1998). At such events I spoke about the proposed research with a view of recruiting appropriate CRG group members for the research. In hearing about how socio-economic issues impacted Maori Pacific Island migrants in Townsville at these meetings I was encouraged to speak about my own personal and professional experiences and issues of being a new immigrant to Townsville. The approach of using a CRG values democratic decision making, power sharing and the importance of community knowledge (Fredericks et al., 2011; Mooney-Somers et al., 2009; Tsey & Every 2000; Selener 1997).

The opportunity to gather and engage in *talanoa* is a common feature of life for Pasifika families and such an event was a large annual Pasifika Cultural Festival in Townsville that took place in November 2014. At this event, the important work of obtaining the support of the Maori Pacific Island community leaders through *talanoa* (talking) and gaining their standpoint was undertaken.

I attended various other Pacific social gatherings and religious gatherings to canvass the idea of the research. For example, in early March 2013, I attended a Townsville Pacific Island Catholic Committee meeting in which a Pacific Samoan community elder was recruited for the community reference group. The Townsville Pacific Island Catholic Committee is positioned under the diocese of Townsville St Theresa's parish and the presiding Catholic priest offered an office located at this parish for potential CRG members

to meet. In February 2013, I attended a meeting between the Indigenous Community Leaders group and Townsville City Council staff members and was introduced to a social worker with the Townsville Blue Care Social Services who was highly aware of socio-economic issues surrounding migratory Maori and Pacific Island families as they resettled in Townsville. The social worker JS who was recognised the significance of the research and agreed to be part of the CRG And arranged a meeting with prominent Maori and Pacific Island Community Elders within the Townsville community held at a Townsville Queensland Health Multicultural Stakeholders event. Two members of this meeting, a social worker and a community support worker, both Maori. agreed to participate in the CRG. More recently, in 2015, an overseas academic and a Pacific Island person who held extensive knowledge on Maori Pacific Island communities became a member of the CRG. An overview of the research proposal was submitted and accepted to present the plan of the research methodology and data collection methods at a national Conference held in North Queensland, Cairns, 2014 titled “*Talanoa* Pasifika: Chances, Opportunities, Education is the Future”. Participants at the conference encompassed the concept of using traditional methods such as *Talanoa* to dialogue with potential participants for the study.

The members of the CRG (see Appendix 5) held extensive knowledge on Pacific Islander youth, community health and social justice. The ongoing consultation was paramount to the project especially in the first three years during recruitment where some members of the CRG linked the researcher to potential participants for the research. The approach of using a community reference group (CRG) is similar to participatory action research (PAR) to the extent that it values democratic decision making, power sharing and the importance of community knowledge (Fredericks et al., 2011; Mooney-Somers et al., 2009; Tsey & Every 2000; Selener 1997).

Inherent to this approach is Ramsden’s (2002) cultural safety model which addresses the socio-political issues of power, vulnerability and control between the consumer and provider. Thus, the *Talanoa* process and the use of a CRG sought to maximise participant control and ownership over the design and implementation of research, and to hear the perceptions of people whose ideas are often marginalised by others (Smith 1999; Kindon, Pain & Kesby, 2007; Gaventa & Cornwall 2001). The process of providing an empowering space for Maori Pacific Island Families in Townsville was essential given the aims of a decolonisation methodology and the theoretical framework of this research.

## ***Research Sites and Recruitment***

### **Townsville Setting**

Townsville, a rapidly growing regional city, is Australia's largest urban centre north of the Sunshine Coast, with a total population in 2014 of 178,649 (ABS, 2015). Townsville city is situated approximately 1,350 kilometres north of Brisbane and 350 kilometres south of Cairns (Wikipedia Encyclopaedia, 2015). Townsville's climate is characterised as a tropical savanna due to mostly fine and warm weather.

In 2005, the researcher and her family migrated from Auckland to Townsville for work purposes and this assisted in locating Maori Pacific Island Families in Townsville with a view to recruit for the research. A notion of trustworthiness, as specifically discussed by Ravulo (2015) for Pacific Islanders in Australia, was heavily reliant on my long-term association with the Maori Pacific Island Families study participants in Townsville. It was envisaged that Maori Pacific Island study participants would be willing to entrust to me their perceived realities and concerns and to handle their stories with care and faithfulness. While there may have been some discomfort these experiences were significant examples of why culturally diverse professionals in positions of privilege should have a strong advocacy, transparent and mutual activism presence in both their profession and their community (Sandolewski, 2010).

Furthermore, when doing research with groups from minority population it is important that the researcher assumes a position of "insider" rather than "outsider" (Baugh & Guion, 2006). It was significant for me in recruiting Maori and Pacific Island participants both from Townsville and Brisbane communities to adequately reflect and respect these communities in terms of being an effective and informed advocate.

According to the Queensland Health Maori and Pacific Island Health Needs Assessment Report (2011a), all New Zealanders and including Maori Pacific Island Families population in Townsville, who migrated to Queensland after February 2001, are considered New Zealand citizens due to their migration to Australia on a New Zealand passport. Hence, the number of Maori Pacific Island Families that continued to resettle in Townsville is unclear or according to the Queensland Health Assessment Needs Report (2011a, p.4.), at that time remained "statistically invisible".

Citizens of New Zealand are not entitled to benefits associated with Australian permanent residency and yet these citizens are classified as Special Category Visa (SGV) holders that allow them to stay in Australia as permanent residents. Maori Pacific Island Families, who are of working age, are expected to work on arrival to Australia. Most Maori Pacific Island members who were unable to secure employment prior to migration or on arrival are financially supported by their families until they find work (Schwartz, 2012; Anderson et al., 2011).

The large number of Maori Pacific Island Families that continued to participate in events such as the annual Townsville Multicultural Festival, more recently (2018) funded by the Townsville City Council, confirmed an ongoing presence of Maori Pacific Island Families living in Townsville. Purposive sampling of Maori Pacific Island Families and Child Health Service Providers was undertaken in Townsville at the beginning of the recruitment phase.

Purposive sampling is dependent upon the availability of and access to relevant participants (Charmaz, 2006).

### **Recruitment Maori Pacific Island participants in Townsville**

In this research, participants were recruited based on an initial discussion regarding cultural, migratory, and socio-economic factors, age and gender related issues, and level of knowledge. Participants were young immigrant Maori and Pacific parents and Maori Pacific Elders. Inclusion criteria were that the immigrant participants had resettled in Townsville and were between 18 to 60 years of age. The reason for these criteria is that this age group may have had recent and rich life experiences of being parents to children being born and raised in Townsville and overseas. Parents under the age of 18 years were excluded as they may not have had a length of experience to draw upon.

Distribution of study information involved face to face consultation, email, telephone, talking to Maori Pacific Island people and ex-work colleagues and through staging two stalls to provide information about the research project at two multicultural festivals. The annual multicultural festival held in Townsville, in November 2014, was a popular festivity held over five days (Wednesday to Sunday) and many Maori Pacific Island Families were involved in the festival and took on roles in governance and as stall holders and performers. In the process of recruitment, the prime demographic targets at the festival were parents and community Elders who identified themselves as Pacific Islander or Maori,

and who primarily resided in Townsville, or who had resettled in Townsville over the past five to ten years.

Contact was made with the festival organisers two months to book a stall with a view to recruitment. Once ethics approval was obtained from QUT Health Research Ethics Committee (HREC: approval number 1300000821) a meeting was arranged with the organisers of the festival prior to travel to Townsville for the first visit.

The first phase of recruitment, in November 2014, involved setting up a recruitment stall with help from two CRG members based in Townsville. During the five- day multicultural festival the details from thirty-five Maori Pacific Island Families were obtained to be contacted later for interviews. Some Maori Pacific Island families made enquiries at the stall but declined to leave contact details. These individuals were instead given a flyer with contact details if they decided to participate. A total of fifty flyers were handed out over the five-day period to people who self- identified as Maori Pacific Island. Travel, other costs, and fees for the stall were covered by the financial assistance from student allocation funds from QUT.

A coincidental meeting with a Townsville based Catholic priest at Brisbane domestic airport in May 2015, on the second journey to Townsville, led to an oral presentation of the research to the congregation the following Sunday with a view to recruitment. This congregation was attended by a significant number of Pacific Island people and eight flyers were handed out on the day which led to recruitment of two community Pacific Island Elders.

Travel for the third time in November 2015, led to recruitment of seventeen participants. A recruitment stall was set up during a three-day Pasifika festival and the researcher walked around distributing research and participant information to Maori Pacific Island people. Eleven participants were recruited and individually interviewed over the first two days of the festival and six community elders were recruited and participated in a focus group on the last day of the festival, immediately after the Sunday church service held at the festival.

## **Recruitment Child Health Service Providers in Townsville**

In 2014, before the November Townsville visit, several emails with a recruitment flyer attached were sent to child health service providers including service providers highly utilised by Maori Pacific Island Families in Townsville.

The Mum's and Bub's Clinic was a child health clinic funded by the Townsville Aboriginal Islander Health Services and managed by Townsville Queensland Health midwives and child health nurses. A significant number of young and old Maori Pacific Island Families in Townsville utilised these services including the child health services (Mum's and Bub's Clinic). The Maori health worker based at the clinic had made contact and an appointment was made to meet and *talanoa* with two of the practising midwives once the researcher arrived in Townsville.

By May 2015, a total of five child health service providers who offered child health services to Maori Pacific Island Families and Elders in Townsville were recruited. The first two study participants recruited were early intervention workers from an early childhood health service provider as a result of an email distributed to Child Health Service Providers. The third and fourth study participants were staff midwives from Queensland Health Townsville Hospital and were recruited with the help of a Maori Health Worker based at the Mum's and Bub's Clinic.

## **Brisbane setting and recruitment**

Brisbane is the capital of Queensland and the third most populous city in Australia. In June 2012, the researcher and her family moved to Brisbane mainly for work and educational opportunities. Brisbane is increasingly a multicultural city including migration of Maori Pacific Island Families from Aotearoa (Queensland Health Maori and Pacific Islander Population Size and Distribution, 2006). Most Maori Pacific Island Families are scattered and living in low-decile areas such as Logan, Deception Bay, and Ipswich Redbank Plains (Qld Health Needs Assessment Report, 2011a).

Queensland Health is the main Child Health Service Provider provided under the Multicultural Health Unit which subsequently sub-contracted service delivery to community organisations such as the Multilink Services Ltd and Good Start Programs, as currently accessed by Maori Pacific Island Families living in Brisbane (Queensland Health Needs Assessment Report, 2011a).

Following recruitment in Townsville of Child Health Service Providers a decision was made to submit to QUT HREC an ethics variation to include participants from Brisbane child health service providers. Following ethics variation approval (HREC: 1300000821) at the beginning of 2016, the researcher attended Queensland Pasifika monthly community and service providers network meetings and spoke about her research and was able to recruit a further two Child Health Service Providers from these meetings. A power-point presentation was delivered by the researcher to a group of stakeholders at a community-based health organisation (Multilink) which resulted in a third participant recruited: a Pasifika community engagement officer who was keen to participate in the research. A fourth Child Health Service Provider, a Registered Nurse, was recruited following a discussion about the research while working on a night shift in a private tertiary teaching hospital in Brisbane. An opportunity to speak at a local Indigenous radio station themed “Pasifika Women’s Health” promoted further efforts to recruit potential participants from Child Health Service Providers based in Brisbane.

### ***Demographics***

Sixty percent of study participants had completed year twelve of high school education, one Child Health Service Provider participant had a diploma in teaching, a Maori Pacific Islander had a diploma in health and the other participant from a Child Health Service Provider (CHSP) held a degree in midwifery. All study participants could speak and communicate their views in English. Most study participants who were Maori Pacific Islanders had migrated from New Zealand (NZ) and resettled in Townsville during the previous 4 to 10 years. One out of the two Child Health Service Providers was originally from Townsville and the other had migrated from NZ to Townsville with her family for work purposes (see Appendices 9 and 10).



Figure 6: Images during recruitment of Study Participants at Townsville Cultural Festival



**Figure 7a: Participants and Community Reference Group Overview**

1

**29 Maori Pasifika Townsville- based**

10 Pasifika Community Elders and 1 Maori Community Elder

11 Pasifika Young parents

4 Pasifika Mature parents

**Research Community**

**Reference Group**

3 Current members

**Researcher**

Pasifika Registered

Nurse



**5 Child Health Service**

**Providers in Townsville**

1 New Zealand Queensland Health Midwife

1 Aboriginal Midwife

1 Pasifika Youth Worker

2 Australian Early Child Health Worker

**Data Generation**

3 Child Health Service Providers in Brisbane

1 Maori Community- based Queensland health Child Health Nutritionist

1 Pasifika Multilink Community Health Engagement Officer

1 Pasifika Health Project Worker

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<sup>1</sup> The significance of the kava bowl situated in the middle of the *Talanoa* and drinking of kava prior to a *Talanoa* session is a cultural protocol followed by Pacific Island researchers; pertains to being respectful in acknowledgement of information obtained from research participants.

### ***Individual Interviews with Maori Pacific Island Participants in Townsville***

As noted above, twelve Maori Pacific Island participants were recruited, and individual interviews were undertaken. Two of the individual interviews were held in the respective participant's home while the other two interviews were held at a local eating place in a mall. A further seven individual interviews were undertaken on day one and two of the Townsville Pasifika Festival held in November 2015. A further six individual interviews were completed in participant's homes over a five- day period while in Townsville in November 2015.

*Talanoa* is used as a Pacific Indigenous dialogical approach to capture stories to ensure that the Pacific Indigenous research agenda is real and evolving and is typically linked to Pacific Island paradigms (Latu, 2009). During interviews with participants an integral part of the *Talanoa* process was the construction and generation of new knowledge, and this generation of knowledge continued as I maintained an open-minded approach during analysis, construction and writing participants' stories according to how each story was described (Vaiioletti, 2006; Charmaz, 2017). The researcher and the participants thus coconstructed data by using the *Talanoa* process. Ultimately, as a researcher, it was my responsibility to respect and to acknowledge participation of study participants in the research. The use of the *Talanoa* process to generate data and constructivist grounded theory (GCT) to analyse that data required me as a researcher to stay as close to participants' meanings as possible.

### ***Focus Groups Interviews with Maori Pacific Island participants in Townsville***

During data collection and within a *Talanoa* dialogical approach, the researcher held several focus groups interviews. The focus group attracts and encourages discussion due to a collective exchange of dialogue (Liamputtong, 2013). The *Talanoa* method is collaborative in that stories and experiences are discussed, compared, and shared within a focus group interview. However, as found by the researcher, the open conversation or dialogue presumably presented within the *talanoa* process can be impractical when held during a focus group session, given the long-lead time required to develop this relationship

and the time constraints of some participants. An example of this issue was an experience where a focus group participant needed to exit the session earlier which caused tension among other participants in the focus group since the others felt they were being “rushed” in the discussion. It was far more practical to do individual interviews negotiated and based on a study participant’s availability and to ensure, prior to doing focus groups, that participants were committed to completing a group session.

In May 2015, a small focus group interview consisting of three Pacific Island community elders was conducted in a participant home. In November 2015, a further focus group interview was undertaken with six community elders during day three of the Townsville Maori and Pasifika Festival celebrations. The questions during each audio recorded focus group interview individual interviews with Maori Pacific Island people in Townsville included the following:

- *Tell me about your experience when accessing a child health service and if all right with you please tell me how it went*
- *What would you like to see happen when you visit at your child health service provider?*
- *What does it take for you to feel safe or happy to return to a same health service provider?*

## ***Individual interviews with Child Health Service Providers in Townsville and Brisbane***

### **Townsville**

In May 2015, two individual interviews were completed with two child service staff from The Good Beginnings Service, an early child health developmental service provider. On the following day two interviews were completed with, with two QLD Health midwives based at the Mums and Bubs Clinic participants who were recruited during the first trip to Townsville. A third interview was held at a coffee shop in a shopping mall with a youth service provider who worked with several young Maori Pacific Island people at a Queensland government detention centre based in Townsville. It was important that the research access a wide range of perspectives about child health service delivery for Maori Pacific Island Families from community elders, youth, and community parents.

***Initial questions asked of Child Health Service Providers in Townsville were:***

- *Tell me about your experiences when working with Maori Pacific Island Families here in Townsville when they access your services for service provision*
- *Tell me whether you think your service provision is relevant or culturally safe*
- *Tell me whether you consider social, political, and cultural values of Maori Pacific Island Families when they access your services*

**Brisbane**

Through the application of constructivist grounded theory methods, and through an iterative cycle (Charmaz, 2014), the researcher identified a need to rephrase questions asked of Child Health Service Providers in Brisbane. The initial questions asked were not conducive to open dialogue as reflected in *Talanoa*, but rather targeted Child Health Service Providers participants regardless of whether they understood what constitutes culturally safe practice. As noted by (Otunuku, 2011), in adopting *Talanoa*, ideas are raised and discussed openly whereby knowledge is mutually constructed through active engagement during an interview or *talanoa* process.

Interviews were undertaken with a registered nurse who worked at a large children's hospital, a community nutritionist who worked with Maori Pacific Island Families, a community engagement officer who worked with Maori Pacific Island Families and a community health project worker who is experienced in doing research and working with Maori Pacific Island Families.

***Examples of questions asked of Child Health Service Providers in Brisbane were:***

- *Can you describe the place of cultural issues in your work?*
- *What does cultural safety mean for you as an individual working with Maori Pacific Island Families?*
- *At your workplace what is the reason for your service to exist and why do you work there?*
- *Tell me about your considerations of social, political, and cultural values and whether you consider these values when working with Maori Pacific Island Families?*

- *How can you address issues of culturally unsafe practices in a positive and constructive manner?*

In Brisbane, one individual interview was undertaken and audio-recorded at a workplace, one was held at the researcher's home and two interviews were conducted in a meeting room at a local eatery.

### ***Data generation through interviewing using the (Talanoa process)***

Understandably and as all humans do, Maori and Pacific Island people like to share and learn information through their senses and the *laumalie* (essence or spirit) is encountered via the *Talanoa* process where each participant probes and exchanges ideas throughout focus group sessions (Vaka, 2014). As discussed earlier, a deficit discourse does not recognise the positive skills and talents that most people hold. One example, as found during an interview session, was when asked "what are your issues or challenges when accessing child health services" a Maori Pacific Island member moved into deficit discourse thinking and constrained the development of positive ideas, positive mental wellbeing and constructive thinking. The researcher in an interview with a Child Health Service Providers also found that while it was simple to discuss with someone their way of thinking, encouraging someone to challenge their own assumptions is difficult. The researcher shifted this discourse of deficiency to reflect what the *Talanoa* process encourages researchers to do. The researcher reframed Maori Pasifika identity in a narrative of positivity and self-empowerment to allow the *Talanoa* process to move forward in a positive note.

In reflecting the *talanoa* process, the interviews started with casual strengths-based conversations to encourage rapport development and to explain the nature of the study. A participant information sheet and a consent form were handed over to each participant prior to each interview. Discussion was also undertaken surrounding anonymity of participation and storage of data. The length of time for each interview ranged from one hour to forty-five minutes. During each interview, memos were written, and these memos were compared later to transcripts of audio-recordings of the interviews. This process helped the researcher to reflect and to consider and compare data during analysis.

Furthermore, as Charmaz (2006, 2014) argued, interviews are not neutral and during the *talanoa process*, open engagement was developed between the researcher and participant

which encouraged the co-construction of data. In their presentation in Auckland titled '*Talanoa as Empathic Research*', Farrelly and Nabobo-Baba (2012) discussed how, when participants talk, they carry us on an intellectual journey: "They imaginatively move us from past to present to future so that we can better understand how they live and feel their world" (Farrelly and Nabob-Basa, 2012, p.4). As well as allowing the voices of the research participants to be heard, the researcher wanted to exemplify the decolonisation methodology used in the research.

An absence of rich material from both Child Health Service Providers and Maori Pacific Island Families revealed the need to rephrase earlier prompts. The researcher had to rephrase some research questions. The revised questions, as discussed earlier when asked of Child Health Service Providers, encouraged an opportunity for participants to focus deeply and with some clarity respond to each question according to how they perceived their service provision with Maori Pacific Island Families. Consideration was given to whether Child Health Service Providers considered the environmental, socio, cultural and political factors influencing service provision to Maori Pacific Island Families as they access child health service delivery.

Almost half of the interviews were downloaded onto a hard copy from the audio recorder and emailed overseas for transcription. Data were transcribed from each audio recording by an overseas based trained transcriber and by the researcher. The interviews were transcribed verbatim, and each interview was read and compared to the audio recording. The researcher was aware of potential issues identified, for example any technical difficulties in language interpretation and meanings that may not reflect intended meaning.

Audio recordings were transcribed word by word and each piece of data was compared with the researcher's diary notes. This process was ongoing to ensure that material transcribed reflected what was recorded on tape.

### ***Ethical Issues***

The researcher applied for ethics approval from the QUT Human Research Ethics Committee and ethics approval was obtained for a low- risk study (HREC: 1300000821). The process for gaining ethical approval adhered to NHMRC guidelines. All participation in

focus groups and interviews was entirely voluntary. Permission was sought to audio record interviews and focus groups as part of the consent process. Prior to the start of each interview, a participant information sheet and consent form handed to the participant. Time was given to ensure the participant was aware of the research process and understood the information, prior to signing a consent form. Ethical commitments for maintaining confidentiality, gaining informed consent, and extending the right to withdraw from research at any time was maintained prior and during data collection.

Participants were assured that the research data would remain confidential and that following transcription their contribution would be anonymous. Anonymity was achieved by the omission of any identifying features in any output of the research and by creating pseudonyms for use in the thesis and any publications or presentations arising from the work. They were also advised that access to the data is restricted to the research team. Discussion about health service provision and issues may trigger memories or feelings about previous bad experiences, therefore the possibility of such issues arising was explained prior to discussions and participants were told that, if required, counselling services were available. The study participants were remunerated with a \$20 voucher in return for their time and effort.

### ***Data Analysis***

The fundamental characteristics of decolonisation and *cultural safety* most germane to this study and the data analysis process related to issues articulated with the community and not imposed on the community (Collett, 2008). Data generated were carefully analysed and organised systematically by the researcher and most importantly in an ongoing dialogue with a Pacific Island community elder who was a member of the CRG through a cyclical and iterative process (Collet, 2008; Charmaz, 2017). It was important to engage in dialogue to ensure input from a CRG member, the mentor and relevant community members at workshops and conferences who may notice ideas and concepts not previously captured or translated (Charmaz, 2016; 2017).

### ***Charmaz's Influence and the Talanoa Process***

Constructivist Grounded Theory (CGT) informed the methods used in data analysis and the researcher considered, compared, and analysed possible theoretical understanding of the



data using CGT (Charmaz, 2017). Constructivist grounded theory has similarities with the *Talanoa* process because the flexibility inherent within the *Talanoa* process allows “the research findings to emerge from frequent, dominant and significant themes inherent in raw data, without the restraints imposed by structured methodologies bounded with preconceived knowledge” (Thomas, 2003, p.2). Charmaz et al., (2017) critically discussed constructivist grounded theory as “rooted in pragmatism and relativist epistemology” (Charmaz et al., 2017, p. 418). As such, constructivists assume analysis is constructed because of interactions and interpretations of data.

In posing her view, Charmaz in her discussion on constructivist grounded theory compared findings to previous and current research literature. Charmaz found individualism amid nonalignment of cultural beliefs mostly pervades research inquiry and shapes worldviews which underlies research methods that informs policies when working with vulnerable population (Charmaz, 2016).

Charmaz further discussed how “we develop tentative interpretations about the data through constructing codes, the labels we give fragments of data, the abstract terms we construct to account for batches of data” (Charmaz, 2017, p.2). The above argument reinforced her earlier position (2006; 2011, 2014) on construction rather than discovery of data and proposes that through each interaction between researcher and participant, meanings are constructed based on the social viewpoint and interpretation of the situation. The views of Charmaz converge with principles of cultural safety whereby cultural dynamics such as using *Talanoa* for data generation are fluid and are consistent with the current situation, for example, equalising of power relations during the process of data generation between a participant and the researcher. As described earlier, one of the principles of cultural safety calls for us as researchers to acknowledge and be mindful of our position as contributing to power relations and inequality (Cox and Taua, 2016).

Thus, the analytic stage was influenced by the contextualised perspectives of researcher and participants and the outcomes of analysis are explored in depth in the following two chapters. Importantly, data analysis remained a constructivist exercise in which data analysis and findings were based on constructivist grounded theory and therefore avoided or minimised use of pre-existing assumptions and ideas (Charmaz, 2014; 2017).

As discussed earlier, a constructivist grounded theory framework (Charmaz, 2014) applied during data analysis reflected similar processes, relationships, and interconnectedness among phenomena being studied as underpinned the *Talanoa* process. Charmaz's (2014, 2016) work on constructivist grounded theory, thus aligned with *Talanoa* methods as the mechanism for data generation and analysis whereby data is interpreted and constructed because of meaningful interactions with study participants.

## **Reliability**

The researcher worked to group all data around the experiences of providing and receiving child health services as experienced by the study participants. As reported by Vaiolletti (2006) the *Talanoa* research method may affect both the learning of researchers and the participants (MPIF and CHSP), therefore viewpoints and reactions may change over a period and a possibility of participants concealing their true stories (Faa'vae et al., 2016). And as discussed by (Charmaz et al., 2017, p.420.), "constructivist grounded theorist writes their comparative memos from a position of doubt". Constructivist grounded theorists recognise multiple realities and shifts in viewpoints to compensate for differences or values inherent in meanings given by study participants (Charmaz et al., 2017).

Although reliability is concerned with consistency *Talanoa* when used as a research data gathering method can be an added strength to the research. As argued by Halapua (2007), in (Fa'avae et al., 2016), consistency seen in *talanoa* does encourage a participant to "talk from the heart" (p. 147). Furthermore reliability, trustworthiness and self-determination is established by recognising that research gives value and ownership to the participants through participation (Smith, 1999).

In affiliation with the study population, the following section continued to reflect and *talanoa* (tell a story) about the researcher's journey to add meaning and credibility and to draw visibility to the research. The extra burden is in negotiating how to best conduct research from a diligent, transparent, and respectful perspective. The researcher wants to ensure critical inquiry through reflexivity is achieved when working as a Pasifika researcher with Maori and Pasifika Island Families. Exposing her vulnerabilities as an academic researcher and health professional means an explication of her position and identity in the research which addresses the paradigm of reflexivity in cultural safety. Critical research such as that of cultural safety is embedded in a translated paradigm that seeks to expose

and redress forms of oppression, marginalisation, inequality, and social injustice. As an example, the avoidance of use of the term *Islander* in this research is deliberate because it is a constant reminder of marginalisation for Pacific Island migrants (including the researcher) who live in Australia and New Zealand and are often the focus of language such as; “*You Islanders! go back to where you come from*”.

## **Researcher Reflexivity**

The researcher kept a diary as part of an ongoing reflexive process and recorded thoughts immediately after each interview. Time was then spent on reflecting on each memo, on each *Talanoa* and on stories captured. The researcher on a continuum of reflexivity, continued to ask questions such as why Child Health Service Providers are still not able to deliver services that allow a Maori Pacific Island member to contribute to decisions in regard to management of her or his care plans. Reflexivity allowed me to re-examine any preconceived ideas about possible findings of the study and to critically look at transcripts with a view to contextualising and constructing the interpretations of the data.

Through reflexivity a nurse may also start to question their own beliefs in practice and therefore hopefully start to consider the implications of their own position when working with people from different cultures and life-worlds. I wanted to understand the participants’ views, hope, and struggles, and aimed to deepen these understandings of participants’ views by taking notes as an ongoing process. Memo writing during and post interviewing was crucial in framing theoretical concepts, relationships, and interpretations of experiences (Charmaz 2003; 2008).

This research allowed Maori Pacific Island study participants to decide whether the research process they participated in was culturally safe or otherwise. Sandelowski’s (2010) argument, however, was to see the approach as essentially challenging the role of researchers as being ‘fully’ competent. In turn, the researcher was encouraged to proceed from a respectful starting position of accepted cultural methodologies. Furthermore, the researcher was encouraged to respond accordingly to a carefully honest appraisal of the impact of her own cultural attitudes and life experiences on Maori Pacific Island Families rights in maintaining their ways of knowing and life experiences. Considered a Pasifika *fifine* (woman), a researcher and a registered health professional, I set out on this journey to reflect if my research could be part of such a process including myself as an active

participant. Like Seaton reminds us, the extent to which a researcher participates in their own research differs “but it is to be expected that the author’s viewpoint is present in any research project” (2010, p. 28).

As can be readily seen, my reflections on the above issues are informed by my own position and experiences as a Pacific Island member working within Indigenous health services in Queensland. Like all of us, I bring to my work interpretations and analysis based on my worldview and lifeworld. I make and base my decisions both consciously and unconsciously about what I choose to see, believe and experience based on what is favourable towards my beliefs, values, and interests. There are guidelines underpinning my practice and personal beliefs as a health professional and reflexivity demands an analysis of my practice and position, which is by no means an easy experience. My commitment to reflexivity as a process, is subjecting one’s knowledge, position, and practices to analysis and to open new ways to thinking and practice is a significant factor. It is equally important to understand one’s own culture better, particularly to acknowledge that each of us does indeed have a culture (Ramsden, 2002).

As an Indigenous researcher, I chose to use decolonisation and cultural safety model in this research since Maori and Pacific people today live and move in different contexts. Reflecting Ramsden (2002) this variability is situated within and among same groups of people that may have differing views and beliefs. I know and accept that I am no longer the same Pacific Island *fifine* (woman) my family used to know several years back. I have been through years of experience and complex socialisation processes that formed the person that I am today. Such processes may change the way I view and see the world today or even better made me a stronger person.

My own experiences have positioned me due to centrality of culture in many aspects, for example, my cultural upbringing by my parents, exposure of the relationship between language loss, security in identity, and social disadvantage as an immigrant woman, including believing and respect the significance and ethics of culturally safe care provision.

Whilst my perspectives as a Pacific Island researcher when conducting research with Maori and Pacific Island people is important, according to (McFall-McCaffery, 2010, p.1), “Pacific Studies as a discipline is growing and its approach to incorporating the perspectives of Pacific peoples is relatively new”. Consequently, guidelines in conducting ethical Maori and Pacific research are significant and fluid, particularly in terms of the desire for developing

understandings of own history, language, and reflective data. My aspirations are to add to the development of Indigenous and Pacific scientific enquiry and knowledge particularly in health and education here in Australia.

### ***Analysis process***

Charmaz's (2006) methods of coding and memo-writing were adopted for data analysis. Coding obliges us to stop and ask analytic questions of the data gathered. In this research, the process of coding consisted of three phases: initial (open), focused coding and theoretical coding. Charmaz (2006; 2014) suggests being cautious when attending to coding of data because this is where language, meanings and worldviews are being defined thus enables the researcher to identify conceptual codes (initial coding). Following the construction of conceptualised knowledge or initial coding, the researcher generates focused concepts (focused coding) and ultimately construct theoretical concepts or gives an overall interpretation of what the data is saying (theoretical coding) (Charmaz, 2014).

The methods of coding and memos encouraged the researcher to examine her own worldviews and assumptions and so to avoid an imposition of preconceived ideas being brought to construction of empirical data (Charmaz, 2014). The coding process encouraged the researcher to reflect, compare memos written to recent theoretical constructs, to ask questions and continue to construct data grounded in research.

### **Initial Coding**

Initial coding involved breaking down sentences line by line and listing or coding verbal expressions that re-appear in these sentences. A practical grounded theory analysis of the transcripts of participants' interviews was performed and the entire data were coded manually with emerging concepts or patterns regrouped into diagrammatic categories (Newman, 2012 & Charmaz, 2006). As each interview transcript was read, common concepts that arose were grouped into conceptual codes.

Initial coding involved highlighting material that appeared in each transcript as they were read and then re-read to retrieve further data that may have been missed from the first reading. This process is one of defining useful data and as per Charmaz (2006, 2011, 2014), required the researcher to be "constantly" reforming and reconsidering data. This process

meant dissecting data and re-grouping these data into categories that eventually lead to an interpretation of what is going on in the data (Charmaz, 2014).

According to Charmaz (2003; 2006), a process of questioning data leads to a deeper level of understanding in the coding phase of the process. The researcher analysed raw data verbatim and interpreted the perspectives of participants through identification of concepts and categories from the data collected (Charmaz, 2014).

## **Focused Coding**

The following section provides an overview of how data were analysed step by step in focused coding. Focused coding was undertaken and characterised in an iterative cycle rather than the linear form as seen in initial coding.

Focused coding elevates the analysis to a higher level through constantly comparing open codes in the development of categories. The purpose of this coding stage is to try to make sense of meanings given to each of the categories by transforming study participants' subjective expressions from the raw interviews into meaning units (categories). During focused coding, the aim was to remain open to all possible theoretical constructs specified in data analysis through recognising and comparing common concepts and similarities between words. This process is described by Newman (2012) and Charmaz (2006) where theory is built or grounded in data. Grounded theory is open to interpretations, ponders on questions, and looks for similarities and differences (Newman, 2012). Next, the researcher incorporated and compared initial field memo notes and reflections with raw data that were written down and interpreted earlier. The process began to define what the data was all about through writing down key sentences or statements based on categorised information and their value in giving meaning to each unit or category. Data from transcripts was read and compared with data from initial memos and data from these reflections and memos perceived as relevant were added to the categories. Focused coding of codes and concepts is employed to identify emerging core categories, or a category as seen in theoretical coding.

## **Theoretical Coding**

Elimination of data occurred in this phase during where certain codes or categories of data were made redundant because they were perceived irrelevant to the phenomenon in

question and limiting the development of new concepts. Elimination of irrelevant data allowed the researcher to follow a process of reassessing data and thus, enhanced theoretical constructs.

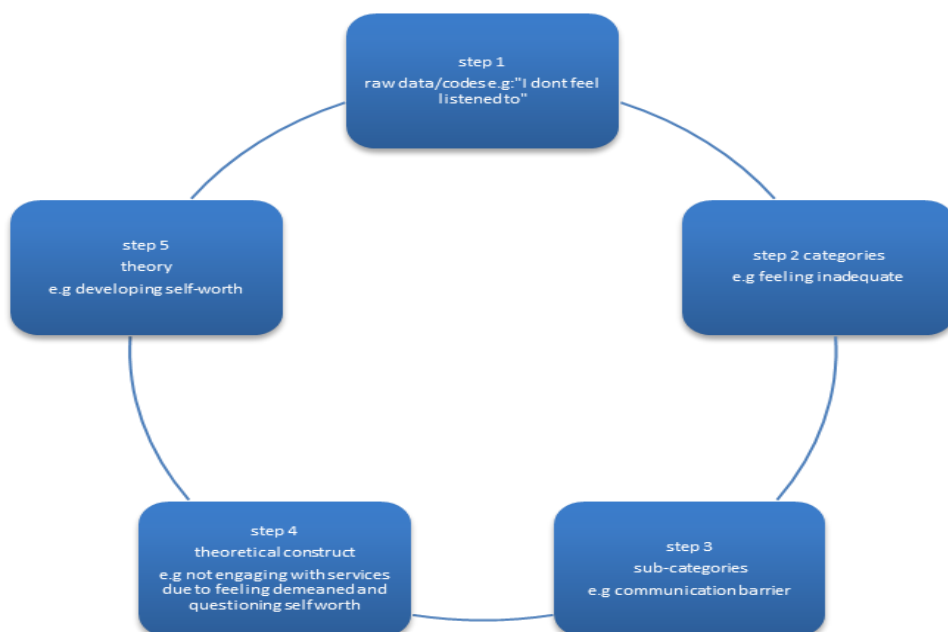
In undertaking theoretical coding, data or bits of data are labelled or grouped into categories. Attempts were made to categorise codes entitled to concepts that characterised the essence of experience for the study participants. These categories were further divided into sub-categories as they surfaced and further categorised into sub-categories as noted below. The categories of data were labelled according to the characteristics identified. For example, a key statement emerged and made by several study participants was related to socio-cultural factors and the category was thus labelled socio-cultural issues. This process is a significant stage of analysis because it requires the researcher to develop conceptual sentences relating to Maori Pacific Island Families' perceptions and lived experiences of child health services and the same applies to child health service providers' perceptions in relation to their work with Maori Pacific Island Families.

Reflecting participants' subjective experiences involved a combination of transformed meaning into a consistent sentence structure of the experience for each study participant. This step is also where the researcher tried to synthesize material and its meanings into sentences where it is understandable not only to the researcher but to the readers.

This chapter articulated the *Talanoa* methods and underpinning principles as they applied to this research (Vaiolletti 2006; Kemmis & McTaggart 2005). The central tenet of this research approach was that it sought to establish a context in which Maori Pacific Island people could explore issues systematically from their perspectives (lived experiences) and whereby the researcher engaged in deep conversation with the participants. In this research project, with a view of increasing uptake of health services, the focus of these conversations was on the Maori Pacific Island participants' experiences in regard to culturally safe service provision of child health services in Townsville and on the Child Health Service Providers participants' viewpoints in regard to working with Maori Pacific Island Families both in Townsville and Brisbane.

**Table 8a: Open, Focused and Theoretical Codes**

<p><b><i>Open Codes from interviews with PI service user</i></b></p>	<p><b>Culture</b>; pondering, misinterpretation, frustration, confusion, upbringing, understanding, positionality, identity, realities</p>
<p>Focused code from interviews with PI service users</p>	<p>Developing self- worth; I am my mothers’ child, and I try and listened and was forbidden to speak as a young child, until I could speak. But now as an adult, when I go to see a Dr, I feel the need to speak up, sometimes I don’t feel listened to, and I am uncomfortable to speak up, so I find I have to explain myself a few times when I am at the Doctor.</p>
<p>Theoretical Coding</p>	<p>Theoretical coding is the last stage of coding. Gives an overall interpretation of what the data is saying. For example, an interpretation to the above concept is that there is a lack of self-worth due to misunderstanding in cultural identity</p>





# **CHAPTER FIVE: An Interpretation of Perspectives from Maori and Pacific Island Participants and Child Health Service Providers Regarding Health Service Delivery (Talanoa moe tau Tagata Maui, Pasifika moe Gahua Leveki Tino)**

## ***Introduction***

This chapter explores three key categories generated from an interpretation of accounts of Child Health Service Providers and migratory Maori Pasifika Island Families around their experiences when accessing child health services within the Queensland Health system and from their family general practitioner (GP) services. One aim was to examine Maori Pasifika study participants' reflections of service delivery through the lens of Cultural Safety as the theoretical tool. A further aim, from the perspective of decolonisation methodology, was to position the study participants, namely Maori and Pasifika Families, within their contextual determinants. Knowledge frameworks and the expectations of Maori and Pacific Island families differed from that of the current dominant healthcare system. This dichotomy of cultural differences which manifested as power imbalances proved to be problematic for both Maori Pasifika Families and Child Health Service Providers during service delivery.

The first category examined the impact of *Positionality* as a broad concept and specifically in relation to the socio-contextual realities (*tua-anga*) of Maori and Pacific Community Elders and their experiences when accessing service provision. The second generated category was the conceptualisation of Cultural Identity (*maama-anga*) and its intersection with Maori and Pacific Island Youth as they accessed service delivery. The third category explores an emerging concept of Western Paradigms of health care delivery (*kehekehe-anga*) which informed and challenged a conceptual understanding of trans-culturalism which was integral to Child Health Service Providers' experiences in their work with Maori Pacific Island Families'. The trickle-down effects of trans-culturalism in service delivery, referred to by a Child Health Service Provider as "common ground ideals" (*tatai oti*), is addressed in depth.

## ***Key Interpretations: Part I***

### **Tua-anga/Concept of Positionality (Socio- Contextual Realities)**

A key concept related to *Positionality (Tua-anga)* as it impacted health service delivery is referred to as “socio-contextual realities”. Positionality is conceptualised, according to the Queensland Health Needs Assessment (2011a), where the positioning including poorer health status among Maori Pasifika population in Queensland was attributed to socio-economic disadvantage, lack of access and uptake of health services due to isolation and lack in health literacy. Maori Pacific Island Families in Queensland are considered a vulnerable population, a situation exacerbated by their classification under a Special Category Visa (SCV) which allows them to live in Australia indefinitely without obtaining permanent residency or citizenship. The SCV status restricts access to welfare payments, NDIS, and social services. As such, all Maori Pacific Island from 18 years of age are required to be employed since they are not entitled to unemployment benefits if required. The 2016 census showed that while New Zealanders have a high labour force participation in Australia the majority of these jobs are in lower-skilled industries and many are offered as casual temporary positions (Spinks & Klapdor, 2016; Batley, 2017; Orton & Edwards, 2020).

The research identified key findings related to (positionality) socio-economic issues and sociocontextual factors that act as barriers in the access to relevant health services. As a result of the visa status issue noted above, medication costs were perceived as a significant burden as described below by a young parent and newly immigrant Pacific Island people to Townsville:

*I really liked the Medicare card, but I am finding it hard to pay for my medication (PI). So sometimes even though I am not well I do not go to a doctor until I have money to pay for my medication and when it's time for me to have money, I feel better, so I don't bother at all plus I have to go to work otherwise I'm kicked out the door for not paying my rent.*

*I was not well but I have to go to work, too scared of losing my job, lose my rental house and the medication is too expensive (newly arrived young (PI) migrant).*

The high cost of living and financial pressures in a home directly affected access to service delivery and participants recalled instances of going to work despite not feeling well. The trickle-down effects of socio-economic disadvantage compound the problem of accessibility to health services and similar issues as seen among Maori and Pacific Island

students in accessing education services in Queensland (Stanley & Kearney, 2017). The added pressure placed on young families with young children places constraints on their ability to readily access health services.

Maori Pacific Island communities are considered a vulnerable and social disadvantaged community group (Queensland Health, 2011) and this translates into a community without power. Foucault (1998) refers to this conceptual understanding as a power and knowledge discourse where the truth is detached, and that truth as outlined in below example is often manipulated through multiple forms of social, cultural and hegemonic constraints usually induced by power dynamics.

Among *the Maori Pacific Island Young Parents* there was a general feeling of frustration with health service delivery influenced by socio-economic, socio-political, and socio-cultural factors. In general, health service provision is seen by many as a financial commodity for the government and this is common within the health service system. Health service delivery was largely based on funding and not on whether services offered were relevant or accessible. As a Pacific Island parent said:

*I believe there is too much politics involved and impacting on health service delivery, (which is) based now on funding and cost effectiveness rather than quality. Most doctors that I see speak to a computer rather than look at me and it is frustrating because of the time I take to travel and see him. They rush and give you that look when I try to ask a question, I feel like he does not know my issues, I am just a financial commodity and what a waste of time for everyone (Young Pacific Island parent).*

As suggested below, several community elders and young parents, who were not readily accessing health services, identified family members and online information sources as helpful and cost-effective as has been found elsewhere (Thurston, et., 2018). There appeared to be a lack of resources that addressed lay or visual information given that health literacy levels affect the care among Maori and Pacific Island community elders (Queensland Health, 2011a). An exception was the ethno-health promotion information for Maori Pacific Island Families participants in the Good Start Program (Queensland Health, 2011a).

## Maori Pacific Island Community Elders

According to *Maori and Pacific Island Community Elders* there were self-inhibiting behaviours due to a lack of communication skills and health literacy skills within the community. A study of Maori Pacific Island parents and service delivery in New Zealand found that a lack of communication skills was perceived a deficit belonging to the migrant service user rather than the inability of a health service provider to supply a translator (De Souza, 2012). Experiences concerning gender and generational issues, lifestyle changes, lack of knowledge, cultural factors, and frustrations during service delivery all have impact on accessibility to health services as explained below:

*Maybe it is my accent which is why they cannot understand me. Unless she is female, I will not let anyone touch me. (Pacific Island community elder).*

*Over here I find it hard for me to speak up and it is not like where I come from, easy to talk to the workers (older Fijian migrant).*

Disparities and disadvantages experienced by Maori and Pacific Island families in Queensland were overt in this research. The identities of *Maori Pacific Island community elders* were also perceived to be threatened during service provision. A Pacific Island community elder, for example, constructed his or her pathway to service delivery through engaging or networking with other family or community members who were using a similar child health service provider. The reflections below suggested frustrations that their concerns were not being heard nor understood by the service providers due to language and comprehension issues. Even for those who could understand verbal English, most were not confident to speak in English and if required were not confident to use a telephone service to make an appointment with a service provider for example. Many referred to their kinship networks such as the extended family, friends, or friends of the family to provide and help with information sharing and tasks identified with access to health services:

*I wait until my daughter can come after work and ring doctors to help me to make a time to see doctors (Pacific Island older migrant).*

The below comments give focus to social processes in highlighting significant issues related to a lack of communication skills and literacy levels:

*Sometimes they speak too fast, and I just walked out, or I don't say anything at all, and they probably think that I don't like them, but it was because I do not understand them and those hard words (medical terms) they speak (newly arrived Pacific Island older migrant).*

The evidence of the role of cultural diversity, such as having limited spoken English skills, converged around the issue of health literacy, as noted above. The role of child health service providers remained a powerful dynamic. A study by Johnstone and Kanitstaki (2008) found that negative attitudes towards service users who have only some verbal English were well embedded within the health system. First, there may be a reluctance to ask for an explanation or help if someone speaks and writes English as a second language. Second, there can be embarrassment on the part of the service user in acknowledging this limitation in understanding. An example is the use of bio-medical discourse where medical terms are foreign to Maori and Pasifika Island families (Rodriguez, et al., 2017; Boag-Munroe & Evangelou, 2012). This issue was verbalised below by a Pasifika Elder who had recently migrated to Townsville:

*I wish they really can see us and listen because they always rush, and I feel like uncomfortable to ask them to explain again what they are saying (Community Elder)*

In the current research, while there were expressions of inadequacy and feeling uncomfortable, most adhered to convention and remained respectful to family GPs during consultations. Such experiences were demeaning for these elders and created barriers to service delivery. The above findings are similar to those from a New Zealand study which highlighted barriers such as stigma and poor literacy levels amongst Pacific People (Gulliver et al., 2010).

Maori Pacific Island community elders in Townsville spoke of how prejudice and racism still exist among Child Health Service Providers and influence the practices of staff members. Racism, as noted below by one community elder, was one causative factor of her ongoing poor health.

*I know my health problems is due to who I am, they look at me differently and I don't bother to get help unless I am really unwell (Aboriginal/Pasifika community elder)*

A person's social, cultural, and economic position strongly affects their health; community elders who are considered further down the ladder are suffering higher rates of illness and requiring intensive health care. Culley (2006), in her study on transcending transcultural healthcare based on ethnicity and racism, described the effects of racism and its impact on clients and their interactions with service providers and their health seeking behaviours. Culley found and recommended that health care providers should not define and assumed healthcare delivery based on ethnicity of people. Transculturalism according to Culley (2006) constructs racism. Another study by Henry, Houston and Mooney (2004) found in their findings that Australia's health services are "institutionally racist" (p517), which may reflect upon some of the reasons behind what seems to be a continuum of failure of health care reform, policy and process for those from minority groups. Whilst implying that such claims may be challenging for service providers to hear, institutional racism is a deficit discourse and thus in the research is posed a barrier for a participant when accessing health services.

## **Maama-anga/Belonging (Cultural Identity)**

### **Maori Pacific Island Youth**

The second category is *cultural identity*, which was associated with a need to develop self-worth interchangeable with a need for the sense of belonging. According to Williams (2001), identity and self-esteem are synonymous in developing good mental wellbeing. Self-esteem is a value linked to a sense of self-worth (Williams, 2001; Spickard, 2002; Kalavite, 2010). Maori Pacific Youth, in the current research, expressed feelings of *cultural and physical disconnection* as they accessed mainstream health services, thus questioning their ability in anticipation of *developing self-worth (Maama-anga)*.

Challenges to identities were highlighted in a study of second-generation Samoan high school students in Queensland (Stanley & Kearney, 2017). Due to a cultural disjuncture within the education system, between a collectivist approach mostly sought by Samoan students (Stanley & Kearney, 2017; Tiatia, 2012) and the individualistic approach embedded within the education system (Noordin & Jusof, 2010), the students were not able to develop an esteemed identity mostly needed to support completion of studies (Berry, 2005). Asghari-Fard and Hossain (2017) also reported on challenges and influences of socio-cultural misalignment in impacting on identity construction and leading to a lack of

uptake of services amongst second-generation Iranians in Australia. Similarly, as described below, Maori Pacific Island Youth in this research experienced a *cultural disconnection* through ongoing *questioning of their identity in anticipation of developing self-worth*:

*Lack of belonging, compared to being in NZ I find it easier, to go on Facebook and talk with other Kiwis to find out about services (young PI Female)*

In relation to decolonisation methodology, the metaphor of a journey links to the core activity of multiple journeys travelled by Maori Pacific Island Families from their homelands whether from New Zealand and or the Pacific Islands (Kalavite, 2010). Resettlement for most Maori Pacific Island people comes at a cost that most are willing to forego in search of a better lifestyle, better paid jobs and for younger generation, a need for change of scenery and a need to expand on their (*faka- akoaga*) knowledge through education. Separation from close family members is a significant cost and a desire to maintain cultural roots, cultural beliefs, and identity with dignity in a new environment can be proven difficult (Vaka, 2014). One example is the overwhelming feelings of missing family members back home in New Zealand or in the Pacific Islands:

*I often feel homesick, but I moved here to better my life and my kids, anyway we sold our belongings and there is nothing back home for us (Young Pasifika Parent)* Kalavite (2010), in her study with Pacific Island University students in Aotearoa, discussed how participants who are familiar and identify with their own culture, fares easily into the system unlike those that do not know their own culture and do not engage with services and tend to (*taka-alo*) drift from places to places. Similarly, McDonald and Rodriguez (2014) in their study on Pacific Island professional rugby league players in Sydney and their relationships with significant others, described and emphasised a requirement of an understanding of the position of socio-cultural and socio-economic issues impacting decisions and lives of these professional rugby league players.

Also noteworthy is the over-representation of Maori Pacific Island Youth within the Australian juvenile system (Ravulo, 2016). A key issue identified in the Ravulo report can be likened to Maori and Pacific children in Queensland who are at risk of being red flagged and at risk of developing negative outcomes because they identify as Maori and Pacific:

*We move here for a reason, I want my children to do better at school, to stay healthy, I hear stories about other kids from the Pacific going to jail for something they didn't do, it's not fair, and I am worried for my children, (Pasifika older parent)*

Assumptions that inform service delivery such as identified in a research project funded by the Queensland government and managed by Queensland Pacific Island Workers Network (QPIWN) is one example of what a transcultural approach to health service delivery looks like. A concern was that data coming out of the project might lead organisations such as the police to draw the conclusion that Pacific Island youth living in low socio-economic areas in Brisbane or Logan are homogenous and have gang related issues (QPIWN) in (Anderson., 2011). Pacific Island nations including Maori are uniquely different in many ways and differences with language and cultural upbringing are quite common (Manu'atu, 2000). Reportedly central to this issue are socio-cultural differences that impact on service delivery between the juvenile system and socio-cultural complexities surrounding Maori Pacific Youth (Ravulo, 2016; Sherperd & Ilalio, 2016). There were many positive feelings when asked to describe cultural identity, strengths, and beliefs. An older parent participant (Pacific Island) was proud of her cultural identity and talked about how cultural aspects in her life mainly shapes her experiences with raising her children which is done according to how she was raised as a young child:

*Being confident in yourself means being able to access and ask questions that impact on the well-being of your children and yourself. It is also particularly good to speak your language also otherwise you just get lost in the system.*

Relationships are integral to the development of good self-esteem (Kalavite, 2010) and thus, personal relationships with members of staff were important. While Maori Pacific Island young people appeared to experience feelings of frustration, confusion, and isolation in accessing service delivery a few described positive relationships with staff members that developed over several years. Consistency of care providers appeared integral to relationship building. Power structures and policies affecting health service provision and opportunities for relationship building with Maori Pacific Island Families will need to acknowledge the role of Maori and Pacific people working as partners with health care workers in their care and treatment.

The above can be compared to a discussion by Rodriguez et al., (2017) in her study of Maori Pacific Island people in New South Wales. Rodriguez argued how the mainstream



health system values and sets goals that may not be taken up easily by Maori and Pasifika community. This situation is especially evident when Maori Pacific Island people feel alienated from the community or organisation. As described below the attitudes of staff rather than their level of competence appeared more important to younger participants:

*Most of the time he looks at the computer and does not look at me when talking, I thought that was rude and so I never bothered to go back, I was taught to respect elders so I shut my mouth and walked off (laughs) (young Pacific migrant).*

A further example is of a Pacific Island young woman who, during a consultation with her GP and despite her feelings of feeling marginalised, did not retaliate due to her cultural upbringing. Maori Pacific Island Families believed in an overriding premise of showing respect (*fakalilifu*) to those that are “*doing good for you*” (reciprocity):

*I am raised to respect my elders so I had to keep quiet but inside I was worried about the effects of my medication. It was hard for me and anyway I returned the next day and saw another Doctor and that was a waste of time (young Pacific woman)*

The reality for the above younger participants was that they felt judged, confused, and belittled due to an upbringing of showing respect to those that provides services may then be left with no choice but to behave when accessing health services. The same young woman noted:

*(The) waiting time was annoying and thinking about lost wages, and felt small when having to explain myself again and again, I tend not to go back unless it's really necessary (young Pacific woman)*

Reflecting an imperative of biomedicine, which often applies to anyone who enters the health system (Willis and Elmer, 2011), Child Health Service Providers often felt a responsibility to solve a presenting issue and their values and beliefs became the norm against which all behaviours and practices were measured. A Maori Pacific Island young client is obliged to respond in the “right way” as defined by the health professional or health profession. The above actions reflect what is referred to as trans-culturalism where service delivery is homogenised. The actions of trans-culturalism were described by Foucault (1998) as using power and knowledge discourse as a major source for achieving conformity and social disciplining. This type of surveillance and assessment in health

service delivery does not encourage a Maori or Pasifika service user to articulate or question their care.

As concluded by De Souza (2012), in her study of Plunket Nurses in New Zealand, although subtle the reinforcement of colonial and liberal discourses was rife in health service delivery. It is evident, as concluded by Johnstone and Kanitstaki (2008), that a lack of support for those entering a health system and who have limited verbal and comprehension skills in English language begs a question to whether child health service providers may or may not have considered the social and mental health issues impacting literacy levels of service users upon presentation to a Child Health Service Provider (also in Boag-Munroe & Evangelou, 2012).

The current research findings suggested that Maori Pacific Island Youth in Queensland experienced a cultural disconnect (to be discussed more broadly in chapter 6) and this was seen through balancing and accommodating ideas and actions to justify feelings of selfworth and sense of belonging. Yet, the discussion above is not to suggest that Maori and Pacific Island Youth were passive participants in the health care system. There were always existed processes of negotiation whether they resulted in maintaining silence, speaking out, or moving on. As appears below, a younger confident Maori woman who asked questions, argued, and challenged a situation and did not hesitate to make changes when she was unhappy with service delivery:

*I was not happy with their services they honestly don't give a crap about my Dad so we changed doctors and found this new Dr who happens to be Kiwi and he is good. He knows where we were coming from (young Maori).*

Expressions of confusion and frustration were evident in the language of the younger population when recounting experiences with health services. The excerpts above reflected diverse philosophies around access to service delivery. One was that health professionals were the experts and thus more powerful and the expectation was that a young person would adhere to their advice without question. This discourse on power discrepancies influences the ways in which a service provider acts and thinks in relation to a health issue during service delivery.

A significant question for service providers is to consider and reflect on whether they are homogenising care to Maori Pacific Island Youth and hence below is an in-depth discussion

on the emerging issue of trans-culturalism. As argued Maori Pacific Island Youth are not a homogenous group (Southwick et al., 2012) and therefore requirements in care will vary.

## ***Key Interpretations: Part II***

### ***Western paradigms of health care provision: Trans-culturalism (Tataioti)***

“Common Ground Ideals”

#### **Child Health Service Providers**

The taken-for-granted views of Child Health Service Providers about cultural differences were identified as barriers to the uptake of child health services by Maori Pacific Island Families living in Townsville and Brisbane. Child Health Service Providers saw service provision as a privilege and a position of “*knowing what is best*” for Maori Pacific Island members. The trans-culturalist approach is entrenched in health service delivery and arguably acts as a barrier (a deficit discourse) to the access of relevant service delivery for Maori and Pasifika people. An example in New Zealand is highlighted by De Souza (2012) who concluded that, the Royal Plunket Well Child Health system oppressed a migratory parent rather than acknowledging their rights to assert their own cultural identities and that socio-cultural differences revealed between the system and parent was problematic.

The effects of trans-culturalism and power imbalances my research found, is reflected in a below statement by a Child Health Service Provider; a perceived ideology that both Child Health Service Provider and interestingly Maori Pacific Island Families believed that it is beneficial to have medical and nursing interventions completed based on ethnicity and racial background:

*It would be ideal I guess to have people from same ethnic background working with each other and providing these services to them (Pacific Island Community Worker).*

*I think it is good to have those common ground ideals known where we can relate to each other (Early childhood language worker).*

The above statement reflects an assumption of the homogeneity of Maori Pacific Island families which may lead to dependency and paternalism rather than self-determination. As

noted below the subtle effects of trans-culturalism and power imbalances appears to be a social constructive factor that shapes experiences of service delivery Maori Pacific Island Families. The following section explores further the effects of such assumptions.

The above assumption prompted reflection on whether the experiences of one Child Health Service Provider can lead to the establishment of meaningful relationships with Maori Pacific Island Families members as they access services. This is because diversity exists between and within cultural groups which can lead to differences in cultural realities and worldviews (Cox & Taua, 2016). Determining Maori Pacific Island cultural beliefs and practices is dependent upon whether a rapport has been established between a Child Health Service Provider and the client. Diversity that exists within Maori Pacific Island Families highlighted a great need for Child Health Service Provider to avoid using a predetermined approach to service delivery (Southwick et al., 2012). Such practices continue to exist as reflected below:

*By having your own people providing care for you and I believe this Pacific for Pacific type of service delivery will be effective and cheaper. I get put off sometimes and wonder what the point is for our patients in coming to see a Dr if they do not understand each other.*

*(Pacific Island Community Worker).*

## ***Key Interpretations: Part III***

### **Trans-culturalism versus Cultural Safety**

The trickle-down effects of trans-culturalism as portrayed in the analytical outcomes reflected Maori Pacific Island Families experiences of cultural disconnection in terms of issues of mistrust and fear of the unknown, dependency and low self-esteem as some of the reasons for not readily accessing health services (seen also in Boag-Munroe & Evangelou, 2012). The above issues constrained Maori and Pasifika families who think of adequate support as having someone in a child health services to trust. Where trust was not established and where needs were not met there was the choice not to access service delivery (as found in Sartorius, 2015). Through a process of developing mutual respect, a Maori Pacific Island Family can feel valued by being listened to without disposing predetermined assumptions or judgement.

To deliver relevant service delivery, health professionals need to take the lead and be willing to respect and accept different values and ideas other than their own (Kildea et al., 2010). Critical self-reflective practice means that the service provider can identify their own values, beliefs and assumptions guiding their thinking and actions, then engage in a practice that reflects an understanding and respect for what all people (including Maori Pacific Island families) which is important as a way to influence increased access to service delivery (Willis et al., 2006).

As evidenced in this research, Maori Pacific Island participants rightly drew on their cultural beliefs and cultural values as a way to shape their understanding in response to health-care interventions and treatment (as promoted in Vaughan, et al., 2018; Queensland Health (Transcultural Mental Health Report), 2006). Such an example manifests through the ideology of trans-culturalism in (Leininger, 2002; Bruni, 1988; Vaughan et al., 2018), where Child Health Service Providers are encouraged to understand healthcare needs through learning about Maori Pacific Island culture, ethnicity and their cultural nuances. Thus, Child Health Service Providers also appeared to adhere to a transcultural approach in service delivery (Cruickshank, et al., 2018; Queensland Health (Transcultural Mental Health Report), 2006).

The ideology of trans-culturalism is embedded in service delivery where both Maori Pacific and Child Health Service Providers believed in the overall premise of transformational knowledge through learning about a culture intrinsic to the service user, which was seen at Maori Pacific Island child health service users in Logan, Queensland (Queensland Health Good Start Program). The risk of practising from a transcultural approach therefore encourages service provision that leads to reductionism in service delivery (Cox & Taua, 2016).

In terms of health service provision for Maori and Pacific families it could be interpreted that Leininger's (2002) approach in developing a transcultural approach in service provision reflects a colonising approach especially in terms of providing care to Maori and Pacific families. This approach is one where Maori and Pacific Island families become dependent and non-participatory in regard to their care because service providers have learnt predetermined values on what and how care should be delivered (Cox & Taua, 2013). An analogical example is the focus of Petrus (2017) on trans-culturalism as the next step in the creation of a homogenous global culture. Although Petrus is not writing about

acculturation or cultural synthesis of health service delivery to Maori Pacific Island people, his argument on globalisation of culture converges with the notion that child health service providers gain control of Maori and Pacific Island culture (at their expense) are acknowledged and or misinterpreted as providing culturally safe care during service delivery.

## ***Summary***

The three key interpretations as explored above, reveal a trans-cultural viewpoint. By contrast, Cultural Safety involves the recognition that we are all bearers of culture, and we need to be aware of and challenge unequal power relations at the individual, family, community, and societal level. Any type of research involves power and control, therefore this research underpinned by an Indigenous-led methodology and methods could help rectify what Smith (2008) referred to as Indigenous people being “tired” of research and being tokenised as sources of information without receiving gains in return.

The underpinning problem was that service provider’s beliefs were based on previous knowledge and learning about a different culture whereby nursing interventions were paternalised based on the premise that Maori Pacific Island families think and do things in the same way (Vaughan, Schubert, Mavoa & Faa’vare, 2018). Similarly, Mirshani et al., (2017), maintained culturally tailored programs for Maori Pacific Island families, such as Good Start Program, be a focal point and to be recommended when working with Maori and Pasifika families in Queensland. The Mirshani (et al., (2017) evaluation of the Queensland Health Good Start Program and its perceived success reinforced the use of Multicultural Health Workers of Maori Pacific Island background to work on health promotion initiatives with Maori Pacific Island Families in Queensland. Both Maori Pacific Island Families and Child Health Service Providers assumed the need to be ethno-specific (trans-culturalism-based care) to provide “*culturally safe services*”.

More recently, trans-culturalism appears in the conclusions of two Queensland Health studies where it is states that an awareness of Maori Pacific Island women of maternity service options needs to “incorporate cultural needs and preferences based on their cultural background” (Cruickshank., 2018, p.1; Cruickshank., 2017).

## **Conclusion**

Maori Pacific Island Families in Queensland and nationwide rank second highest in low socio-economic groups, a community without power. Socio-economic disadvantage is a critical factor that contributes to further social disadvantage in terms of reduced employment opportunities and increased likelihood of poor health access and low self-esteem (Queensland Health Needs Assessment, 2011a; Rodriguez., 2017). As attested from this research and as argued by Swendson and Windsor (1996) in their review on “*rethinking cultural sensitivity*”, health education is better directed at the development of critical understanding of the complex political and socio-contextual impacts on human behaviours including health-seeking behaviours.

It can be argued that Maori Pacific Island people seldom question their identity and or selfworth until it is challenged and quite often experiences of culturally unsafe health practices predispose behaviours “that demean, diminish and disempower the cultural identity and well-being of an individual” (Nursing Council of New Zealand, 2002, p.9). Certain challenges often result in a Maori Pacific Island service user feeling powerless, unsafe, and intimidated leading to not readily accessing services. This reaction is often described by Child Health Service Providers as non-compliance (Wilson & Neville, 2008).

While participants felt accepted into Australian society, some found it difficult to anchor themselves within an Australian community:

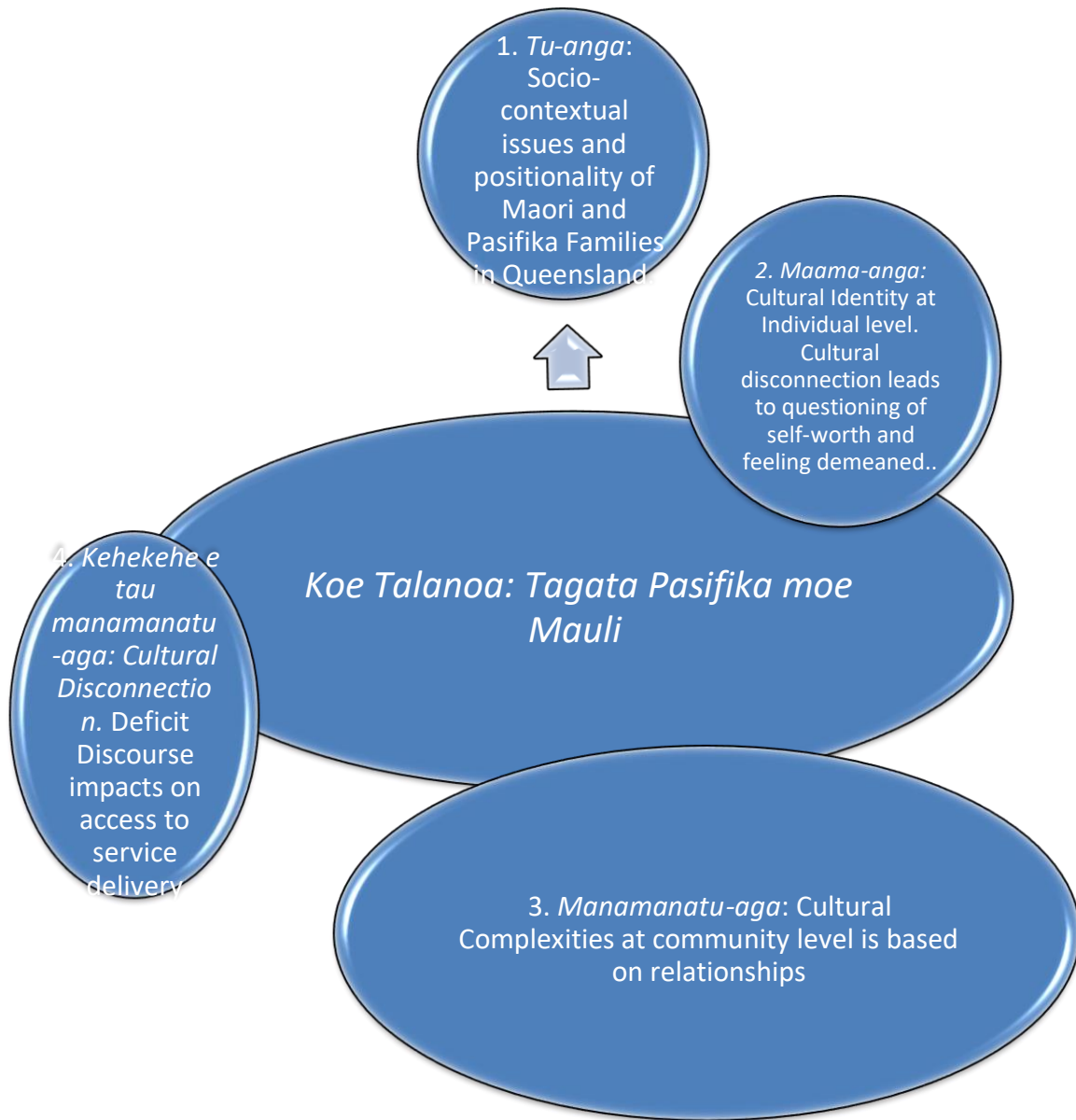
*I like it here in Australia, money is better here. But unlike NZ we have to try our best to know their ways to feel belong, or I just hang out mainly with people that come from NZ mainly friends on Facebook (young migrant Townsville)*

This is particularly salient, given the high number of young Maori Pacific Island people who are resettling here in Queensland. Young Maori Pacific Island people experience barriers to education and health services which exacerbates social problems within families, communities, and broader Queensland (Stanley & Kearney, 2017). Simultaneously, amid these understandings exists an evolving health system and governing policies, that mainly serve the dominant population and does not consider the inequities and socio-cultural differences concerning those that are affected (Allen, 2006).

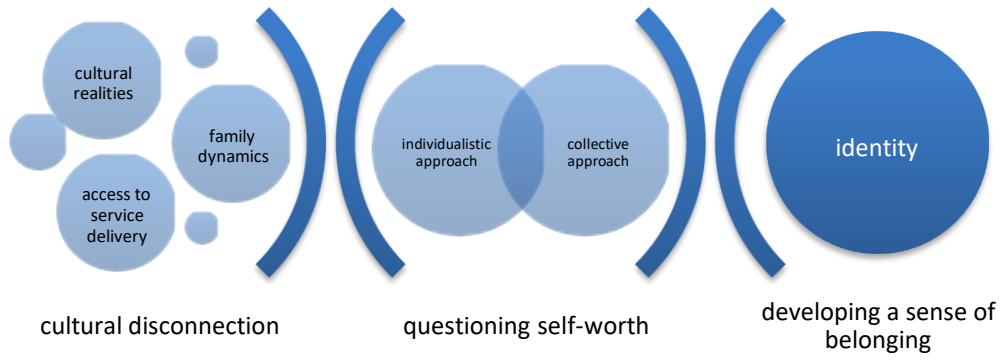
The following chapter explores further three key categories focused on Power Imbalances, Deficit Discourse and experiences of Cultural Disconnection among Maori Pacific Island Families as they access health service delivery.



Figure 9a: represents four categories as constructed from findings



**Figure 9b: represents an example of a sub-category constructed during data analysis**



# CHAPTER SIX: A Continuation of Key Interpretations (Talanoa moe tau Tagata gahua leveki tino moe Maui Pasifika)

## *Introduction*

This chapter continues the exploration of key interpretations in addressing: *Power imbalances* in service delivery, *Deficit Discourse* and *Cultural Disconnection*. The above key concepts are broadly examined as they underpin experiences and approaches to health service delivery for Maori Pacific Island people. Findings suggested that a transcultural approach to healthcare concerning Maori Pacific Island Families was encouraged and was one common denominator service delivery by health providers.

The chapter explores new knowledge through the lens of cultural safety and argues the largely unacknowledged power dynamics that underpinned health service delivery to Maori Pacific Island Families. As Foucault (1998) maintained power and knowledge was often manipulated in subtle ways and allows detachment of the truth where a person cannot recognise, nor question, socialised norms and constraints. For example, Child Health Service Providers in Queensland play an important role in service provision and its healthcare system is well developed and deemed to be of world standard. However, in terms of equity, this developed healthcare system can be of little benefit if a vulnerable population is not accessing services as readily as they should be (Jennings et al., 2014). Jennings et al., (2014) identified a deficit discourse pertaining to low staff morale, low staff motivation and low cultural competency that contributed to low uptake of Aboriginal and Torres Strait Island health care assessments.

The key interpretations of *talanoa* (stories) held with Maori Pacific Island Family study participants suggested that a collaborative and relationship- based approach had not been successful in the research. A relationship approach is where Maori Pacific Island Families are likely to disclose information and to access services only when they perceive rapport and trust has been developed. Ramsden (2002) argues that the concept of cultural safety overtly deals with issues of trust, power imbalances and as applied to the current research, the stances, and actions of service providers and how these are communicated to service users. Of critical importance are the social, political, and powerful structures that underpinned service delivery (Willis et al., 2006; Laverty et al., 2017, Cox & Best, 2019). One question asked of Child Health Service Providers was whether they thought about the

social, historical, and political position of Maori Pacific communities in Queensland. One CHSP responded as follows:

*I don't really see a lot of Maori Pasifika clients, but I have travelled to a few Pacific places overseas and loved it, I can only go by what I learn, see and hear from others (Community Health Worker)*

If context is inadequately understood, it can distort an articulation of service delivery issues to be investigated (Thurston, et al., 2018). The principle of Cultural Safety requires the engagement of reflexivity or one's own contextual and socio-cultural determinants to better understand and question the needs and position of those who access service delivery.

A misconception revealed in the research was that health care delivery that engaged a transcultural approach was assumed to be a culturally safe approach. As noted earlier, a dominant view within the health care system was that learning and understanding Maori Pacific Island cultural beliefs and their ethnicity would better equip health care workers such as Child Health Service Providers to provide services to Maori Pacific Island Families (Vaughan et al., 2018). Vaughan et al., (2018) promoted the transcultural approach and believed that embedding cultural beliefs into child health professionals when working with Maori Pacific Island Families will transform a Child Health Service Provider into a culturally safe and competent child health practitioner.

Key categories as explored above and below identified a need to disrupt the discourse of trans-culturalism and simultaneously shift a mindset from deficit discourse and dependency. The focus on power relations surrounding service provider's self-awareness in their work with Maori Pacific Island families rejects the notion that learning about Maori Pacific Island People and their culture is effective in addressing health issues. Such an approach is reflected in the following excerpt:

*I think it is necessary to learn the culture of this people so I can feel like I am able to relate to them in my work with them, half of the time I don't know what they think and whether I am getting through to them (Queensland Health Worker)*

By contrast, self-awareness, a principle of cultural safety, poses reflexivity as “concerned with any actions or attitudes that diminish or demean an identity or actions of an individual” (Cox & Taua, 2013, p.30; New Zealand Nursing Council, 2002).

*Safety* is a doing word intentionally selected to impart power to the service user (Ramsden, 2002). Ramsden refers to this exchange of knowledge as a shift of power dynamics from the service provider to the service user. This research went further and asked the question pertaining to the underlying issue of power such as “*do you feel safe with the care provided?*” As interpreted, the “*safety*” aspect of the question was perceived by service users to refer to whether they felt “physically safe” rather than “culturally safe”. In clarifying the meaning of cultural safety, the following discussion focuses on power imbalances identified in the current research between Maori Pacific Island Families and Child Health Service Providers.

## ***Key Interpretations Part IV***

### **Power and the ideology of individualism in service delivery**

#### *Child Health Service Providers*

The overriding premise of power that underlies service delivery is never in question because Maori Pacific Island Families when accessing service delivery may expect and depend on a Child Health Service Provider to understand their healthcare needs. As maintained by Foucault (1998), a person may not recognise socialised norms due to power and knowledge effects being manipulated in subtle ways. In other words, the principle of reciprocity, through showing respect to those that are helping you, enables Maori Pasifika families but with right intentions to hand over their power to child health services providers. Yet at the same time, the fear of the unknown is compounded since Maori Pacific Island Families finds it difficult to question and challenge issues pertaining to their care. Thus, a taken for granted position was one of power and control as part of an assessment and intervention during service delivery (Altman & Fogarty, 2010; Foucault, 1998). Although Altman and Fogarty were not referring to health service delivery to Maori and Pasifika people, their identification of a deficit discourse as commonly exists among service delivery to Aboriginal and Torres Strait people may be a stark reminder of the power imbalances that repressed rather than encouraged positive development models. Gaventa and Cornwall (2001) also drew on Foucault's work to describe how professionals position themselves in a position of power as those 'who know better' and to whom decisions for action should fall. Gaventa et al. (2001, p.73) described these power dynamics "as ways in which professionals imposed their 'realities' on to patients with power effects that devalue the knowledge and experience of patients".

As noted earlier the individualistic approach locates a Maori Pacific Island person's diagnosis and treatment within a bio-medical perspective and does not address socio-political and cultural inequities that influence lives and health-seeking behaviours. Relative to health service delivery focussing on Maori Pacific Island Families, there is an implicit assumption that health issues are individually experienced and located according to medical policies and interventions based on cost efficacy. As stated below by a health professional:

*I expect people to know their condition and its common sense, we can only do so much, people need to take responsibility for their health (Early Language and Health Worker)*

This approach to service delivery results in treatment and interventions of care that may further isolate Maori Pacific Island families from health service delivery. Such an approach is framed within the premise that a Maori Pacific Island person is solely responsible and accountable for her or his own health circumstances (Rodriguez et al., 2017; Altman & Fogarty, 2010). Similarly, Maori and Pacific Island values and beliefs are commonly played out by their health seeking behaviours towards service delivery. For example, a Maori Pacific Island person presenting late to an appointment with a Child Health Service Provider can create conflict due to rigid timeframes. Making and keeping appointments was one of the challenges Maori Pacific Island Families noted when trying to access health service delivery. Distance from health services and a lack of transport are usually cited as a potential barrier to accessing services (Erick., et al., 2008).

Rodriguez et al., (2017) argued how existing messages delivered in health promotion continue to focus on the individual. This is despite a move away by many health services from the structured bio-medical approach to improve and to include the social experience when doing health assessments (Rodriguez, et al., 2017). As Sallis et al., (2015) maintained individualising care delivery is problematic. The Sallis et al., (2015) argument reinforces and supports the ecological model developed by Bronfenbrenner (1992) which is inclusive of social, political, and organisational factors. The corresponding model of service delivery evident in this research continued to focus on the individual in society and does not consider the overall nature of inequities and socio-cultural and contextual factors that influence decisions while accessing a health service provider.

The concept of individualism in this research mirrors Charmaz's (2016) reference to *Individualism* as underpinning service provision amongst mainstream services. Working in collaboration requires the Child Health Service Provider to support Maori Pacific Island service users to use their own knowledge and resources which will increase their sense of belonging and control.

Nevertheless, while there are some broad beliefs that may characterise a Maori and Pacific worldview, it must be remembered that no population is homogenous. There are

differences between and within groups of people and Maori and Pacific people are no different. The social and political diversity in terms of class, gender and age within Maori and Pacific people requires an approach that focuses on principles of partnership and understanding. Working in partnership with Maori and Pacific Island families requires the health provider to acknowledge, support and understand families needing to develop, secure, and use their own resources that will in turn increase their sense of control and selfdetermination. We cannot work in partnership if we, as service providers, do not believe in the capacity of the families to make a positive contribution to their health. As reported in below studies concerning access by Indigenous families to health services, the attitudes of the staff are often more important to the family than their level of competence and for many Indigenous families they suffer judgement, discrimination and prejudice when accessing mainstream health services (Kildea et al., 2010; Jennings et al., 2014).

An important factor to consider is the development of a relationship to work in partnership with Maori and Pacific Island families rather than assuming Maori Pacific Island group think and act the same as stated in below comment:

*I feel appreciative of my experience as growing up exposed to different cultures and Maori Pacific Island in New Zealand, this I felt has helped me to understand issues Maori Pacific Island are going through when working with them (QLD Health Midwife).*

The research sought to disrupt the above discourse and posed the health professional as a critical social actor in constructing the health experiences of Maori Pasifika Island people in Queensland. An example in the below comment gives insight into possible communication factors contributing to Maori Pacific Island Families lack of engagement with services:

*I know I take up their time because I need plenty of time to understand what they saying and I feel guilty and gets put off to go see a doctor (Pasifika Community Elder).*

One of the central tenets of culturally safe practice is that the voice of service users should be heard (Ramsden, 2002; Smith, 2007). Consequently, the vulnerability of service users is recognized amid a strong sense of justice and caring enough to find ways in which they can express themselves (Wilson, 2006; Lupton, 1998). So far culturally safe care provision for Maori Pacific Island Families in Queensland has remained an illusion (Sheridan, 2015) and



largely because the term *cultural safety* is yet to be fully understood by both most health professional and service users.

## **Manamanatu-aga/ Deficit Discourse Part V**

### **(Socio-Cultural Norms)**

#### **Maori Pacific Island Older parents**

Amongst the Pasifika Community, collectivism is a highly valued approach usually practised within a *whanau*, or the extended family or community (*Kau -fakalatahanga*), as in opposed to the individualist approach that underlies service delivery. In this capacity, working in a collaborative arrangement does not deny the clinical expertise of a Child Health Service Provider; it simply recognises the complementary expertise of a Maori Pacific Island service user (Smith,1999).

Fear of stigma and judgement by others in their own community, for example in the case of mental health issues, is one key barrier to service delivery for Maori Pacific Island families (Sheridan, 2015; Thurston & Phares, 2008; Tufala, 2018). Deficit Discourse where treatment and care are a responsibility of the service provider and associated with anticipated medical treatment seemed to compound this fear and therefore could complicate the process of accessing health services. These concerns were deemed to have a significant impact on health-seeking behaviours and yet there appeared not to be great deal of awareness of these issues within the wider Child Health Service Provider community (Sheridan, 2015).

It is alleged that health service providers and their staff members often given little thought to their own culture, to their attitudes and beliefs (Winkworth et al., 2010). Winkworth et al., (2010, spoke to parents of young children who were not well-connected to services designed to help them. Young parents in this study stated that they felt being judged by service workers when accessing service delivery as reflected below:

*Sometimes I ask myself this question on whether they think about how they speak to people (Young Parent)*

Despite experiencing barriers to health services, most families created alternative pathways to health services. As such families adopted several strategies including talking to

their extended family members and asking for help to find health service providers that offer bulk billing for medical services. It is common, as stated below by a newly immigrant to Townsville to find one family and their extended family members registered to one health service provider:

*My own family and my other families that moved here from NZ all see the same doctor it is easier so we can assist each other sometimes with transport...*

Overcoming time obligations at work to attend to medical appointments are often difficult and can result in doctors' appointments not being kept. Resilience and cohesion of the Maori Pacific Island community had overcome some of these barriers to health services. The socio-cultural norms embedded in Maori Pacific Island families, in general, differ significantly from the cultural expectations and norms of health service providers especially with mental health service providers (Hamer, et al., 2014). For example, the traditional Pacific *Niuean* cultural value of unquestioning obedience and respect for authority figures can lead to discourage questioning and critical thinking (Sheridan, 2015). Moreover, parents often overlook their own individual feelings for the sake of their children wellbeing (Thurston & Phares, 2008). Thurston and Phares (2008) examined the influence of parents' gender, race, and psychopathology on perceived barriers and attitudes toward mental health utilisation for themselves and for their children. Dread of stigma and judgement by other Maori Pacific Island people in the community is also a significant barrier as evident in a statement below by a Niuean older parent who has an older son diagnosed with a mental health condition:

*They (friends) try to say to me that my son should have a case manager, I don't want to talk about it, my son refuses to go along and to see his doctor and when he gets very sick, I get worried. They (doctors) know what they doing, who am I to question them? They (doctors) explained why he is not well (non-compliance with medication causing deterioration to condition) and I understand now but I can't force my son to go" (Older Pacific Island Parent).*

The deficit discourse was evident in a study in New Zealand on young migratory parents whose parenting practices being based on their cultural identities, were viewed as problematic to the service provider (De Souza, 2012). On interpersonal level this cultural diversity may then be transposed and define Maori and Pacific Island consumers in terms of deficit (Cox & Taua, 2013).

The embedded theoretical tool used in this research was framed in a way that unearths an understanding of the systemic and structural barriers which governs access to health services by Maori Pasifika people. Structural inequities caused by deficit discourses have always been the underpinning force that governs access to health services and which in turn perpetuates harmful stereotypes and creating further deficit discourses such as chronic comorbidities caused by lack of access to health services by Maori Pasifika people. As claimed by Ramsden (2002), “if care is focussed on the ethnic origin and behavioural activities of the patient, there remains the tendency to promote a stereotypical view of culture, making it difficult to respond to contextual diversity” (p.112). Ramsden (2002) went on to argue that “Cultural Safety is about issues of access to service and communication, rather than technical skills and the ethnicity of the service user” (pg.179). Health service provision were reflected through the lens of trans- culturalism and power discrepancies, which is a reductionist approach to service delivery (Gaventa & Cornwall, 2001; De Sousa, 2012; BoagMunroe & Evangelou, 2012; Cox & Taua, 2013). The research revealed a deficit discourse and assimilatory attitudes in service delivery. One does ask a question as to why Cultural Safety as a powerful theoretical tool to equalise healthcare is not evident enough within service delivery. Rather, the trickle-down effects of deficit discourse impacting service delivery for Maori Pasifika Families continue to manifest as complex, whether that be at the individual, organisational or structural governance levels.

## **Kehekehe-anga/ (Cultural Disconnection) Part VI**

### **Maori Pacific Island Younger Parents**

*Cultural disconnection* as stated in the above discussion about Maori Pacific Youth, is obvious at mainstream level where operational policies and practices designed are constructed to suit the needs of the dominant population (Rodriguez et al., 2017). Following migration to Queensland, participants attributed fear of stigmatisation, adaptation to a new culture, new language, and lifestyle changes as some of the causes of barriers to access a Child Health Service Provider. In addition to the above scenario, the older parent participants by showing cultural respect to the Child Health Service Provider expect and depend on the Child Health Service Provider to provide all care and will go along with their treatment despite their frustration with experiences, such as not understanding most medical terms that were used as stated below:

*I respect the hard work they do even though I do not understand half of the words they are saying (Pasifika Elder)*

The researcher asked the participant whether this family would access the same health provider again and if they do, what is it that would need to improve and if not why? Predictably their desires first and foremost were to feel like they were part of the conversation or according to (Kalavite, 2010) be part of a family (a pathway towards developing a relationship) and decisions made regarding their treatment and care.

Differences in culture are then blamed for shortcomings which can result in both the Child Health Service Provider questioning compliance and a Maori Pacific Island service consumer questioning her or his self-worth. The sense of isolation is an important factor to consider when younger parents are not readily accessing health services but are using online sources to access information. The above could be compared to the Hamer et al., (2014) and Gulliver et al., (2010) studies on mental wellbeing which found that Pacific people due to their differences felt ostracised and marginalised when accessing care:

*I find it hard to look them in the eye when they talk to me, I was taught growing up not to talk back or look people in the eye because that is rude (Young Pacific Island)*

As reflected in the work of Hamer (2009), there were perceptions of feeling like “second class citizens” due to a lack of social engagement and financial services. The broader Queensland community was misinformed about the contextual financial situation of the Maori Pacific Island community in Queensland as determined where the members of a Maori Pacific Island community were labelled “*bludgers*” despite not being eligible for unemployment benefits (Hamer, 2009).

There is also an awareness of a risk of perpetuating oppression through failing to critically discuss and acknowledged the experiences of marginalised individuals and groups (in this instance Maori Pacific Island Families). While tolerance and sensitivity towards cultural differences is articulated in principle as reflected in policy and standards Queensland Health system remains largely monocultural in terms of social institutions, norms and attitudes. Ten years ago, the Queensland Health Needs Assessment (2011a) report identified a need to reverse the socio health disadvantage impacting Maori Pacific Island families, yet there appears to be an ongoing lack of improvement in health status and co-morbidities as seen

for example in a recent study on effects of diabetes on Queensland Maori Pacific Island people (Akbar et al., 2021).

The marginalisation continues for Maori Pacific Island people whereby nursing interventions and medical treatment are often based on an individualised bio-medical approach. The dominant approach results in an experience that is demeaning and disempowering for Maori and Pacific families. The power imbalances that contribute to and result from the above processes shaped the experiences of a Maori Pacific service user when accessing health service delivery. Cultural safety as portrayed below by one young parent in this study is posed deliberately as a powerful tool for the young parent to decide whether she “*feels safe*” with service delivery. Absence of continuity of care was frustrating where a medical condition had to be explained over again to different staff members each time in accessing a GP and may act as one barrier as explained below:

*Sometimes, my Mum who is a diabetic ask me to take her to the doctors but I can't because of work so I feel bad thinking about her at home or at the doctors by herself, but I hope there is same doctor to see her so she does not need to explain herself over and over again (young Pacific Island migrant).*

## ***Discussion***

### **Cultural Safety and the Maori Pacific Island lens**

Brascoupe and Waters (2009) in their definition of cultural safety, “explored practical strategies, approaches and lessons learned that addressed the key drivers of risk and crisis for First Nations communities” (p.7). Brascoupe and Waters (2009) argued that cultural safety as a concept could contribute to a greater understanding of this crisis within healthcare delivery. Similarly, in Australia, Kildea (2006) found that cultural safety provides a useful framework to enhance the provision of healthcare services to Indigenous people, specifically to Aboriginal and Torres Strait Island mothers who were accessing birthing services in Queensland. In this research partnership, protection and participation were the three main principles, as posed by Ramsden (1990) and Arches (2001), as integral to the relationship between the participant and the researcher.

This research sought an outcome where the principles of cultural safety become entrenched within service delivery aimed at Child Health Service Providers; cultural safety must be

practiced by individuals who make up organizations. When applied to this research project, cultural safety began with the development of a research idea where relationships with Maori Pacific Island participants are established and extended to the publication of findings. Explaining a culturally safe research project was guided by using a framework based on partnership, participation, and protection (Ramsden, 2002).

This research applied a decolonisation viewpoint, as informed by Smith (1999), in seeking to deconstruct the impact of power and control on Indigenous (Maori) people.

Decolonisation methodology for research purposes and Cultural Safety as a model for health practice has been around for several years in New Zealand and Australia. Several Child Health Service Providers as found in my research have yet to fully embrace its' dialogue which is influential to service delivery. The conceptualisation of Cultural Safety was not and never had been conceptualised as static with a lineal progression. Cultural Safety is and always fluid, is circular and will continue to evolve without an endpoint (Williams, 2019, Cox & Taua, 2016). A misconception that equates trans-culturalism to cultural safety clearly addressed a need for Child Health Service Providers to acknowledge the power imbalances that constitutes most practices in service delivery. As interpreted from above reflections, the term Cultural Safety is yet to be fully articulated by Child Health Service Providers.

The ideology of trans- culturalism is embedded in service delivery where both Maori Pacific and Child Health Service Providers believed in the overall premise of transformational knowledge through learning about an ethno-centric culture intrinsic to the service user, as seen in some Maori Pacific Island child health service user programs. The risk of practising from a transcultural approach therefore encourages service provision that leads to reductionism in service delivery for Maori Pasifika Families (Cox & Taua, 2016). Ongoing processes for reductionism in service delivery for example, can be found in a qualitative study completed by Cioffi in (2006) who reported that although nurses were acquiring knowledge to care for patients from a different cultural background, stereotypical views of the patient's culture were often used rather than the perspective of the service user.

## ***Conclusion***

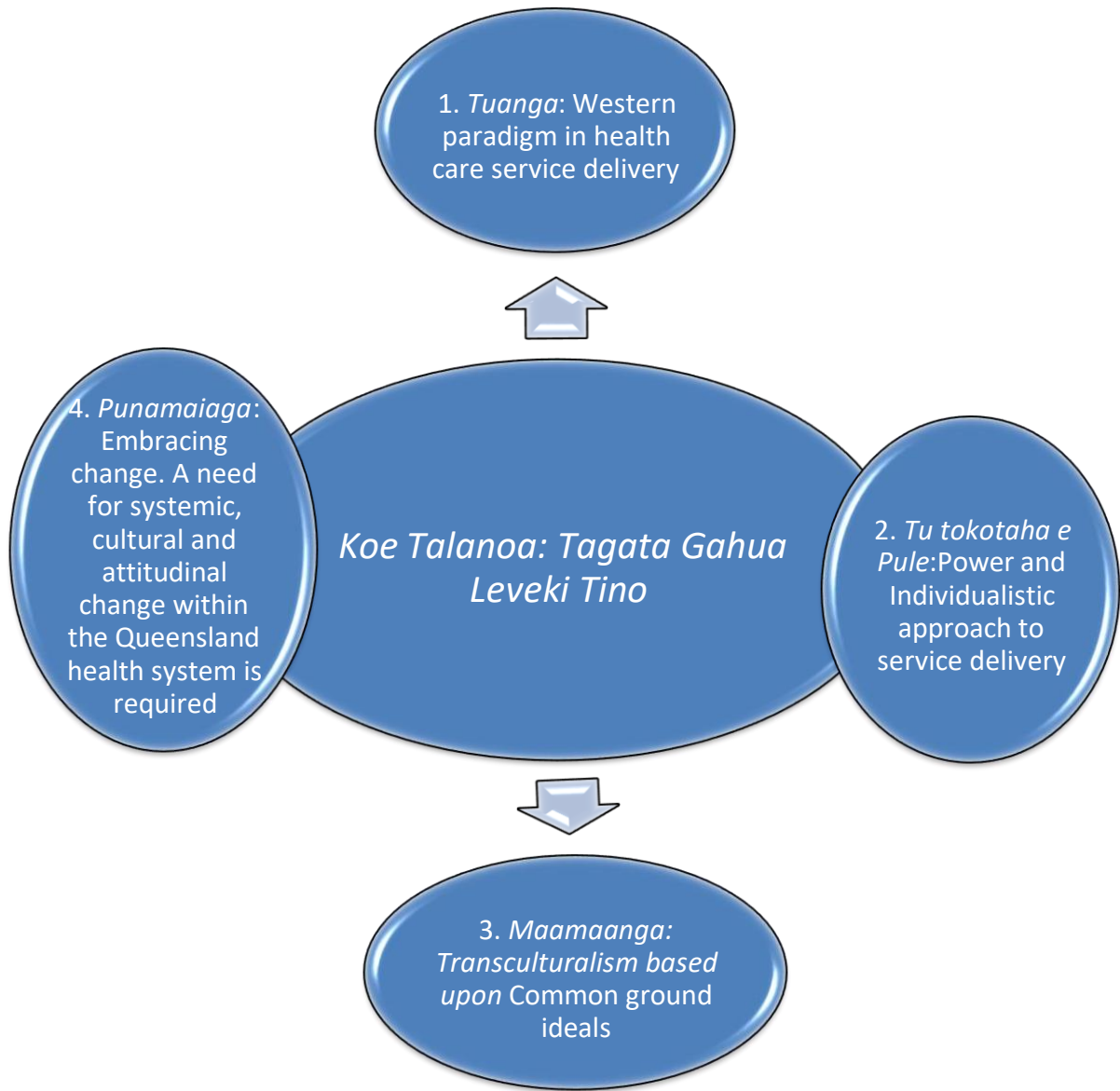
It is argued that Leininger's (2002) development of a transcultural model in service provision reflects a colonising approach especially in terms of providing care to

Queensland Maori and Pacific families. This approach, as seen in this research, is one where Maori and Pacific Island families become dependent and non-participatory in regard to their care because service providers have learnt pre-determined values on what and how care is delivered (Cox and Taua, 2013). An analogical example is compared to the work of Petrus (2017) on transculturalism which underpins a homogenous globalised culture. Although Petrus is not talking about acculturation of health service delivery to Maori Pacific Island people, his argument on the globalisation of culture reflects a concept of global trans-culturalism. In its application, the approach is one where child health service providers gain control of Maori and Pacific Island cultural and healthcare aspects (at the expense of Maori and Pacific health) in order to be acknowledged as experts in providing culturally safe care during service delivery.

Reflecting Bronfenbrenner's concept of a macro-system, most services delivered by child health service providers are governed by operational guidelines and cost-effective management protocols, which means that most critical nursing and medical interventions are performed and prioritised based on financial rather than quality concerns. The aim of this research was thus not to discredit services but to construct and translate empirical data into significant knowledge because the Queensland Government is concerned about the poor access that Maori Pacific Island Families have to Child Health Service Providers.

(Sheridan, 2015; Dawes & Gopalkrishnan, 2014; Krauss et al., 2014; Queensland Health Needs Assessment, 2011a). The Queensland government has called for approaches which addressed service delivery deemed culturally safe especially for targeted population considered to be vulnerable (Queensland Health Needs Assessment, 2011a). Although some small gains had been made in terms of heightened awareness of the need to reverse the position of Australia Maori Pacific Island socio disadvantage, further work is needed that embodies genuine social justice which benefits all.

Figure 10: represents four key concepts in service delivery by child service providers





# **CHAPTER Seven: Conclusion and Arrival of Journey: Koe Fakaotiaga he Fenoga**

## ***Introduction***

The final chapter locates the Cultural Safety Model and Decolonisation Methodology as the overarching framework to conceptualise interrelationships between key categories associated with social, political, cultural, and contextual processes and impacts.

## ***Situating Ramsden's Cultural Safety and Decolonisation methodologies to contextualize interrelationships between key categories***

Ramsden (2002) refers to a cyclicity of low socio-economic, cultural differences and contextual disadvantages as deficit discourses that continue to underpin access to health systems, thus compounded issues for example, of low uptake of child health services among Maori Pacific Island Families. On a larger scale and according to Bronfenbrenner (1992), a macro-system defines the social norms, lifestyle, and cultural identities of a human being. Affordability and socio-economic issues impacted greatly on accessibility of services where priorities around survival for Queensland Maori Pacific Island Families came first rather than general well-being. Access to healthcare is a balancing act for most Maori Pacific Island Families, and efforts to maintain this balance within their journey is ongoing. While the experiences of Maori Pasifika families living in Queensland may differ, the research in identifying health inequities and deficit discourses surrounding contextual disconnection for Queensland Maori Pasifika families are indeed linked to their economic, cultural and social position. Although most families reported and presented unique skills and resiliency to navigate access to health services, efforts to maintain access to wellbeing are ongoing.

The following section turns to other social and cultural processes that underpins Maori Pacific experiences with a view of understanding health-seeking behaviours.

## **Cultural identities versus healthcare systems in maintaining inequities**

### **Impacts of Identity on health-seeking behaviours**

In accordance with the Cultural Safety model the socio-political effects of contextual determinants and identities are crucial in understanding the health-seeking behaviours of

Maori Pacific Island Families. For instance, evidence suggests that, despite higher aspirations by parents, Queensland-based Maori Pacific Island students achieve comparatively lower educational outcomes due to non-alignment caused by cultural differences between family and school expectations (Cuthill & Scull, 2011; Stanley & Kearney, 2017). Kalavite (2010), in her study of Pacific Island high school students in New Zealand found that having a strong sense of one's own familial affiliation helped students build a strong positive cultural identity for themselves.

There are four fundamental features in the development of Maori Pacific Island Identity, genealogy, family, cultural practice, and place (Spickard, 2002). Although, there is a suggestion on how the approach to culture impacts on identity which tacitly impact on health seeking behaviours of Maori Pacific Island Families as they access health services in Queensland.

As explained by Kalavite (2010), Pacific Island students in New Zealand who were not familiar with their cultural identity lacked self-esteem and tended to isolate themselves from their community. In contrast, George and Rodriguez (2009) noted the importance of cultural identity to the development of self-worth among Maori Pacific Island rugby players in New South Wales and many have been able to take ownership of their identity and to capitalise on their identity portrayed as powerful players on the field. Radclyffe (et al., 2023) also reports on need for Maori Pasifika Youth in Logan Queensland to mitigate labels of social stereotypes by capitalise on their cultural identity and differences.

Evidently, purporting a lack of trust and rapport in service delivery, Maori Pacific Island Youth in the research expressed a need to access a health service in the community known to be commonly accessed by other Maori Pacific Island Families. Communal connections among Maori Pacific Island families, as identified in the research equals a strong positive cultural identity and more so for support on building self-worth when accessing health service delivery (Spickard, 2002; Tufala, 2018). As found in the research, in order to secure feelings or sense of *belonging*, Maori Pacific Youth and Elders would seek help in asking their family or friends and source online information about existing health services (also see Ravulo, 2016). Sacrifices influenced family relations and as described to the researcher Maori Pacific Island people start to question and doubt their self-worth. As much as it was significant to understand cultural differences and identities, it was just as important to align and reflect on the power imbalances that underpins each relationship during service

delivery. A non-aligned school expectation and health service delivery as found in the research is one example of how disconnect or misaligned beliefs and policies can impact on success and uptake of services.

The Queensland health care system and its policies in maintaining health inequities are reflected in the rising prevalence of preventable childhood diseases and adult morbidities amongst the Maori and Pacific Island families in Australia including structural and individual processes affecting access to service delivery for Maori Pacific Island families in the research (Rodriguez et al., 2014 & Akbar et al., 2021). This brings our next discussion to focus on the emerging issue of trans-culturalism in its approach in sustaining service delivery to Maori Pasifika Families.

## **Maori Pacific Island Families versus Child health Service Providers**

### **Transcultural approach within the Queensland Health System**

Our Queensland Health system as found in the research and elsewhere has proven to be an environment that values trans-culturalism and is arguably “too rigid” in approach to provide service delivery for Maori Pacific Island Families (Sheridan, 2015; Dudgeon & Walker, 2015). Dudgeon et al., (2015) spoke of the colonial manifestation and its failure to acknowledge the political, cultural, and contextual determinants that influence positionality of the service user.

While the current efforts are commendable, child health services available in Queensland and North Queensland region do not provide adequate levels of culturally safe care (Sheridan, 2015; Kendall, et al., 2011). These experiences affected family dynamics and cultural identity which impact on the self-worth of youth and exacerbated social disadvantages among Maori Pacific Island Families in Queensland (Rodriguez, 2007).

With regard to service delivery, the analytical outcomes reflected the socio-cultural and political standing of Maori Pacific Island Families in Queensland, compounded by cultural norms of both service providers and Maori Pacific Island Families, power dynamics, misconceptions and contextual diversities in accessing health services. The outcomes converged with New Zealand research which found that a number, if not all, of Maori and Pacific Island patients often delay seeking treatment for chronic conditions (Scott et al., 2011; Taufala, 2018). The research participants represent a diversity of nationalities and

ethnicities from across the Pacific. Most Maori and Pasifika assumed a strong holistic perspective comprising the body, mind, spirit, social and environmental aspects, also shown in New Zealand research on Maori and Pacific Island perspectives around accessing primary health care (Southwick et al., 2012).

It appears from the research that health service providers continue to apply, accept funding, and maintain service delivery that deflects rather than reflects power imbalances affecting service delivery issues concerning care to Maori Pacific Island Families. In the meantime, Maori Pacific Island healthcare needs continue to evolve on a day- to- day basis which requires ongoing decolonising of actions, treatment, interventions, and policies.

Simple approaches such as Cultural safety acknowledges the health inequities and including the barriers to service delivery effectiveness that are embedded in the inherent power imbalance between provider and patient (Lavery et al., 2017; Cox & Best, 2019). Culturally safe care means that there is no unintentional disempowering of the recipient, and recipients are involved in the decision making and become part of a team effort to normalise the effectiveness of care (Ramsden, 2002). Hence culturally safe care is being aware of health inequities, considering power relationships, implementing reflective practice, and allowing the Maori Pacific Island (service user) to determine what safety means in terms of service delivery (Lavery et al., 2017). To date, limited literature or evidence suggests why the lack of uptake of services by Maori Pacific Island families in Queensland. It could be that the current health system and its policies are set up to mask the way that people are disadvantaged based on their culture and positionality (transculturalist and individualistic approach) (Browne & Smye, 2002).

## **Decolonising Practices of Queensland Child Health Service Providers**

### **Addressing lack of engagement in service delivery at individual level**

Mainstream child health service providers, researchers, funding bodies and policymakers need to understand and acknowledge why Maori Pacific Island Families continue to resist access to child health services as can be seen in New Zealand on lack of access to mental health services amongst Pasifika families (Taufala, 2018). Curiously, would this resistance be viewed as a protest to an ineffective service implementation system? Rather than talking about Maori Pacific Island issues through using culture to highlight plight of these issues, service providers need to reflect, deconstruct and to concentrate on their actions and

attitudes when working with Maori Pacific Island Families (Cox & Taua, 2013). This research is not necessarily asking child health service providers to jump on board readily, it is asking for a chance to maintain a process of building a relationship through understanding of each other's position. Cultural awareness through learning about cultural nuances and traits is ineffective and should not necessarily be a part of the current solution because information widely circulated by proponents and educators of Cultural Safety had been addressed for a few years here in Australia.

While families were commenting, they were getting "good care", when presenting for treatment, there are still cultural, social and economic factors surrounding health-seeking behaviours to be addressed, if access to healthcare service provision is proven effective towards increased engagement in this community as found in a study by Kingi (et al, 2021). Results in this research confirmed a need for an effective model of service delivery that is relevant, shows mutual respect and reflects the social and contextual positioning of Queensland Maori Pacific Island communities. As found in the research the fundamental decolonising issue is that service providers need to recognize that they are in effect, are the power holders when it comes to service delivery. Moreover, Child Health Service Providers need to consider the fundamental question of whether service delivery is culturally safe from service users' perspective and if the answer is no, then ask again on what and how they can influence that change in their practice (New Zealand Nursing Council, 2002). The above is described by Ramsden as a health system whereby experiences are shaped by cultural impacts within individual levels and this research certainly had identified a need for child health service providers to decolonise or reconsider practices within and at individual level.

The above findings require service providers to abandon any idea that they can fully comprehend their clients' cultural life and practices. Rather, service providers are encouraged to respond accordingly to a carefully reflected and honest appraisal of the impact of their own cultural attitudes, history and life experiences on Maori Pacific Island rights in maintaining their own cultural ways of knowing (Woods, 2010).

Increasingly this two-way process involves service delivery and outcomes, and the expectation is that service providers who understand his or her own culture and the power dynamics inherent in this relationship can be culturally safe. Although in retrospect transculturalism assumed as cultural safety was the underpinning constructivist factor that influenced child health service delivery to Maori Pacific Island Families.

# Decolonising Queensland Health Policies and Systems

## A radical re-think to address change at organisational and structural level

In a review of policy within the UK, Western Pacific, Canada and New Zealand countries the World Health Organization (WHO) concluded that policies which tackle the macroenvironmental factors (income and education) and the physical and social environment are more successful in dealing with health inequities (World Health Organization, 2019; Queensland Health, 2011a). This review of policy by the WHO is consistent with frameworks, plans and policies in New Zealand and can be applied here in Queensland.

Where the focus of health inequality is linked to socio-economic inequality (Carroll et al., 2011). Key socio-economic indicators such as insufficient money for medical care, adequate food (Cheer, Kearns & Murphy, 2002), or educational opportunities may affect social outcomes directly. For instance, there are higher rates of hospitalisation of people living in more deprived areas (Tukuitonga, 2012; Crampton, 1998; Cruickshank, et al., 2019). Adverse living conditions in childhood, and particularly the effects of inadequate income, are strong key indicators of adult illness (Galobardes., 2006). Parental poverty and exposure to unhealthy environments (smoking, low level of literacy, poor nutrition) reduce a child's chances in life (Leggat, 2004; Jones, Lattof & Coast, 2017). Socio-economic deprivation plays a role in accessing services and should be made a fundamental part or a key performance indicator of the initial overall assessment when working with Queensland Maori Pacific Island population. Rather than showing a lack of political will the Queensland government needs to readdress these health inequities impacting its vulnerable population.

Other studies on Maori Pacific Island health in New Zealand show a correlation between economic and social inequalities and equitable health and social outcomes. There is enough evidence for Queensland Health systems to understand that "countries that minimise economic inequalities are societies where children are more likely to be able to develop to their full potential" (Howden-Chapman, Blakely, Blaiklock & Kiro, 2000, p. 301-302). Of significance is that increasingly we are now seeing a number of studies undertaken here in Australia, as seen in the literature review that focused on the health burden carried by Maori Pasifika people.

Since Maori Pacific Island Families in Australia are contributing significantly to the economic growth in Australia through payment of taxes (Rodriguez, 2007), there should be sustained pathways and policies in recognition towards wellbeing of Maori Pacific people through provision of health service delivery. For instance, a provision of an outreach service specific to all those that are disadvantaged in health including Maori Pacific Island Families in the community. The outreach service is conducive by alleviate the effects of structural and behavioural power dynamics that controls service delivery. Indisputably, Maori Pacific Island Families when positioned within their familiar environment can feel safe to speak and openly discuss their care.

Another possible resolution is contextualisation of management and nursing care plans to effectively and with compassion articulate care to a service user (Henry et al., 2004.) This process will include an understanding of the need to dismantle colonial thinking, in specific to idealised medical and nursing hegemony. Rather the bipartisan support and commitment over the long haul can speak volumes regarding relevancy and effectiveness (Rodriguez, et al, 2017). New Zealand Pacific Island and Maori citizens and ‘back door’ migrants from other Pacific Island spend most of their working lives in Australia but are struggling to meet financial costs to become permanent residents (Rodgriguez, 2007; Sheridan, 2015). The taxes paid to the government by Maori Pacific Island people could contribute to programs for parents and children if they are unable to flourish as well as they might, because they cannot equitably access child and family health services, tertiary education and sporting scholarships.

Most of the study participants migrated to Australia after the Trans-Tasman Migration Act of February 2001 and many were experiencing economic disadvantage due to the trickle down effects of this Act (Anderson et al., 2011; Stanley & Kearney, 2017). Preceding migration to Australia, there was an assumption that opportunities for Maori Pacific Island Families would be much better in Australia. Although some families are financially doing well many were unaware that they had to pay for their medications and for most medicalrelated procedures otherwise covered by medical insurance. Majority were unable to afford to take out medical cover for themselves and for their family members (Heather, 2012; Hamer et al., 2014; Orton & Edwards, 2020). As it currently stands, most Maori Pacific Island Families who migrated to Australia after the introduction of the 2001 Trans-Tasman Act do not qualify for the National Disability Insurance Scheme (NDIS) and or

financial stimulus packages offered during times of need (for example, job losses due to current impacts of the COVID-19 crisis and economic losses due to recent fire and flooding). Such challenges caused ongoing stress to the family and members who described mainstream health services perceived their relative deprivation as a fault of their family (also in De Souza, 2012; Jones et al., 2017). The research had identified a need for child health service providers to commit to action based on social justice and human rights.

## **Decolonising Power Imbalances within service delivery**

### **Lack of uptake of Child Health Service Delivery is an ethical dilemma**

The research, through the lens of decolonisation and cultural safety revealed power dynamics underpinned by the ideologies of individualism and trans-culturalism in the delivery of services to Maori Pacific Island Families. Expressions of confusion and frustration were evident in the language of the younger population when recounting experiences with health services. The excerpts above reflected diverse philosophies in access to service delivery. One appeared where health professionals were perceived to be more powerful and the response of the young person was to adhere to their advice without question. According to Ramsden (2002), the above findings translate as power and knowledge discourse, that plays out different levels of power due to cultural differences and social upbringing. This discourse on power discrepancies can influence the way a service provider to act and think in relation to a health issue during service delivery.

This interrogation of power relationships was found in New Zealand where service provision for Maori has been recognised as a challenge and where the cultural safety theory (*Kawawhakaruru*) was introduced to highlight a more focused response to power imbalances between service providers (nursing) and service users (Woods 2010; Ramsden 2002; Curtis et al., 2019). In other words, service providers in this research and elsewhere were asked to consider whether they believed their service delivery was deemed culturally safe by the service users (Bishop, 2005). Furthermore, Bishop (2005) presents a collaborative epistemological model of (*Kaupapa*) Maori research which is characterised by the absence of the need to be in control. Likewise, this research is driven by participant-driven criteria including metaphors underlining self-determination, embedded understanding, and compassionate understanding of another's moral position (Bishop, 2005).



Furthermore, a comparison of the *Talanoa* process to Charmaz's (2006; 2011; 2016) work on constructivist grounded theory is premised on the construction of information or knowledge portrayed on a journey underpinned both by participant and researchers' knowledge, actions and attitudes. Decolonisation methodology fits the focus on cultural safety and the related methods relate to my life world and my cultural assumptions as a member of the target population as I advocate them to be best suited to achieve the outcomes of this research. The research methodologies of decolonisation, *Talanoa* and cultural safety have the capacity to promote a more equal partnership between the researcher and participants by ensuring that participants are empowered to vocalise from their own perspective the (relevance) of this research to their wellbeing. Nabobo-Baba (2008), in her study with her people in Fiji, stated that to profess and define realities and aspirations, the voices of the Pacific people must be upheld.

As an outcome of the research, cultural safety is intended to foster the development of a workforce that is self-reflective of the contextual position of Maori Pasifika people, being open-minded, sustaining attention to self-awareness during practice and non-judgmental (Ramsden, 2002). In the event the voices of Maori Pacific Island Families are absent in decisions that are made with respect to their healthcare, their non-participation is interpreted as their own inefficacy. This research as argued by Charmaz (et al., 2017) embraced a dialogical process of co-construction of realities from the unique perspective of the service user and the child health service provider. In the study an ethical dilemma is posed, whereby despite calls for improvement in health inequities from the Queensland government, issues for a clear solution regards access of service delivery needing to be managed over time are still ongoing (Woods, 2010). Theoretical interpretations confirmed a need for policy reform in which education about cultural safety can play a role into refinement and reshaping of current policies and health practices. Likewise, I was attracted to Ramsdens' work on cultural safety, which is underpinned by decolonisation, reflexivity, and social justice. Reflexivity, the first step in culturally safe practice, is powerful and assisted the researcher and participants to explore their assumptions, biases, and value judgements (Bourdieu, 2001; Charmaz, et al., 2017). As suggested by Fook (2002), permitting the researcher's positionality to become text in the research provides an insider's view into the research. Similarly, Charmaz, Thornberg & Keane (2017) advocates how constructivists grounded theories" engaged in reflexivity throughout inquiry about their constructions and interpretations of data" (2017, p. 417).

As argued by (Wilson, 2006. p. 12), “nurses will move their gaze from negative stereotypes, victim blaming and deficit explanations to recognize the strengths that Indigenous people possess to enable self-determination”, and the same could be applied to Maori Pacific people.

Through using *talanoa* methods, the research decolonised conventional academic research methods to ensure that Maori and Pacific Island participants benefited directly not only from participatory knowledge gained through the research but as partners in decision making regarding access to care during the research (Smith, 1999; Nabobo-Bara, 2008). Another method recommended and due to its suitability to *talanoa* and could be cost effective to participants, is the use of technological software like Zoom which is currently being taken up by most education providers as a method to communicate and learn together.

Given the fact that cultural safety specific nursing programs were targeted on programs for Maori Pacific Island Families in New Zealand, under-resourced funding capabilities have seen cultural safety practitioners experienced “burn-out” (Rodriguez, 2013). These experiences are seen in the aftermath of budget cuts and lack of formal training, while demands for such services remained higher (Rodriguez, 2013;). A study by Durey (2010), also by (Hughson, Marshall, Daly, Woodward-Kron, Hajek & Story, 2018), assessed the role of education to impact health literacy, for both undergraduate students and health practitioners, in the delivery of culturally responsive health service with a view of linking service delivery to disparities in health care between Indigenous and non-Indigenous Australians. Both studies found that cultural safety programs may lead to short term improvements to health practice, but that evidence of sustained change is more subtle because few programs have been subject to long term evaluation in terms of health literacy (Durey, 2010). In Australia Parker and McMillian (2007) reports that although there were multiple strategies designed for diversity in teaching curriculums there still appeared to be little commitment to fundamentally changing the preparation of cultural care in nursing curriculum.

The above dichotomy could be compared to earlier antagonists who were against the education in development of Cultural Safety in New Zealand (Ramsden, 2002).

Nevertheless, according to Ramsden the biggest threat is the deliberate misinterpretation of what Cultural Safety is all about. Cultural Safety in terms of education is relevant to this research project in that, as a model it is concerned with the education of individual health

professionals and nursing students in the hope of prompting social and health equity in health service provision (Curtis et al., 2019). A study in New Zealand recommended Cultural Safety as the overarching framework that will achieve health equity for its Indigenous population and the same efforts could be applied here in Queensland.

## **Conclusion**

The concept of cultural safety and decolonisation methodologies is used in the research to express a concept to healthcare provision that recognizes the social, political, and contemporary conditions that shaped Maori and Pacific people's health status. Maori and Pacific people have experienced a history of colonisation, and cultural and social assimilation through healthcare service provision, leading to historical trauma and loss of cultural cohesion (Smith, 1999). It is assumed that current power structure and policies affecting health service provision for Maori Pacific Island Families will continue to undermine the role of Maori and Pacific people working as partners with health care workers in their care and treatment. Simultaneously suggesting a cycle of lack of engagement with health services and leading to a reproduction of service provision that maintains health inequities. Of most significant is that many health service providers in principle are purporting to reversing the statuses of socio- disadvantage affecting its vulnerable population. Regrettably and despite noted diversities we are yet to achieve a fair and distributive justice where good health is attainable for all.

As illustrated in the literature review, Maori and Pacific children continue to live in deprived areas and are most likely to be hospitalised with asthma and or a respiratory condition. As detailed in the Queensland Health (2011a) report, Maori Pacific Island Families living in Queensland do experience poverty and unhealthy living conditions and do require extra services to offset the impact of poverty including, for example, hospitalisation due to chronic conditions.

In contrast to the communitarian approach to health care desired by many Maori Pacific Island families', viewpoints by Child Health Service providers concerning child health service delivery to Maori Pacific Island Families are based on an individualistic, bio-medical, and transcultural approach. The capacity to work in partnership does not deny the clinical expertise of a Child Health Service Provider; it simply recognizes and acknowledges the expertise of a Maori Pacific Island service user (Kenney, 2011). This joint care is particularly

important in influencing policy with a view to increased engagement when working with marginalised groups, such as Maori Pacific Island communities who have experienced service delivery for many years in Queensland and are yet to readily engage with Child Health Service Providers.

Child health service providers are defining what is relevant in health service provision while not acknowledging an understanding of the underlying socio, political and historical factors that are crucial for providing relevant and culturally safe health services. The current health service delivery does not lend itself to changing their ways of providing services easily which posed a question into why governance of health systems enables a continuation in terms of service delivery that maintain health inequities.

### ***Was Cultural Safety addressed at Organizational and individual level?***

Considering the aims of this research, the outcome of cultural safety as judged by service users is still an actuality in which an achievement of cultural safety is confirmed by the service user (Seaton, 2010). In overview the underpinning assumption is to see whether Cultural Safety and Decolonisation as a theoretical tool do address change at structural and individual level. Ramsden, before her passing, envisioned a journey that would outline how Cultural Safety as a service delivery model could be used as a framework to “tease out” issues during health service delivery in real circumstances. From a social justice viewpoint, the research findings in this study suggest that at micro level, education of health professionals on self- reflexivity in relation to the deficit discourse in part with minimal awareness addressed some of the barriers that characterise service delivery to vulnerable groups. The implication was that government departments must evaluate and re-evaluate what is working and be open to changes in service delivery and health care. Health care changes need to be informed by Maori and Pacific people individually to avoid stereotypical assumptions, attitudes and actions of service providers because despite often being grouped together, populations from Maori and Pacific Island groups are heterogeneous with diverse cultures, language and religions (Southwick et al., 2012).

More importantly the findings suggested a need for child health service providers to understand the role of contextual, power and knowledge effects as evidenced in the research where it had unearthed its origins in the socio and contextual disadvantage borne by Maori Pacific Island Families that impacts on a lack of uptake of services. The same is

seen in a recent study in New Zealand which highlighted the need for health service providers to address determinants of health inequities amongst Indigenous population in New Zealand by applying cultural safety as a model of care at both individual (micro) and organizational (macro) level (Curtis et al., 2019). Furthermore, the researcher is beginning to appreciate that the processes and outcomes of colonisation are shown in multiple ways. As such, the generation of 'new knowledge' makes it possible in the production, development, improvement and transparency of health policies impacting Maori Pacific Island position here in Queensland.

As demonstrated in New Zealand, guidelines for cultural safety in nursing practice and education for registered and student nurses' mean being able to engage with compassionate and within a socio-political context. In Australia the same principles and guidelines for cultural safety in nursing education curriculums remained part of the teaching curriculums so there is heightened awareness and momentum.

Nonetheless, if simple and innovative methodologies like cultural safety and decolonisation methodologies are applied in service delivery, decision-makers and funding bodies may save themselves the luxury and risk of facing economic consequences in the longer term. Longer and genuine timeframes for evaluation (Lavery., 2017), a new emphasis on meaningful partnership rather than simply delivery of services and recognition to the value of respect and relationship building are a promising start to this process.

A final consideration is an understanding that Maori families like Pacific families have a high reliance on their own social group for care and support and that this may delay their use of health services (Queensland Health, 2011b). It is anticipated that minor health issues will be the responsibility of the family unit and health services only used if emergency care is required (Queensland Health, 2011b). In this situation the following pre-empted a model related to working in partnership with health providers and including the involvement of the family unit.

### **Where to from here (Punamai-aga): A new beginning**

As I arrived at the end of my journey, I am grateful of the many blessings, prayers, support, tears, sweat, frustrations and energy that have contributed to this journey. Of great divine while writing this piece of work is the birth of my first *mokopuna* (grandchild) in Townsville. My grandson was named after his father, followed by his two grandfathers. A

below poem is dedicated to this new familial root in the belief and hope for better days to come regarding health service delivery for an upcoming generation here in Queensland.

*Koe Tala Fakatu/Poem*

..... ***Dear Jonathan Jolly Salesian.....*** .....

***The day I first laid eyes on you and held your little hand to say hullo***

***Something in my heart clicked***

***Is it joy, is it an overwhelming emotion, is it stress?***

***No, it was HOPE, HOPE in the idea***

***That your birth is a sign that a new journey has begun***

***I looked at your eyes and saw my dad, in you smiling***

***For once in a lifetime, I looked up with joy and HOPE***

***HOPE that your little life will grow to bear productive fruits***

***In joy and happiness towards our family tree of life***

.....***Fakalofa atu ma haaku mokopuna fakamua! Kia monuina a koe!.....***

### ***Lalaga/Talaga Model for Service Delivery (To Construct a model based on Partnership)***

The birth of the above model is recommended in a way of a case study focusing on one specialized area in health. Such a collective specific designed pioneer model could be introduced that is interchangeable to service providers and community groups with simple localized changes, particularly in relation to communication, integration, and intervention. This situation may either be very threatening or extremely rewarding to the existing power structure. Distinction will depend on the partnership between the service provider and the service user and expectations of what both parties expect at beginning of each intervention. Researchers including health professionals working within a strengths-based framework emphasised strengths-based approach as a critical step towards seeing the strengths and competencies of children and families (Ledwith, 2001). A strengths-based approach provides

health service providers a reliable and valid way to assess change in individuals following participation in child health programs (Ledwith 2001). The strengths-based approach is founded on the following principles of Cultural Safety:

- Only the service user and family can determine if service delivery is culturally safe or not
- Culturally safe health services are more likely to be accessed by Maori and Pacific families
- One-size healthcare does not fit all; it results in systems that is designed for the dominant rather than minority groups
- Often misinterpreted as trans-culturalism is a reductionist approach to service delivery
- Rather than a lineal progression it is fluid circular and evolves on an ongoing journey to well-being
- Focus specifically on the power imbalances between service provider and service user

### ***Partnership Model for Health Service Delivery***

#### **Talanga/Lalaga Model**

A partnership model: *Talanga/Lalaga* underpins a collaborative model and is constructed to portray a holistic viewpoint regarding well-being. In extension it assists in construction of a meaningful relationship through dialogue (*talanoa*) between Maori Pacific Island Families and Child Health Service Providers.

The *Talanga/Lalaga* model is constructed for use within the Australian context and portrays a metaphorically representation of *Potu Lalaga (traditional Pasifika woven mat)*. *As we come to the end of a journey, we reiterate the proverb stated at the beginning of this journey and that is to signify a beginning of a new journey. As we sit to talanoa (talk), each thread is interwoven to construct a strong fine mat (platform) for both Maori Pacific Island people and Child Health Service Providers in their journey towards well-being.*

The four cornerstones of the mat (as shown in Fig 11) represent the values and principles underpinning a collaborative approach to service delivery mostly sought by Maori Pacific

Island Families. Under this model the whole team aims to work together in partnership and to build relationships to allow for construction of localised knowledge to thrive.

Currently, the researcher is making tentative arrangements with several Pacific Island community leaders in Townsville to provide a community presentation of outcome of findings. An anticipation is that the presentation will occur during the time of the Townsville annual Pasifika Festival exactly where recruitment of study participants took place 3-4 years ago. More recently the researcher attended and presented the findings of her study at a national conference themed “Indigenous Wellbeing 2021” at Cairns North Queensland. Further research that focussed entirely on the experiences of nursing staff in using the Lalaga/Partnership model is anticipated. An outstanding issue may include exploring why Maori for Maori or Pacific for Pacific health service delivery not effective despite evidencebased models of such care being delivered for so many years?

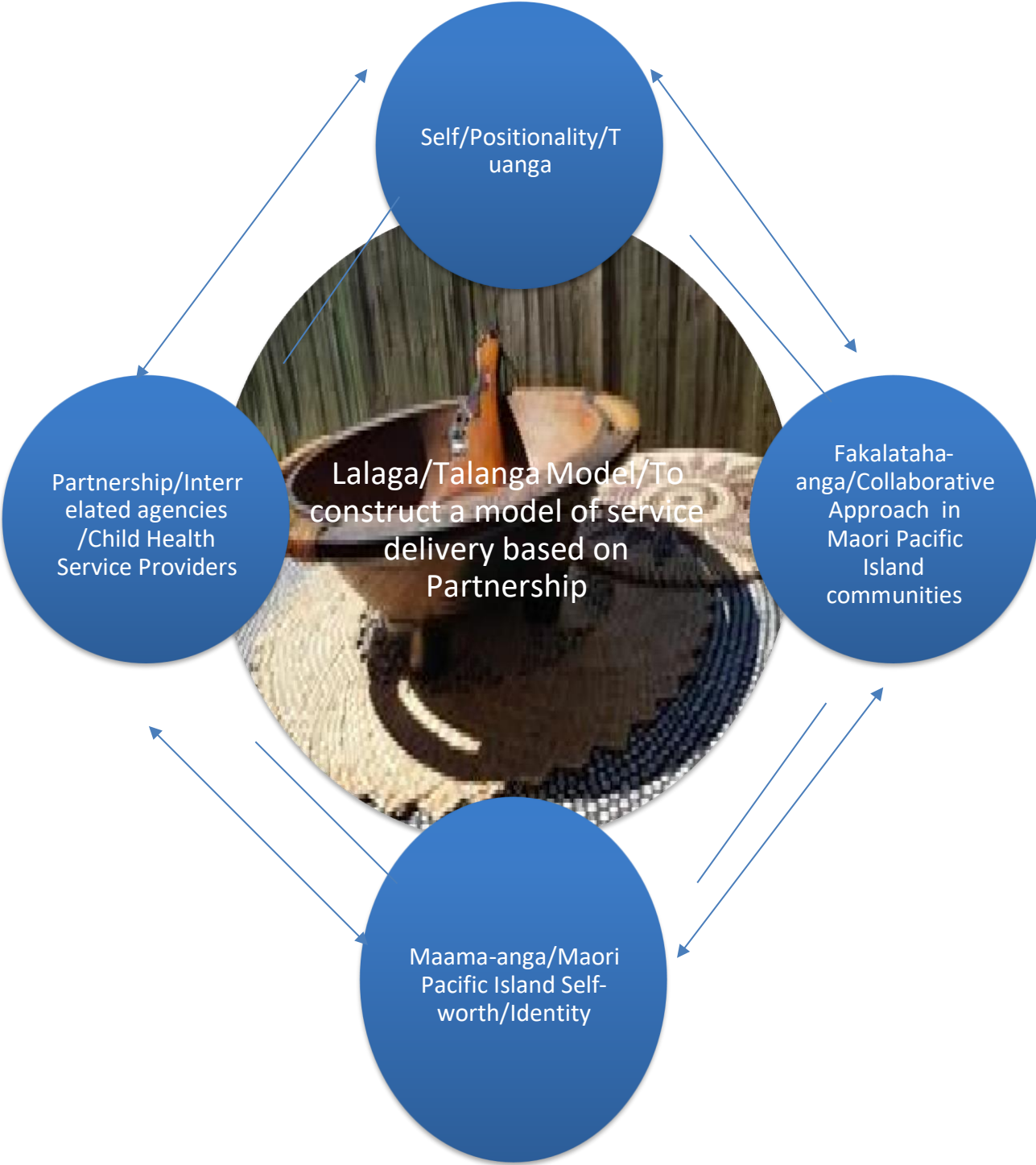
### ***Recommendations***

- Advocate for mandatory training in Cultural Safety for Queensland Health staff and Child Health Service Providers to enable staff to reflect on their actions, attitudes and receive education about the historical and required transparency of contemporary power relations inherent in client-provider communication.
- Recommend for annual appraisals concerning service delivery that embeds quality safe care delivery which enables self- reflection of service providers
- Advocate for data collection of key socio-economic indicators and experiences of Maori Pacific Island communities as they access health services to improve the level of understanding of socio- economic disadvantages impacting on health seeking behaviours, research, and health programs.
- Through talanoa with Maori Pacific Island Families in Queensland, I argued and recommended that a constructivist process of aligning needs identified with health interventions that are considered, reflected and safe from a consumer’s perspective is to be developed. Thus, an interpretation of what a collective voice can achieve is a construction from and within a sustainable model of Lalaga/Talaga.



- Recommend and mandate evidence of cultural safety as a requirement for accreditation in organisations including university nursing curriculums

Figure 11: Talanga/Lalaga Model of Care



## ***Limitations***

There were a number of limitations worth noting. One risk anticipated is that Talanoa is largely through interviewing and focus groups discussions, both for Maori Pacific Island Families and Child Health Service Providers, which is a subjective exercise; therefore, efforts and support was made for those with limited understanding of English comprehension using a translator to explain a question asked in lay terms. There was a great deal of time and effort taken up by the researcher in understanding, reporting, writing and interpreting information. Even though most participants could understand and verbally communicate in English language, efforts were made to ensure that all participants understood the ethical procedures, storage and use of their information including publication and feedback.

There was a high cost in terms of energy, time and resources involved with collaborative team-based decision making and sharing of information (Erick, Mooney-Somers, Akee & Maher, 2008). Keeping in contact with a disadvantaged group of people in the face of lack of accessibility to transport, telephone and culturally appropriate resources is a challenge and requires perseverance (Mooney-Somers et al., 2009). As mentioned above vulnerable groups can be hard to gain access thus making recruitment a difficult process for the researcher. As experienced by the researcher, most mobile and telephone contacts that were recorded down from her previous recruitment in Townsville in August 2014 had either been disconnected and/or a recruit is not responsive. At the time of preparation for recruitment, the researcher was dependent on family, friends, community reference members, annual festival gatherings and the directory of child health service providers in Townsville through distribution of recruitment flyers and word by mouth and email to recruit potential participants. The researcher felt the total number of thirty-seven participants recruited in Townsville and Brisbane was “constrained by costs in terms of time, money, support, stress and resources” (Cohen et al., 2000, p. 93).

By adopting a decolonised methodology through using a traditional method for data collection limited my ability to make broader generalisations to other Maori Pacific Island people in Australia who do not identify in using traditional methods or prefer not to speak a Maori or Pacific Island language. Considering the limited literature pertaining to research with and on Maori Pacific People here in Queensland, the researcher is grateful and acknowledged the great work of Pioneers that had led the way. The reactive notion of

Cultural Safety as a model can be overwhelming to the study participants, so it is necessary to maintain and for current researchers to remain calm and respectful when doing research with and on Maori Pasifika People.

Lack of rigour can occur both ways if there is a communication barrier due to language and comprehension issues. Misrepresentation of data in data collection and the interpretation of data may become questionable if the possibility of bias is not acknowledged and addressed (Baum et al., 2006; Roberts & Taylor, 2002). Kvale (1996) and Bessarab and Ng'andu (2010) talked briefly about the criticism of conversation or *yarning* as a research method. Bessarab and Ng'andu (2010) discussed the lack of clarity and uncertainty about how conversation might achieve the purpose of research. The researcher during her *Talanoa* with study participants is often reminded of the above when keeping the participant on track was sometimes difficult as the tendency to stray is always present. The researcher felt being disrespectful during an interview, when she had to interrupt an Elder that had strayed from the topic in discussion.

*Talanoa* in comparing to yarning has its own resolution and style in the telling of a story and can be messy and challenging (Martin 2008). As shared by (Martin, 2008, p.21) "telling stories is part of an Indigenous pedagogy and an established method in passing on information and to erase messiness is to deny my identity". Leading questions are questions worded in such ways as to influence participants' responses so asking leading questions risks relaying the researcher's own value judgements and beliefs thereby imposing a perspective on participants. While all the interviews went well, a participant became distressed during a discussion in a focus- group and this impacted on other participants. The need to react accordingly was dealt with instantly to avoid further disruptions or possible withdrawal from the study. Lack of clarity of information obtained from the participants led to study results lacking validity, therefore there was a need to re-interview participants later resulting in further costs in terms of time and efforts both for researcher and participants (Erick et al., 2008). Sometimes approaching and talking to someone unfamiliar to you is difficult, since lack of confidentiality is a concern for some. A study participant from a Brisbane-based CHSP withdrew from the study for reasons unknown due to not wanting to explain her reasons for withdrawing. This work is based on a small, purposive sample and their views may not be representative of the Maori Pasifika population in Townsville, Brisbane, and Australia.

## References

- Airini. (1997). Climbing up to check the sky: Culture and Curriculum. *Journal of Curriculum Theorising*, 3(3), 22-27.
- Akbar, H., Windsor, C., Gallegos, D., Manu-Sione, I.F. & Anderson, D. (2021). Deconstructing type 2 diabetes self-management of Australian Pacific Islander women. *Research, Education, and Action*. (Accepted/in press).
- Akbar, H., Gallegos, D., Anderson, D. & Windsor, C. (2021). Using a community participatory research and *Talanoa* approach. *Health and Social Care in the Community*. (Accepted/in press).
- Akbar, H., Radclyffe, C.J.T., Santos, D., Mopio-Jane, M., & Gallegos, D. (2022). "Food is our Love Language". Using *Talanoa* to Conceptualise Food Security for the Maori and Pasifika Diaspora in South- East Queensland, Australia. *Journals/Nutrients*, 14 (10).
- Alfred, T. (2008). Sovereignty. Sovereignty matter: Location of contestation and possibility of Indigenous Struggles for self-determination. In J. Barker (Ed.). (Contemporary Issues) (pp. 33-50). Lincoln, NE: Board of Regents of the University of Nebraska.
- Allen, D. (2006). Do organizational socialization tactics influence newcomer embeddedness and turnover? *Journal of Management*, 32 (2), 237-256.
- Altman, J. & Fogarty, W. (2010). "Indigenous Australians as 'no gaps' subjects: Education and development in remote Australia. In I, Snyder & J. Nieuwenhuysen (eds), *Closing the Gap in Education? Improving Outcomes in South World Societies*, Monash University, Melbourne, pp. 109-128.
- Anderson, J. (2001). Writing in subjugated knowledge: Towards a transformative agenda in nursing research and practice. *Nursing Inquiry*, 7(3), 145-147.
- Anderson, T., Latta, R., Leonard, J., & Stock, J. (2011). *Out of reach, out of sight: Unequal opportunities across the Tasman*. Retrieved 5 December 2012, from <http://content/uploads/2012/.../Tasman-Research-Report.pdf>
- Ape-Esera, L., Nosa, V., & Goodyear-Smith, F. (2009). The Pacific Primary Healthcare Workforce in New Zealand: What are the needs? *Journal of Primary Healthcare*, 1(2), 126133.

- Arches, J. (2001). Powerful partnerships. *Journal of Community Practice, 9*(2), 15-30. Retrieved from [http://doi:10.1300/J125v09n02\\_02](http://doi:10.1300/J125v09n02_02)
- Asghari-Fard, M., & Hossain, S. Z. (2017). Identity construction of second-generation Iranians in Australia: influences and perspectives. *Social Identities, 23* (2), 126-145
- Asthma Foundation (2014). *Asthma Foundation statistics support Child Poverty Monitor link between poverty and poor respiratory health*. Retrieved December 13, 2014, from Maori and Pacific Island Health Report 2013, New Zealand, Scoop Independent News: <http://www.scoop.co.nz/stories/GE1412/S00014/asthma-foundation-link-between-poverty>
- Australian Bureau of Statistics. (2006; 2007). *2006 Census of Population and Housing\_Cat.No.2068.0 Census Tables*. Australian Bureau of Statistics. Retrieved 4 June 2012 and 2016, from <http://censusdata.abs.gov.au>
- Australian Bureau of Statistics. (2012; 2016). *2011 and 2015 Census of Population and Housing\_Cat.No.3412.0 Census Tables*. Australian Bureau of Statistics. Retrieved 18 September 2013 and January 2020 from <http://censusdata.abs.gov.au>
- Australian Bureau of Statistics. (2015). Estimated Population Townsville 2014. Retrieved 05/05/2016 from <http://en.wikipedia.org/wiki/Townsville>
- Azzopardi, P., & Gray, N. (2010). Developing country health in a developed country: Personal perspectives. *Journal of Paediatrics and Child Health, 46*, 549-551.
- Baker, C. (1997). Cultural relativism and cultural diversity: implications for nursing practice. *Advances in Nursing Science, 20*(1), 3-11.
- Barclay, L., & Kent, D. (1998). Recent immigration and the misery of motherhood: A discussion of pertinent issues. *Midwifery, 14*, 4-9.
- Batley, J. (2017). What does the 2016 census reveal about Pacific Island communities in Australia? *Development Policy, ANU*. Retrieved February 2020 from <https://devpolicy.org/2016-census-reveal-about-pacific-islands-communities-in-australia20170928/>
- Baugh, E. J., & Guion, L. (2006). Using culturally sensitive methodologies when researching diverse cultures. *Journal of Multi-Disciplinary Evaluation, 3*(4), 1-12.

- Baum, F., McDougall, C., & Smith, D. (2006). Participatory action research. *Journal of Epidemiology and Community Health*, 60(10), 854-857. doi:10.1136/jech.2004.028662
- Bedford, R., Ho, E., & Hugo, G. (2003). Trans-Tasman Migration in Context: Recent flows of New Zealand Revisited. *People and Place*, 11(4), 53-62.
- Bedford, S. (2009). Care of Chronic Diseases in Queensland Culturally and Linguistically Diverse (CALD) communities; a qualitative study in primary care. Ethnic Communities Council of Queensland and Primary Healthcare research evaluation and development program of Bond University: Queensland.
- Berry, J.W. (2005). 'Acculturation: Living successfully in two cultures', *International Journal of Intercultural Relations*, 29: 697-712.
- Bese, K (2014). Engaging Young people: Journey of Pasifika Families from the Pacific to the West. *Work Together for Young People, Queensland State Youth Affairs Conference 2014*. Retrieved May 2016 from Youth Affairs Network QLD (YANQ) plenarry\_outcomes\_yanq\_conf\_2014\_1\_pdf
- Besnier, N. (2015). "Sports Mobility's Across Borders: Postcolonial Perspectives." *The International Journal of the History of Sport* 32 (7): 849–861. doi: 10.1080/09523367.2015.1023713
- Best, O., & Fredericks, B. (2014). *Yatdjuligin: Aboriginal and Torres Strait Islander nursing and midwifery care*. Port Melbourne, VIC: Cambridge University Press.
- Bessarab, D. (2012). *Yarning: A culturally safe method of indigenous education*. Presentation, Curtin University.
- Bessarab, D., & Ng'andu, B. (2001). Yarning about yarning as a legitimate method in indigenous research. *International Journal of Critical Indigenous Studies*, 3(1), 37-50.
- Bishop, R. (2003). Changing power relations in education: Kaupapa Maori messages for "mainstream" education in Aotearoa/New Zealand. *Comparative Education*, 39(2), 221-238.
- Bishop, R. (2005). *Freeing ourselves from neo-colonial domination in research: a Kaupapa Maori Approach to creating knowledge* (3rd ed., pp. 109-138). Thousand Oaks, CA: The Sage Handbook of Qualitative Research.

Boag-Munroe, G., & Evangelou, M. (2012). From hard to reach to how to reach: A Systematic review of the Literature on hard- to- reach families. *Research Papers in Education*, 27 (2), pp. 209-239

Brackertz, W. (2007). *Who is hard to reach and why? ISR working paper*. Retrieved 21 July 2013, from <http://sisr.net./publications/0701brackertz.pdf>

Brascoupe, S., & Waters, C. (2009). Exploring the applicability of the concept of cultural safety to Aboriginal health and community wellness. *Journal of Aboriginal Health*, 5(2), 6-41.

Braverman, P., & Gruskin, S. (2003). Defining equity in health. *Journal of Epidemiology & Community Health*, 57, 254-258.

Bronfenbrenner, U. (1992). *Ecological systems theory*. US: Jessica Kingsley Publishers.

Bronfenbrenner, Y. (1988). Foreword. In A.R. Pence (ed.), *Ecological research with children and families: From concepts to methodology* (pp. ix-xix). New York: Teachers College Press.

Browne, A., & Fiske, J. (2001). First Nations women's encounters with mainstream health care services. *West Journal Nursing Resource*, 23, 126-147.

Browne, A., & Smye, V. (2002). A post-colonial analysis of healthcare discourses addressing Aboriginal women. *Nurse Researcher*, 9(3), 28-41.

Browne, A., Varcoe, C., Smye, V., Reimer-Kirkham, S., Lynam, M., & Wong, S. (2009). Cultural safety and the challenges of translating critically oriented knowledge in practice. *Nursing Philosophy*, 10, 167-179.

Bruni, N. (1988). Critical Analysis of trans-culturalism Theory. *Australian Journal of Advanced Nursing*. 5, pp. 26-32.

Bryant, A., & Charmaz, K. (2007). *The Sage Handbook of Grounded Theory*, (eds.). Sage Publications, London.

Bryant, R., Foley, E., & Percival, E. (2008). The role of RCNA in promoting transcultural nursing as a discipline of study, research, practice and management in Australia. *Contemporary Nurse*, 28(1-2), 3-11.



Bulman, K., & McCourt, C. (2002). Somali refugee women's experiences of maternity care in West London: A case study. *Critical Public Health, 12*, 365-380.

Carey, M. (2018). The transformative process of Indigenous autoethnography: (re)connecting with Kaupapa Maori [Online case study]. In: *SAGE Research Methods Cases Part 2*. Sage Publications, London, United Kingdom. ISBN 9781526439994

Carr, W., & Kemmis, S. (1986). *Becoming critical: education, knowledge and action research*. London: Farmer Press.

Carroll, P., Casswell, S., Huakau, J., Howden-Chapman, P., & Perry, P. (2011). The widening gap: Perceptions of poverty and income inequalities and implications for health and social outcomes. *Social Policy Journal of New Zealand, 37*, 1-12.

Carson, B., Dunbar, T., Chenhall, R., & Bailie, R. (2007). *Social determinants of indigenous health*. Australia: Allen and Unwin.

Cash, T., F. & Pruzinsky, T. (2004). *Body image: A handbook of theory, research and clinical practice, (Eds.)*. New York, Guilford Press.

Cassel, K. D. (2010). Using a socio-ecological model as a research and framework to understand and mitigate obesogenic factors in Samoan populations. *Ethnicity and Health, 15*, 397-416.

Cass, A., Lowell, A., Christie, M., Snelling, P., Flack, M., & Marrnaganyin, B. (2002). Sharing the true stories: improving communication between Aboriginal patients and healthcare workers. *Medical Journal of Australia, 176*, 466-470.

Charmaz, K. (2003). *Inside interviewing: new lens, new concerns*. Thousand Oaks, California: Sage publication (pp. 311-330).

Charmaz, K. (2011). Grounded Theory Methods in Social Justice Research, in N. K. Denzin and Y. E. Lincoln (eds.), *Handbook of Qualitative Research, (4th ed.)*, Thousand Oaks, CA. SAGE.

Charmaz, K. (2014). *Constructing grounded theory (2<sup>nd</sup> ed.)*. London, England: SAGE.

Charmaz, K. (2016). The Power of Constructivist Grounded Theory for Critical Inquiry. *Qualitative Inquiry, 1-12*. Retrieved from <http://sagepub.com/journalsPermissions.nav>. DOI: 10.1177/1077800416657105

Charmaz, K. (2017). Special Invited Paper: Continuities, Contradictions, and Critical Inquiry in Grounded Theory. *International Journal of Qualitative Methods*, 16, 1-8.

Charmaz, K., Thornberg, R., & Keane, E. (2017). Evolving Grounded Theory and Social Justice Inquiry. In: *The SAGE handbook of qualitative research/* (ed) Norman, K. Denzin & Yvonna, S. Lincoln, Thousand oaks, CA: Sage Publications, 5, 411-443.

Cheer, T., Kearns, R., & Murphy, L. (2002). Housing policy, poverty and culture: Discounting decisions among Pacific peoples in Auckland, New Zealand. *Environment and Planning C: Government and Policy*, 20, 497-516.

Cioffi, J. (2006). Culturally diverse patient-nurse interactions on acute care wards. *Journal of Nursing Practice*, 12 (6) 319-325.

Clark, N., Hunt, S., Jules, G., & Good, T. (2010). Ethical dilemmas in community-based research: Working with vulnerable youth in rural communities. *Journal of Academic Ethics*, 10, 1-19.

Cockerham, W. (2007). A note on the fate of postmodernism and its failure to meet the basic requirements for success in medical sociology. *Social Theory and Health*, 5, 285-296.

Collet, B. (2008). Confronting the insider-outsider polemic in conducting research with diasporic communities: Towards a community-based approach. *Refuge: Canada's Journal on Refugees*, 25(1).

Cohen, L., Manion, L., & Morrison, K. (2000). *Research methods in education* (5<sup>th</sup> ed.). London: Routledge.

Cooney, C. (1994). A comparative analysis of transcultural nursing and cultural safety. *Nursing Praxis in New Zealand*, 9(1), 6-11.

Cooperrider, D.L., Whitney, D., & Stavros, J. M. (2008). *Appreciative inquiry handbook*. For leaders of change (2<sup>nd</sup> Ed.). Brunswick, Ohio: Crown Custom publishing Inc.

Corbin, J., & Strauss, A. (2008). *Basics of Qualitative Research: Techniques to developing Grounded Theory*. (3<sup>rd</sup> Ed.). Thousand Oaks, CA: Sage.

- Cox, L., & Taua, C. (2013). *Socio-cultural considerations and nursing practice*. In *Potter and Perry's Fundamentals of Nursing* (4th ed., pp. 320-345). Elsevier, Chatswood, NSW, Australia.
- Cox, L., & Taua, C. (2016). *Cultural Safety: Cultural Considerations*. In *Jarvis's Physical Examination and Health Assessment* (2<sup>nd</sup> ed., pp. 38-59). Elsevier, Chatswood, NSW, Australia.
- Cox, L., & Best, O. (2019). Cultural Safety history repeats: why are we taking the redefinition road? *Croakey, independent, in-depth social journalism for health*. Retrieved February 2020 from <https://croakey.org/cultural-safety-history-repeats-why-are-we-taking-the-redefinition-road/>
- Coxon, E., Anae, M., Mara, D., Wendt-Samu, T., & Finau, S. (2002). *Literature review on Pacific Island issues*. Wellington: Ministry of Education.
- Craig, R.D. (2011). *Historical Dictionary of Polynesia* (3<sup>rd</sup> ed.). Lanham, The Scarecrow Press, Inc.
- Cram, F. (2009). *Maintaining indigenous voices: Handbook of Social Research* (pp. 308-322). Thousand Oaks, CA: Sage publications.
- Crampton, P. (1998). Measuring deprivation and socio-economic status: Why and how? *New Zealand Public Health Report*, 5(11/12), 81-84.
- Creswell, J., & Plano-Clark, V.L. (2011). *Designing and Conducting Mixed Methods Research* (2<sup>nd</sup> ed.). Thousand Oaks, CA: Sage publications, Inc.
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. London: Sage publications.
- Crowe, M. (2002). The nurse patient relationship: A consideration of its' discursive context. *Journal of Advanced Nursing*, (31), 962-967.
- Cruickshank, A., Porteous, H.E., & Palmer, M. A. (2017). Investigating antenatal nutritional education in South- East Queensland in Queensland, including Maori and Pasifika Women. *Women & Birth*. Retrieved January 2019 from <https://doi.org/10.1016/j.wombi>

- Cruickshank, A., Lilley, T., Radcliffe, B., Nosa, V., & Fenwick, J. (2018). Maori and Pacific perceptions of their local maternity care in Logan, Australia. *Connectedness*, 1-3. Retrieved September 2018 from <https://doi.org/10.1016/2018.08.164>
- Culley, L. (2006). Transcending trans-culturalism? Race, ethnicity and health-care. *Nursing Inquiry*, 13, 144-153.
- Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S & Reid, P. (2019). *Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition*. Available from: <https://www.researchgate.net/publication/337263187> [accessed Mar 15 2020].
- Cuthill, M., & Scull, S. (2011). Going to university: Pacific Island migrant perspectives. *Australian Universities Review*, 53(1), 5-13.
- David, M. (2002). Problems of participation: The limits of action research. *International Journal of Social Research Methodology*, 5(1), 11-17. doi:10.1080/13645570110098037
- Davies, M., & Bath, P. (2001). The maternity information concerns of Somali women in the United Kingdom. *Journal of Advanced Nursing*, 36, 237-245.
- Davies, M., & Papadopoulos, I. (2006). *Notions of motherhood and the maternity needs of Arab Muslim Women* (pp. 145-163). London.
- Dawes, G., & Gopalkrishnan, N. (2014). *Far North Queensland Culturally and Linguistically Diverse (CALD) Communities Homelessness Project*. Report. Cairns Institute, James Cook University, Cairns, QLD, Australia.
- Denzin, N. (1994). *The art and politics of interpretation* (pp. 500-515). London: Sage publications.
- Denzin, N., & Lincoln, Y. S. (2003). *Strategies in Qualitative inquiry*. (2<sup>nd</sup> ed.). Thousand Oak, CA: Sage.
- DeSouza, R. (2008). Wellness for All: The possibilities of Cultural Safety and Cultural Competence in New Zealand. *Journal of Research in Nursing*, 13 (2) 125-135.
- DeSouza, R. (2012). Regulating migrant maternity: Nursing and midwifery's emancipatory aims and assimilatory practices. *Nursing Inquiry*. doi:10.1111/nin.12020

DeSouza, R. (2011). *Migrant Maternity. A PhD Thesis submitted to Auckland University Technology*. Auckland, New Zealand.

Dudgeon, P. & Pickett, H. (2000). Psychology and reconciliation: Australian perspectives. *Australian Psychologist*, 35, 82-87.

Dudgeon, P. & Walker, R. (2015). Decolonising Australian Psychology: Discourses, Strategies, and Practice. *Journal of Social and Political Psychology*, Vol. 3(1), 276-297, doi:10.5964/jspp.v3i1.126

Durey, A. (2010). Reducing racism in Aboriginal health care in Australia: where does cultural education fit? *Australian and New Zealand Journal of Public Health*. Retrieved March 15<sup>th</sup> 2020 from <https://doi.org/10.1111/j.1753-6405.2010.00560>

Eckermann, A., & Dowd, T. (1992). Strengthening the role of primary healthcare in health promotion by bridging cultures in Aboriginal health. *The Australian Journal of Advanced Nursing*, 9(2).

Eckermann, A., Dowd, T., Chong, E., Nixon, L., Gray, R., & Johnson, S. (2006). *Binan Goonj: Bridging Cultures in Aboriginal Health* (2nd Ed.). Churchill, Livingstone Elsevier, Chatswood, Australia.

Eckermann, A., Dowd, T., Chong, E., Nixon, L., Gray, R., & Johnson, S. (2010). *Binan Goonj: Bridging Cultures in Aboriginal Health* (3rd Ed.). Churchill Livingstone Elsevier, Chatswood, Australia.

Eckermann, A., Dowd, T., Martin, M., Dixon, I., Gray, R., & Chong, E. (2005). *Binan Goonj: Bridging Cultures in Aboriginal Health*. Australia: University of New England.

Edwards, T., Smith, J., & Elston, J. (2007). *Cultural Perspectives*. In Smith, J (e.d) *Australia Rural Remote Health: A Social Perspective* (2nd Ed.). Melbourne: Tertiary Press.

Elder, H., Milne, M., Witehira, H., Mendes, P., Heslin, A., Cribb-Su'a, & Kalra, V. (2009). Whakaorangamoemoea o ngatupuna - Living the dreams of the ancestors. Future planning in a Kaupapa Maori CAMHS team. *Australasian Psychiatry*, 17(S1), S104-S107.

Erick, W., Mooney-Somers, J., Akee, A., & Maher, L. (2008). Resilience to blood borne and sexually transmitted infections: The development of a participatory action research project

with young Aboriginal and Islanders people in Townsville. *Aboriginal and Islander Health Worker Journal*, 32(6).

Fa'avae, D., Jones, A., & Manu'atu, L. (2016). Talanoa 'I' A E Talanoa- Talking About Talanoa: Some dilemmas of a novice researcher. *AlterNative: An International Journal of Indigenous Peoples*, Vol 12, Issue 2.

Fang, M. L., Sixsmith, J., Lawthom, R., Mountian, I., & Shahrin, A. (2015). Experiencing 'pathologized presence and normalized absence'; understanding health related experiences and access to health care among Iraqi and Somali asylum seekers, refugees and persons without legal status. *BMC public health*, 15(1), 1.

Farrelly, T., & Nabobo-Baba, U. (2012). *Talanoa as Empathic Research: Proceedings from the International Development Conference 2012*. Retrieved August 23, 2014, from <http://www.arts.auckland.ac.nz/webdav/site/arts/shared/Department/centre-for-pacific-studies/documents-publications>

Finau, S. (1994). The value of Pacific Children: Perspective for a way forward. *Pacific Health Dialog*, 1(2), 52-63.

Finau, S. (1996). Health, environment and development: towards a Pacific paradigm. *Pacific Health Dialog*, 3(2), 266-278.

Foucault, M. (1982). The Subject and Power. *Critical Inquiry*, 8(4), 777-795.

Foucault, M. (1998). *The history of Sexuality: The Will to Knowledge*, London, Penguin.

Foliaki, S., Kokaua, J., Schaaf, D., & Tukuitonga, C. (2006). Twelve-month and lifetime prevalence's of mental disorders and treatment contact among Pacific Island people in Te Rau Hinengaro: The New Zealand Mental Health Survey. *Australian and New Zealand Journal of Psychiatry*, 40(10), 924-934.

Fook, J. (2002). *Social work: Critical theory and practice*. London: Sage Publications Ltd.

Franklin, R. (2007). *HPV Vaccination Health Policy Monitor*. Retrieved 20 June 2012, from <http://hpm.org/survey/nz/a/o/z>

Fredericks, B. (2007). Australian indigenous visions and voices enacted through research. *World Indigenous Nations Higher Education Consortium Journal*, 42-49.

Fredericks, B., Adams, K., Finlay, S., Fletcher, G., Andy, S., & Briggs, L. et al. (2011). Engaging the practice of yarning in action research. *ALAR Journal*, 17(2), 7-12.

Galobardes, B., Shaw, M., Lawlor, D., Lynch, J., & Davey-Smith, G. (2006). Indicators of socioeconomic position (part one). *Journal of Epidemiology and Community Health*, 60, 7-12.

Ganga, D., & Scott, S. (2006). Cultural "insiders" and the issue of positionality in qualitative migration research: Moving "across" and moving "along" researcher-participant divides. *Forum: Qualitative Social Research*, 7(3). Retrieved from <http://nbnresolving.de/urn:nbn:de:0114-fqs060379>

Gartrell, A. (2015). *Malcolm Turnbull to extend student loan access to Kiwis*. *National Political Correspondent*. Retrieved January 2016 from <http://www.smh.com.au/federalpolitics/political-news/malcolm-to-extend-student-loan-access-to-kiwis-20151017gkbke.html>

Gaventa, J. (1993). *The powerful, the powerless and the experts: Knowledge struggles in an information age. Voices of change: Participatory research in the United States and Canada* (pp. 21-40). London: Bergin and Garvey.

Gaventa, J. (2006). Finding the spaces for changes: A power analysis. *IDS Bulletin*, 37(6), 23-33.

Gaventa, J., & Cornwall, A. (2001). *Power and Knowledge. Handbook of Action Research: Participative Inquiry and Practice* (pp. 70-80). London: Sage publications.

Geia, L.K., Hayes, B. and Usher, K. (2013). Yarning/Aboriginal storytelling: Towards an understanding of an Indigenous perspective and its implications for research practice. *Contemporary nurse*, 46(1), pp.13-17.

George, J. R., & Rodriguez, L. (2009). Hybrid Youth Identity in the Maori/Pacific Island Diaspora in Australia: A Study of Young Polynesian Men in Sydney. *New Zealand Sociology*, 24.

Gibbs, K. (2005). Teaching student nurses to be culturally safe: can it be done? *Journal Transcultural Nursing*, 16, 356-360.

- Gluckman, P. (2011). *Improving the transition: Reducing social and psychological morbidity during adolescence*. *Australian Policy Online*. Retrieved 10 August 2012, from <http://apo.org.au/node/30290>
- GMSBML News (2014). *Pasifika and Maori Mental Health Forum: Connecting health to meet needs*. Retrieved December 12, 2014, from <http://www.gmsbml.org.au/issue 22>
- Grove, N., Brough, M., Canudo, C., & Dobson, A. (2003). Aboriginal and Torres Strait Islander health research and the conduct of longitudinal studies: issues for debate. *Australia and New Zealand Journal of Public Health*, 27(6), 637-641.
- Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. *BMC psychiatry*, 10(1), 113.
- Halapua, S. (2007). *Talanoa: Talking from the heart*. *SJI Quarterly*, 47, 9-10.
- Hamer, P. (2009). One in Six: The rapid growth of the Maori population in Australia. *New Zealand Population Review*, Vol 33, 1, 153-176.
- Hamer, H. P., Finlayson, M., & Warren, H. (2014). Insiders or outsiders? Mental health service users' journeys towards full citizenship. *International journal of mental health nursing*, 23(3), 203-211.
- Havea, Jione. (2013). "Disapora Contexted: Talanoa, Reading, and Theologizing as Migrants", *Black Theology. An International Journal*, 2, pp. 185-200.
- Heather, B. (2012). *Australian Streets are Tough for a Growing Kiwi Underclass*, Dominion Post.
- Henderson, S., Kendall, E., & See, L. (2010). The effectiveness of culturally appropriate interventions to manage or prevent chronic disease in culturally and linguistically diverse communities: a systematic literature review. *Health and Social Care in the Community*, 19(3), 225-249.
- Henderson, S., & Kendall, E. (2011). Culturally and linguistically diverse peoples' knowledge of accessibility and utilisation of health services: exploring the need for improvement in health service delivery. *Australian Journal of Primary Health*, 17(2) 195-201. Retrieved January 08, 2015, from CSIRO Publishing database.



- Horton, P. (2014). Pacific Islanders in professional rugby football: Bodies, minds and cultural continuities, *Asia Pacific Journal of Sport and Social Science*, 3, 222-235.  
10.1080/21640599.2014.970428
- Henry, B. R., Houston, S., & Mooney, G. H. (2004). Institutional Racism in Australian healthcare: a plea for decency. *The Medical Journal of Australia*, 180 (10), 517-520.
- Howden-Chapman, P., Blaikely, T., Blaiklock, A., & Kiro, C. (2000). Closing the health gap. *New Zealand Medical Journal*, 113(1114), 301-302.
- Hughson, J.A., Marshall, F., Daly, J.O., Woodward-Kron, R., Hajek, J. & Story, D. (2018). Health professionals' views on health literacy issues for culturally and linguistically diverse women in maternity care: barriers, enablers, and the need for an integrated approach. *Australian Health Review*, 42 (1), 10-20.
- Hunt, S. (2013). Ontologies of Indigeneity: the politics of embodying a Concept. *Cultural Geographies*, 1-6
- Jennings, W., Spurling, G., & Askew, D. (2014). Yarning about health checks: barriers and enablers in an urban Aboriginal medical service; *Aust J Prim Health*, 20 (2), pp. 151-157.
- Johnstone, M., & Kanitsaki, O. (2009). The spectrum of the new racism and discrimination in hospital contexts: a reappraisal. *Collegian*, 16, (2), 63-69.
- Johnstone, M-J., & Kanitsaki, O. (2008). Cultural racism, language prejudice and discrimination in hospital contexts: An Australian study. *Diversity in Health and Social Care*, 5(1), 19-30.
- Jones, E., Lattof, S.R., & Coast, E. (2017). Interventions to provide culturally appropriate maternity care services: factors affecting implementation. *BMC Pregnancy Childbirth*, 17(1) 267.
- Kalavite, T. (2010). *Fonoga a' Falahalafononga; Tongans' student journey to academic achievement in New Zealand tertiary institution*. PhD Thesis, The University of Waikato, Hamilton.  
Retrieved May 12, 2016 from <http://hdl.net/10289/4159>
- Kanitsaki, O., & Johnstone, M. (2004). *Cultural safety in nursing - are patients at risk*.  
Retrieved 22 January 2014, from <http://www.rmit.edu.au>

- Kanitsaki, O., & Johnstone, M. (2007). Healthcare Provider and consumer understanding of cultural safety in healthcare: An Australian study. *Journal of Cultural Diversity*, 14(2), 96-105.
- Katz, I., La Placa, V., & Hunter, S. (2007). *Barriers to inclusion and successful engagement of parents in mainstream services*. Water End, York: Joseph Romtree Foundation.
- Kearney, J. F., Fletcher, M., Dobrenov-Major, M. (2011). Nonaligned worlds of home and school: A case study of second-generation Samoan children. *Journal of Family Studies*, 17, 146-156.
- Keast, R., Mandell, M. P., Brown, K., & Woolcock, G. (2004). Network structures: Working differently and changing expectations. *Public administration review*, 64(3), 363-371.
- Kemmis, S., & McTaggart, R. (2000). *Participatory action research: Handbook of Qualitative Research* (pp. 567-605). Thousand Oaks, CA: Sage Publications.
- Kemmis, S., & McTaggart, R. (2005). *Participatory action research: Communicative action and the public sphere* (3rd Ed.). Beverley Hills, CA.
- Kenney, C. (2011). Midwives, women and their families: A Maori gaze towards partnerships for maternity care in Aotearoa New Zealand. *Alter Native: An International Journal of Indigenous*, 7(2), 123-137.
- Kildea, S. (2006). Risky business: contested knowledge over safe birthing services for Aboriginal women. *Health Sociology Review*, 15(4), 387-396.
- Kildea, S., Kruske, S., & Sherwood, J. (2010). *Midwives working with Aboriginal and Torres Strait Islander Women. Midwifery Preparation for practice* (2nd Ed.). Sydney: Elsevier.
- Kildea, S., Stapleton, H., Murphy, R., Low, N.B., & Gibbons, K. (2012). The Murri Clinic: a comparative retrospective study of an antenatal clinic developed for Aboriginal and Torres Strait Islander women. *BMC Pregnancy Childbirth* 12, 159
- Kindon, S., Pain, R., & Kesby, M. (2007). *Participatory action research approaches and methods: Connecting people*. London: Participation and Place Routledge.

- Kingi, R., Erick, W., Nosa, V., Paynter, J., & de Silva, D. (2021). "Pasifika preferences for mental health support in Australia: a focus group study. *Pacific Health Dialog* 21 (7), 373379
- Kirk, R., Barnett, B., & Clayden, C. (2002). *Evaluation of the Pegasus Health Global Budget Contract*. Christchurch, New Zealand: New Zealand Health Technology Assessment.
- Kovach, M. (2010). Conversational method in indigenous research. First Peoples child and family review. *An Interdisciplinary Journal Honoring Voices, Perspectives, and Knowledge's of First Peoples through Research, Critical Analyses, Stories, Standpoints and Medical Reviews*, 5(1), 40-48.
- Krauss, U., Angus, H., Bor, W., & Crichton, N. (2014). *Cultural Pride and Transition. A pilot survey on the mental health needs of Samoan and Tongan adolescents*. Queensland, Mater Kids in Mind.
- Kruske, S., Kildea, S., & Barclay, L. (2006). Cultural safety and maternity care for Aboriginal and Torres Strait Islander Australians. *Women and Birth*, 19(3), 73-77.
- Larkins, S., Page, P., Panaretto, K., Scott, R., Mitchell, M., & Alberts, V. (2007). *The "U Mob Yarn Up" Project: Young Indigenous Women in Townsville Speak About Relationships, Pregnancy, and Parenthood*. Townsville Aboriginal and Islander Health Services Ltd.
- Latu, M. (2009). *Talanoa: A contribution to teaching and learning of Tongan primary school children in New Zealand*. Thesis from Auckland University Technology. Retrieved January 10, 2015 from <http://www.auckland.aut.edu/pacific-studies>
- Laverty, M., McDermott, D., & Calma, T. (2017). Embedding Cultural Safety in Australia's main health standards. *The Medical Journal of Australia*, Vol 207 (1), 15-16.
- Ledwith, M. (2001). Community Development: A critical approach. *Community Development Journal*. 36 (3), 17-18. Retrieved 2015 from [http://www.researchgate.net/journal/0010-3802-Community\\_Development\\_Journal](http://www.researchgate.net/journal/0010-3802-Community_Development_Journal)
- Leggat, S. (2004). Health children, healthy country: the use of governing instruments in shifting the policy paradigm. *Australia and New Zealand Health Policy*, 1(1), 4-7.

- Leone, V., Mason, A., & Metcalfe, E. (2012). Improving child and family health services for families in need. *Community Pediatric Review*, 20(1), 1-6. Retrieved from <http://www.rch.org.au/cch/cpreview>
- Leininger, M. (2002). Culture Care Theory: A Major Contribution to Advance Transcultural Nursing Knowledge and Practices. *Journal of Transcultural Nursing*, Vol. 13 No. 3, pp. 189-192.
- Lester, S. (1999). *An introduction to phenomenological research*. Retrieved 05/05/2016 from <https://www.rgs.org>rdonlyres>Seaweed>.
- Liamputtong, P. (2009). *Qualitative research methods*. Melbourne: Oxford University Press.
- Love, J. & Klapdor, M. (2020). New Zealanders in Australia: a quick guide', *Parliament of Australia*. Accessed 18<sup>th</sup> February 2020 from [http://www.aph.gov.au/About\\_Parliament/Parliamentary\\_Departments/Parliamentary\\_Library/pubs/rp/rp1617/Quick\\_Guides/NZAust](http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1617/Quick_Guides/NZAust).
- Lovell, S., Kearns, R., & Friesian, W. (2007). Socio-cultural barriers to cervical screening in South Auckland, New Zealand. *Social Science & Medicine*, 65(1).
- Luedema, J., Cooperrider, D., & Barrett, F. (2000). *Appreciative inquiry: The power of unconditional positive question*. *Handbook of Action Research* (pp. 189-199). Thousand Oaks, California: Sage Publications.
- Lupton, D. (1998). *Medicine as culture*. (ed). London: Sage Publications.
- Macpherson, C., & Macpherson, L. (1990). *Samoan Medical Belief and Practice*. Auckland: Auckland University Press.
- Maloney-Moni, J., & North, N. (2003). Innovations in service delivery to improve Maori health outcomes: a mobile disease state management nursing service. *Pacific Health Dialog*, 10(2), 171-177.
- Manu'atu, L. (2000). Kato'aga Faiva: A pedagogical site for Tongan students. *Educational Philosophy and Theory*, 32 (1)74-79.
- Martin, K. (2003). Ways of Knowing and Doing: A theoretical framework & methods for Indigenous and Indigenist re-search. *Journal of Australian Studies*, 76, pp. 203-214.

Martin, K. (2008). *Please knock before you enter: Aboriginal regulation of outsiders and the implications for researchers*. Teneriffe, QLD: Post Pressed.

Mauri Ora Kite Ao. (2009). *Te Toi Hauora Nui: Achieving excellence through innovative Maori health service delivery- A Report prepared for Ministry of Health*. Wellington: Ministry of Health.

Marques, J. F., & McCall, C. (2005). The Application of Inter-rater Reliability as a Solidification Instrument in a Phenomenology Study. *The Qualitative Report*, 10(3), 439-462.

McClelland, A. (2011). Culturally Safe Nursing Research: Exploring the use of an indigenous research methodology from an indigenous researcher's perspective. *Journal of Transcultural Nursing*, 22(4), 362-367.

McGonaghy, C. (2000). *Rethinking Indigenous education: Culturalism, Colonialism and the politics of knowing*. Flaxton, Australia: Post Pressed.

McDonald, B., & Rodriguez, L. (2014). "It's our meal ticket: Pacific bodies labour and mobility in Australia. *Asia Pacific Journal of Sport and Social Science*, 3 (3), 236-249.

McFall-McCaffery, J. (2010). *Getting started with Pacific research: Finding resources and information on Pacific research models and methodologies*. Presentation, MAI Review, Library Workshop 8.

McGibbon, E., Mulaudzi, F., Didham, P., Barton, S., & Sochan, A. (2014). Toward decolonizing nursing: the colonization of nursing and strategies for increasing the counter-narrative. *Nursing Inquiry*, 21 (3), 179-191.

Mila-Schaaf, K., & Hudson, M. (2009). The interface between cultural understandings: Negotiating new spaces for Pacific mental health. *Pacific Health Dialogue*, 15(1), 113-119. Retrieved from <http://pacifichealthdialog.org.fj/>

Milroy, H. (2020). *COVID-19: Ethics and Equity in a pandemic: Indigenous Perspectives*. University News, University of Western Australia.

Millichamp, A., & Gallegos, D. (2011). *Meeting the food needs of Queensland's culturally and linguistically diverse (CALD) aged: A review of the literature*. Brisbane, Queensland University of Technology.

Mills, J., Bonner, A. and Francis, K. (2006). The development of constructivist grounded theory. *International journal of qualitative methods*, 5(1), pp.25-35.

Ministry of Health. (2010). *Lalaga: Pacific Providers Making a Difference*. Wellington. Ministry of Health.

Ministry of Health. (2018). *'Ala Mo'ui Progress Report: Pacific Child health November 2018*. Wellington: Ministry of Health.

Mihrshahi, S., Vaughan, L., Fa'avale, N., De Silva Weliang, S., Manu-Sione, I., and Schubert, L. (2017). Evaluation of the Good Start Program: a healthy eating and physical activity intervention for Maori and Pacific Islander children living in Queensland, Australia. *BMC Public Health* 17:77

Mooney-Somers, J., Erick, W., Scott, R., Akee, A., Kaldor, J., & Maher, L. (2009). Enhancing Aboriginal and Torres Strait Islander young people's resilience to blood-borne and sexually transmitted infections: findings from a community-based participatory research project. *Health Promotion Journal of Australia*, 20(3), 195-201.

Nabobo-Baba, U. (2008). Decolonising framings in Pacific research: Indigenous Fijian Vanua research framework as an organic response. *AlterNative: An International Journal of Indigenous Peoples*, 4(2), pp.140-154.

Nairn, R. (1997). Cultural justice and ethics in psychological practice. In Love, H. & Whittaker, W. (Eds.). *Practice issues for clinical and applied psychologists in New Zealand*. The New Zealand Psychological Society, pp. 127-135.

Nakata, M., Nakata, V., & Chin, M. (2008). Approaches to the academic support of Australian Indigenous students for tertiary students. *Australian Journal of Indigenous Education*, 37, 137-145.

Newman, L. (2008). Attachment theory and personality disorder: Approaches to high- risk families. *Communities Children and Families Australia*, 3, 4-18.

Newman, L. (2012). *Basics of Social Research: Qualitative and Quantitative Approaches*. 3<sup>rd</sup> Ed., Upper Saddle River, NJ, Pearson Publishing.

Noordin, F., & Jusoff, K. (2010). 'Individualism-collectivism and job satisfaction between Malaysia and Australia', *International Journal of Educational Management*, 24 (2): 159-174.

Nursing Council of New Zealand. (2002). Guidelines for cultural safety, the treaty of Waitangi, and Maori health in nursing and midwifery education and practice. Wellington: Nursing Council of New Zealand.

Nursing Council of New Zealand. (2009). *Guidelines for cultural safety, the treaty of Waitangi, and Maori health in nursing education and practice*. Retrieved 19 August 2012, from <http://www.nursingcouncil.org.nz/cultural-safety09.pdf>

O'Brien, R. (2001). *An Overview of the Methodological Approach of Action Research*. In Roberto Richardson (Ed), *Theory and Practice Research*. Retrieved 27 June 2012, from <http://www.web.ca?robrien/papers/arfinal.html>

Ortley, J. (2005). Decolonising Methodologies: Research and Indigenous Peoples. *American Indian Quarterly*, 29(1/2), 285-288.

Orton, B., & Edwards, R. (2020). *Pacific Islander communities and Employment in Australia*. Development Policy, ANU. Retrieved October 14, 2021, from <http://devpolicy.org>

Otsuka, S. (2006). *Talanoa: Culturally appropriate research design in Fiji*. Proceedings from the Australian Association for Research in Education (AARE) 2005 International Education Research Conference. Retrieved January 10, 2015, from <http://www.arts.auckland.ac.nz/webdav/site.Department/Centre-for-pacificstudies/document-publications>

Otunuku, M. (2011). How can *Talanoa* be used effectively as an Indigenous research methodology with Tongan people. Pacific-Asian Education. *The Journal of the Pacific Circle of Consortium for Education*, 23(2), 43-52.

Pacific Islands Monitor (2022). *International Monetary Fund*. Retrieved from <https://www.imf.org/-/media/Files/Countries/ResRep/pis-region/small-states-monitor>

Parker, V. & McMillian, M. (2007). Challenges facing internalisation of nursing practice, nurse education and nursing workforce in Australia. *Contemporary Nurse*, 24 (2), 128-136.

Paterson, J., Percival, T., Schulter, P., Sundborn, G., Abbott, M., Carter, S., & The PIF Study Group. (2008). Cohort profile: The Pacific Islands Families (PIF) study. *International Journal of Epidemiology*, 37, 273-279. doi:10.1093/ije/dym171

Petrus, T. (2017). Globalism vs culture(s): a critique of transculturalism and the one world, one culture globalist narrative in Africa. *John Wiley & Sons Ltd*.

- Pirani, C. (2007). Billions wasted in Hospital Systems in Australia. *The Australian*.
- Prescott, S. (2008). Using Talanoa in Pacific business research in New Zealand: Experiences with Tongan entrepreneurs. *Alternative*, 4(1), 128-148.
- Pulotu-Endemann, K., Suaali'i-Sauni, S., Lui, D., McNicholas, D., Milne, M., & Gibbs, T. (2007). *Seitapu Pacific Mental Health and Addiction Clinical and Cultural Competencies Framework* (1st Ed.). Auckland: TePou. Retrieved from <http://www.networknorth.org.nz/file/Resources/cultural-practice-lo-res.pdf>
- Pulver, L. J., Haswell, M., Ring, I., Waldon, J., Clark, W., Whetung, N., Kinnon, D., Graham, C., Chino, M., Lavelly, J., Sadana, R. (2010). *Indigenous Health- Australia, Canada, Aotearoa New Zealand and the United States: Laying claim to a future that embraces health for us all*.
- World Health Report (2010), Background Paper, No 33.
- Puzan, E. (2003). The unbearable whiteness of being (in nursing). *Nursing Inquiry*, 10, 193200.
- Queensland Health. (2006). *Promoting stronger families: "Fausia O AigalaMautu" family violence prevention in the Samoan community. Queensland: Transcultural Mental* (1st Ed.). Brisbane: Queensland Government.
- Queensland Health. (2006). *Maori and Pasifika Population Size and Distribution*. Retrieved from [https://www.health.qld.gov.au/multicultural/health\\_workers/pac-island-pop](https://www.health.qld.gov.au/multicultural/health_workers/pac-island-pop)
- Queensland Health. (2011a). *Queensland Health response to Pacific Islander and Maori health needs assessment* (1st Ed.). Brisbane: Division of the Chief Health Officer.
- Queensland Health. (2011b). *The health of Queensland's Maori population 2009* (1st ed.) Retrieved from [http://www.health.qld.gov.au/multicultural/health\\_workers/hlth-statuspac-isl.pdf](http://www.health.qld.gov.au/multicultural/health_workers/hlth-statuspac-isl.pdf)
- Queensland Metro South Health. (2016). *Summary of Findings: Maori and Pasifika Women & Newborn Health Forum*. Retrieved from [www.preventativehealthmatters.org.au](http://www.preventativehealthmatters.org.au)
- Razi, S. (2020). The Pasifika Project. *A mixed method clinic supporting the Pasifika Community in the Western Suburbs of Melbourne*. Retrieved April 2023 from <https://www.westjustice.org.au/cms/uploads/docs/pasifika-report-final.pdf>



Radclyffe, C.J.T; Aia-Faaleava, A; Avia, P., Utiku-Roberts, D., Choon, G.S., Tafa, S., & Durham, J (2023). 'FOB', 'plastic' and polycultural capital: experiences of social labelling of Pasifika young peoples in South- east Queensland, Australia. *Journal of Youth Studies*.  
<https://doi.org/10.1080/13676261.2023.2199147>

Ramsden, I. (1992). Teaching cultural safety. *New Zealand Nursing Journal*, 84(9), 21-23.  
Retrieved from [http://www.researchgate.net/journal/0028-8535\\_The\\_New\\_Zealand\\_nursing\\_journal\\_Kai\\_tia](http://www.researchgate.net/journal/0028-8535_The_New_Zealand_nursing_journal_Kai_tia)

Ramsden, I. (2002). *Kawa Whakaruruhau: Cultural safety. Unpublished thesis* (1st ed., p. 1). Victoria: University of Wellington. Retrieved from  
<http://www.trc.org.nz/files/Cultural%20Safety.pdf>

Ramsden, I. (2003). *Cultural safety in nursing education in Aotearoa and Te Waipounamu. Doctoral thesis*. Retrieved 21 October 2013, from <http://culturalsafety.massey.ac.nz>

Ravulo, J. (2015). Pacific Communities in Australia. Penrith, NSW. *University of of Western Sydney*. Retrieved September 15<sup>th</sup> 2017 from  
[https://www.uws.edu.au/\\_data/assets/pdf\\_file/0006/923361/SSP5680\\_Pacific\\_Communities\\_in\\_Australia.pdf](https://www.uws.edu.au/_data/assets/pdf_file/0006/923361/SSP5680_Pacific_Communities_in_Australia.pdf).

Ravulo, J. (2016). Pacific Youth offending within an Australian context. *Youth Justice*, 16 (1), pp. 34-48.

Reason, P., & Bradbury, H. (2007). *Handbook of Action Research* (2nd Ed.). London: Sage Publications.

Richardson, S., Williamson, T., Finlay, A., & Farrell, M. (2009). Senior nurse's perceptions of Cultural Safety in an acute clinical practice area. *Nursing Praxis in New Zealand*, 25(3), 27-36.

Riggs, E., Davis, E., Gibbs, L., Block, K., Szwarc, J., Casey, S., Waters, E. (2012). Accessing maternal and child health services in Melbourne, Australia: Reflections from refugee families and service providers. *BMC Health Services Research*, 12, 117.  
<http://doi.org/10.1186/1472-6963-12-117>

Roberts, K., & Taylor, B. (2002). *Nursing research processes: An Australian perspective* (2nd Ed.). Southbank, VIC: Nelson Thompson Learning.

Rodriguez, L. (2007). *Impact of migration and social disadvantage on Maori and Pacific Islander health in Australia: Proceedings from the Hawaii International Conference on arts and humanities* (Version ISSN: 1541-5899). Honolulu, Hawaii.

Rodriguez, L. (2012). *Obesity is killing our people: the social construction of obesity and related illness in the Maori/Pacific Island migrant community in Australia*. PhD thesis. University of Newcastle.

Rodriguez, L. (2013). The subjective experience of Polynesians in the Australian Health System. *Health Sociology Review*, 22(4), pp. 411-421.

Rodriguez, L., George, R. J., & McDonald, B. (2017). An inconvenient truth: why evidencebased policies on obesity are failing Maori, Pasifika and the Anglo working class. *Kotuitui: New Zealand Journal of Social Sciences Online*, Volume 12 (2), 192-204. Retrieved from <http://www.tandfonline.com/doi/full/10.1080/1177083X.2017.136305>

Sallis, J. F., Owen, N., & Fisher, E. (2015). Ecological models of health behaviour. In K. Glanz, B. K.

Rimer, & K. V. Viswanath (Eds), *Health behaviour: Theory, research, and practice*, (5), pp. 4364.

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in nursing & health*, 33(1), pp. 77-84.

Sartorius, N. (2015). Changes of concepts and consequences. [Editorial]. *Psychiatry and Clinical Neurosciences* 2015; 69: 509–511.

Savin-Baden, M., & Wimpenny, K. (2007). Exploring and implementing participatory action research. *Journal of Geography in Higher Education*, 31(2), 331-343. doi: 10.1080.03098260601065136

Schwartz, D. (2012). *Maori expats in danger of becoming an economic underclass*. ABC Correspondents Report. Retrieved from <http://www.abc.net.au/correspondents/contents/2012/s3625001.htm>

Scott, K., Kokaua, J & Baxter, J. (2011). Does having a Chronic Physical Condition Affect the Likelihood of Treatment Seeking for a Mental Health Problem and Does this Vary by Ethnicity? *The International Journal of Psychiatry*, 42 (1), pp. 421-436.

- Scull, S., & Cuthill, M. (2010). Engaged outreach: Using community engagement to facilitate access to higher education for people from low socio-economic background. *Higher Education Research and Development, 29*(1), pp. 59-74.
- Seaton, L. (2010). *Cultural Care in Nursing: A critical analysis* (Unpublished PhD thesis). Queensland University of Technology.
- Selener, D. (1997). Participatory Action Research and Social Change. *The Cornell Participatory Action Research Network, Cornell University*.
- Shahid, S., Finn, L., & Thompson, S. (2009). Barriers to participation of Aboriginal people in cancer care: communication in the hospital setting. *Medical Journal of Australia, 190*(10), 574-579.
- Sheridan, N. F., Kenealy, T. W., Connolly, M. J., Mahony, F., Barber, P. A., Boyd, M. A., ... Dyall, L. (2011). Health equity in the New Zealand health care system: a national survey. *International Journal for Equity in Health, 10*(1), 45.
- Sheridan, S. A. (2015). Pathways to achieving complete social, emotional and spiritual wellbeing: The Pasifika and Maori community vision for culturally safe mental health support services in South-East Queensland. *Pasifika and Maori Mental Health Forum. Official Report*. Retrieved December 2015 from [www.multilink.org.au/wpcontent/uploads/2015/10/Pasifika-and-Maori-mental-health-forum-Official-Report-Brisbane-June-2015\\_final-version\\_2.pdf](http://www.multilink.org.au/wpcontent/uploads/2015/10/Pasifika-and-Maori-mental-health-forum-Official-Report-Brisbane-June-2015_final-version_2.pdf)
- Sherperd, S. M., & Ilalio, T. (2016). Maori and Pacific Islander overrepresentation in the Australian criminal justice systems- what are the determinants? *Journal of Offender Rehabilitation, 55* (2)
- Simpson, A. I, F., Brinded, P. M., Fairley, N., Laidlaw, T.M., & Malcolm, F. (2003). Does ethnicity affect need for mental health service among New Zealand prisoners? *Australia and New Zealand Journal of Psychiatry, 37*(6), 728-734.
- Singh, S. (2005). 'South Pacific: Island Populations thinning out from Migration'. Retrieved 11 January 2013, from <http://ipsnews.net/news.asp?idnews=36038>
- Small, C. A. (2007). Pacific Island Youth Cyberspace Pacific: Fiji, Tonga, Samoa. In M. C.

Waters., R. Udea., & H. B. Marrow. *The New Americans: A guide to Immigration since 1965* (Eds.). Harvard University Press, (pp. 534-541).

Smith, J. (2007). *Cultural Perspectives in Australia rural and remote health: a social justice perspective* (2nd Ed.). Melbourne: Tertiary Press.

Smith, L. (1999). *Decolonizing methodologies: Research and Indigenous peoples*. London: Zed Books.

Smith, L., Hudson, M., Hemi, M., Tiakiwai, S., Joseph, R., Barrett, A., & Dunn, M. (2008). *The negotiated space*. Waikato: Waikato University.

Southwick, M. (2001). *Pacific women's stories of becoming a nurse in New Zealand: A radical hermeneutic reconstruction of marginality* (PhD Diss). Victoria University of Wellington, New Zealand.

Southwick, M., Keneally, T., & Ryan, D. (2012). Primary Care for Pacific People: A Pacific and Health Systems Approach. *Pacific Perspectives, Report to Health Research Council and Ministry of Health*. Retrieved December 2018 from [www.pacificperspectives.co.nz](http://www.pacificperspectives.co.nz)

Spickard, P. (2002). Pacific Islander Americans and Multi-ethnicity, "A vision of American's Future?" In P. Spickard., Rondilla, J., & Wright., D. (Eds). Pacific Island peoples in the United States and across the Pacific. *University of Hawaii Press*, Honolulu, pp. 40-55.

Spielberger, J., Rich, L., Gouvea, M., Winjie, C., Scannell, M., & Harden, A. (2009). *Supporting low-income parents of young children: The Palm Beach County Family Study 2009*. Chicago: University of Chicago, Chaplin Hall Centre for Children.

Spinks, H. & Klapdor, M. (2016). 'New Zealanders in Australia: a quick guide', *Parliament of Australia*. Accessed 18<sup>th</sup> December 2018  
[http://www.aph.gov.au/About\\_Parliament/Parliamentary\\_Departments/Parliamentary\\_Library/pubs/rp/rp1617/Quick\\_Guides/NZAust](http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1617/Quick_Guides/NZAust).

Stanley, G. & Kearney, J. (2017). The experiences of second- generation Samoans in Australia. *Journal of Social Inclusion*, 8 (2).

Statistics New Zealand. (2006). *Quick Stats about culture and identity*. *Statistics New Zealand*. Retrieved 17 October 2013, from <http://www.stats.gov.au>

Statistics New Zealand and Ministry of Pacific Island Affairs (2011). *Health and Pacific Peoples in New Zealand*. Pacific Progress, Wellington.

Stewart, S. (2006). Cultural competence in Healthcare. *Diversity Health Institute, Sydney*.

Streubert, H., & Carpenter, D. (1999). *Qualitative research in nursing: Advancing the humanistic imperative* (2nd Ed.). Philadelphia: Lippincott.

Stringer, E. (1999). *Action research: A handbook for practitioners* (2nd Ed.). London: Sage Publications.

Swami, V. (2015). Cultural influences on body size ideals: unpacking the impact of Westernisation and modernisation. *European Psychologist*, 20, 44-55.

Swendson, C., & Windsor, C. (1996). Rethinking Cultural Sensitivity. *Nursing Inquiry*, 3, 3-10

Tait, R. (2009). *An outcomes framework for Pacific peoples in New Zealand*. Retrieved from <http://www.mpla.gov.nz/resources/pdfs/news-publications/Framework%20report%20%20final.pdf>

Taumoefolau, M. (2012). Respect, Solidarity and Resilience in Pacific worldviews: a counselling perspective. In M, Agee et al (eds), *Pacific Identities and Well-Being: Cross Cultural perspectives*. London: Routledge.

Thomas, D. (2009). *Reading Doctors' Writing*. Canberra: Aboriginal Studies' Press.

Thomas, R. M. (2003) *Blending qualitative and quantitative research methods in theses and dissertations*. Thousand Oaks, CA: Corwin Press.

Thurston, I. B., Hardin, R., Decker, K., Arnold, T., Howell, K. H., & Phares, V. (2018). Black and White Parents' Willingness to Seek Help for Children's Internalizing and Externalizing Symptoms. *Journal of clinical psychology*, 74(1), 161-177.

Thurston, I. B., & Phares, V. (2008). Mental health service utilization among African American and Caucasian mothers and fathers. *Journal of Consulting and Clinical Psychology*, 76(6), 1058-1067

Tiatia, J. (2012). "Commentary on cultural diversity across the pacific" Samoan cultural constructs of emotion, New Zealand born Samoan youths' suicidal behaviours and culturally competent human services. *Journal of Pacific Rim Psychology*, 6(2), 75.

Tiatia, J., & Foliaki, L. (2005). *Pacific cultural competency framework for DHBS (Draft 4)*.

Retrieved 13 April 2013, from <http://www.cmdhb.org.nz/Funded-Services/Pacific-Health/docs/cultural-competencies-framework.pdf>

Tiatia-Seath, J., Lay-Yee, R., & Von Randow, M. (2017). Suicide mortality among Pacific peoples in New Zealand, 1996-2013. *New Zealand medical journal*, 130(1454), 21-29.

Tsey, K., & Every, A. (2000). Evaluating Aboriginal empowerment programs: the case of family wellbeing. *Australian Health and New Zealand Journal of Public Health*, 24(5), 509-514.

Tsey, K., Patterson, D., Whiteside, M., Baird, I., & Baird, B. (2002). Indigenous men taking their rightful place in society? A preliminary analysis of a participatory action research process with Yarrabah men's health group. *Australian Journal of Rural Health*, 10, 278-284.

Tufala, S. (2018). Tuvaluan People's Explanations of Pacific Underutilization of Mental Health Services in New Zealand. Submitted in Fulfillment to a Degree in Philosophy (PhD) AUT. Retrieved March 2019 from <http://openrepository.aut.ac.nz>

Tukuitonga, C., & Finau, S. (1997). The health of Pacific Peoples in New Zealand up to the early 1990. *Pacific Health Dialog*, 4, 59-67.

Tukuitonga, C. (2012). *Pacific Island health: Causes of poor health*. Te Ara: The Encyclopedia of New Zealand. Updated 13th July 2012.

Vaughan, L., Schubert, L., Mavoa, H., & Fa'avale, N. (2018). Hey, we are the Best Ones at Dealing with our Own: Embedding a Culturally Competent Program for Maori & Pacific Island Children into a Mainstream Health Service in Queensland, Australia. *Journal of Racial/Ethnic Health Disparities*, 5 (3), pp. 605-616

Vaiolletti, T. (2006). Talanoa Research Methodology: A developing position on Pacific Research. *Waikato Journal of Education*, 11(2), 21-34.

Vertovec, S. (2011). The cultural politics of nation, migration and diversity. *Annual Review of Anthropology*, 40, 241-311.

Waserman, J., & Clair, J. (2011). Housing patterns of Homeless People: The Ecology of the Street in the Era of Urban Renewal. *Journal of Contemporary Ethnography*, Vol 40, Issue 1.

Wepa, D. (2005). *Culture and ethnicity: What is the question? Cultural safety in Aotearoa New Zealand* (pp. 31-38). New Zealand: Pearson Education.

West, R., Usher, K., & Foster, K. (2010). Increased numbers of Australian Indigenous nurses would make a significant contribution to 'closing the gap' in Indigenous Health: What is getting in the way? *Contemporary Nurse*, 36 (1-2), 121-130

Williams, E., & Harris, N. (2010). Understanding the nutrition information needs of migrant communities: the needs of African and Pacific Island communities of Logan, Queensland. *Public Health Nutrition*, 14(6), 989-994. doi:10.1017/S13689800100027

Williams, K. (2001). *Identity, culture and power: Towards frameworks of self-determination for communities at the margins* (Unpublished doctoral thesis). Massey University, Auckland.

Williams, L., Labonte, R., & O'Brien, M. (2003). Empowering social action through narratives of culture and identity. *Health Promotion International*, 18(1), 33-40.

Williams, R. (2019). People. Policy. Place. Seminar Series 2019. Retrieved 18 October 2019 from <http://www.cdu.edu.au/>

Willis, K. & Elmer, S. (2011). Society Culture and Health. An Introduction to Sociology for nurses (2<sup>nd</sup> ed) *Oxford Press University*, South Melbourne, Vic

Willis, E, & Smye, V., & Rameka, M. (2006). *Advances in Indigenous health care: building capacity through cultural safety in Australia, New Zealand and North America*. Maleny, Qld: eContent Management

Wilson, D. (2003). Improving Indigenous Health Status: The nurse's role in moving beyond the rhetoric. *Contemporary Nurse*, 15(3), 232-240.

Wilson, D. (2006). The practice and politics of indigenous health nursing. *Contemporary Nurse*, 22(2), 10-13.

Wilson, D. (2008). The significance of a culturally appropriate health service for Indigenous Maori women. *Contemporary Nurse*, 28(1-2), 173-188.

Wilson, D., & Neville, S. (2008). Nursing their way not our way: Working with vulnerable and marginalised populations. *Contemporary Nurse*, 27(2), 165-176.

Wilson, D., & Neville, S. (2009). Culturally safe research with vulnerable populations. *Contemporary Nurse, 33*(1), 69-79.

Winkworth, G., McArthur, M., Layton, M., & Thompson, L. (2010). Someone to check in on me: Social capital, social support and vulnerable parents with very young children in the Australian Capital Territory. *Child & Family Social Work, 15*, 206-215.

Winkworth, G., McArthur, M., Layton, M., Thompson, L., & Wilson, F. (2010). Opportunities Lost: Why some parents of young children are not well-connected to the service systems designed to assist them. *Australian Social Work, 63*(4), 431-444.

doi:10.1080/0312407X.2010.508170

Woods, M. (2010). Cultural safety and the socio-ethical nurse. *Nursing Ethics, 17*(6), 715-725. doi: 10.1177/0969733010379296

World Health Organization. (2019). *Primary Healthcare in Western Pacific*. Retrieved February 2020 from <https://www.who.int/westernpacific/health-topics/primary-health-care>



# Appendix 1 Information for Prospective Participants



Queensland University of Technology  
Brisbane Australia

## PARTICIPATE IN RESEARCH

### Information for Prospective Participants

*The following research activity has been reviewed via QUT arrangements for the conduct of research involving human participation. If you choose to participate, you will be provided with more detailed participant information, including who you can contact if you have any concerns.*

## An Exploration of Maori and Pacific Island Families, Elders and Child Health Providers Perceptions in Townsville about how to make child health services more relevant and culturally safe

### Research Team Contacts

Principal Researcher:	Ms Wani Erick	Professional Doctorate Student
Associate Researchers:	Dr Leonie Cox	Principal Supervisor
	Associate Professor Carol Windsor	Associate Supervisor
	Faculty of Health – Queensland University of Technology (QUT)	

Please contact the researcher team members to have any questions answered or if you require further information about the project.

### What is the purpose of the research?

The purpose of this research is to explore the perceptions of young Maori and Pacific Island families, community elders and child health providers in Townsville about how to make child health services more relevant and culturally safe.

### Are you looking for people like me?

The research team is looking for Maori and Pacific Island parents and elders who have migrated and resettled in Townsville, Queensland for the past 5-10 years. The research is also interested in talking to health workers who work with Maori and Pacific Island families to provide child health services.

### What will you ask me to do?

Your participation will involve an audio recorded focus group discussion and/or one on one semi structured interview.

### Are there any risks for me in taking part?

There are minimal risks associated with this research. You may experience anxiety from participation in a focus group and / or interview. This may be the result of talking about past experiences. Please note that strategies are in place to manage this risk and full details will be provided should you choose to participate. It should also be noted that if you do agree to participate, you can withdraw from participation at any time during the project without comment or penalty.

### Are there any benefits for me in taking part?

This project may benefit you and other Maori and Pacific Island families in the future by improving knowledge and understanding of your community health care needs and informing clinical care to be delivered to your community.

### Will I be compensated for my time?

We would very much appreciate your participation in this research.

To compensate you for your contribution, should you choose to participate, the research team will provide you with \$20 for your time and efforts.

### I am interested – what should I do next?

If you would like to participate in this study, please contact Wani Erick via email ([w.erick@qut.edu.au](mailto:w.erick@qut.edu.au)) or phone 07 3240 8962

You will be provided with further information to ensure that your decision and consent to participate is fully informed.

**Thank You!**

QUT Ethics Approval Number: 1300000821

# Appendix 2 Ethics application

University Human Research Ethics Committee

APPLICATION FOR REVIEW OF LOW RISK RESEARCH INVOLVING

## HUMAN PARTICIPANTS



May 2013

APPLICATION SECTIONS: A Research Proposal Overview | B Participant Overview | C Data Management | D Check List

### SECTION A: RESEARCH PROPOSAL OVERVIEW

#### A1 Summary Information –

##### A1.1 Project Title

An exploration of Maori and Pacific Island Families, Elders and Child Health Providers Perceptions in Townsville about how to make child health services more relevant and culturally safe

##### A1.2 Brief summary of project in lay language

This qualitative research will explore the perceptions of Maori and Pacific Island families, elders and child health providers living in Townsville about how to make services more relevant and culturally respectful by using the decolonisation and culturally safe methodology. Through focus groups and face to face interviews participants in Townsville will be asked about their experiences of child health services and their views on what and how services should be delivered. Through interviews participants with child health service providers in Townsville will be asked of their own cultural beliefs and attitudes and how do they perceive their service delivery to Maori and Pacific Island people. The objectives of this research are to explore the concept of relevant and culturally safe service delivery as perceived by Maori and Pacific people and to explore child health providers actions, interests, attitudes and assumptions when working with Maori and Pacific Island people.

##### A1.3 Participant summary

Eligible participants are immigrant Maori and Pacific Island families (parents) and elders who have resettled in Townsville during the past 5-10 years and health providers who provide child health services to Maori and Pacific Island families in Townsville. Participants will be asked to participate in an audio recorded, focus group discussion at a local catholic community centre. The focus group will take 60-90 minutes of their time. However, if a participant feels,

uncomfortable discussing information within a larger group there will be an opportunity to participate by taking part in an individual semi structured interview with the researcher. Health service providers will participate in individual interviews with the researcher. Individual interviews for both groups of participants will take approximately 60 minutes. The family and elder participants will be reimbursed with \$20 upon completion of attendance at the focus group and interview.

This amount is for reimbursement for a participant's time and cost (petrol) to attend the focus group.

#### **A1.4 Lay summary of research merits**

A Queensland Health Report (2011a) identified Maori and Pacific population in Queensland as one of two priority

population groups in Queensland because of relative social disadvantage. Socio-economic disadvantage is a known barrier to community socio-economic development and over time may create social and economic costs for Australia. Previous research on the Maori and Pacific population living in New Zealand points to increased social disadvantage evident in post colonial dislocation, household overcrowding and childhood diseases. Research undertaken with Maori and Pacific families who have migrated to Australia in the past few years has also found social disadvantage such as overcrowded housing, social isolation, lower rates of high paid employment and preventable childhood illnesses (Rodriguez 2007). A critical issue for these families who are socially disadvantaged is health care access (Queensland Health 2011a). Research that could potentially be used to improve access to health care services appears crucial. It is expected that the research will draw some conclusions from the perceptions of Maori and Pacific Island people and child health service providers who are providing services to Maori and Pacific Island families about how to make child health services relevant and culturally safe and will make recommendations to enhance current guidelines in relevant existing services. The following question is posed; how do Maori and Pacific Island families in Townsville describe their experiences of health services and are they perceived as relevant and culturally safe and to explore the child health providers in Townsville actions, attitude, interests and assumptions and how do they perceive their service delivery to Maori and Pacific Island people? The methodology adopted for this research project is decolonisation and cultural safety where the study population are encouraged with decision-making pertaining to their healthcare. The decolonisation methodology seeks to equip researchers from Indigenous communities with concepts and worldviews to conduct research from an Indigenous perspective (Smith 1999).

#### **A1.5 Provide a brief justification for considering this a low risk application.**

A cultural safety and decolonisation methodology will be applied for the purposes of engaging with young immigrant families, community elders and child health service providers. These methodology moves away from the traditional top-down approach to research in recognising that people with knowledge about their life situations are best

positioned to bring about change. There are negligible risks associated with this research beyond those in everyday life.

The research will not ask about sensitive issues but will ask about experiences about previous service provision.

## A2 Potential Risks and Benefits –

### A2.1 Potential Risks — indicate if there are any potential risks associated with the project?

Currently, I am seeking input from the Townsville St Theresa's Catholic Centre and Townsville Samoan Catholic Community group in relation to ethical considerations in this research. The health and safety aspects regarding the participants have been discussed with some of the prospective members of a community reference group and include, for example, issues identified by participants when asked of previous experiences. A potential risk of harm to the participants may be anxiety when asked to speak of previous experience. However the benefit of input into service provision is likely to outweigh any risks identified. In the event a participant may feel anxious a focus group discussion and/or interview will be stopped. The researcher is experienced in facilitating group discussion around such issues and will endeavour to contact appropriate local medical services available to offer counselling sessions should participants need it. The interview may continue later if a participant so decides or may withdraw from the study.

### A2.2 Managing the risk

A group discussion and or interview will be stopped until the participant feels he or she is ready to recommence the interview. Several available services within the local medical services in the community that offers counselling will be made available to the participants should they require these services. There is a local Indigenous health service provider that has a psychologist based at their centre, and the researcher will ask this service provider to allow referral of research participants should they require counselling.

### A2.3 Potential Benefits — indicate if there are any potential benefits associated with the project and who benefits?

The methodology of this research encourages participation whereby participants will reach consensus as a group on what they want out of relevant health care services. The potential benefit for the participants is that they may develop a stronger sense of identity and empowerment through the opportunity to directly contribute to their community. This research may lead to better well being and health outcomes in the development of more appropriate services. The relevant health service providers may use information from the research to help guide services they provide to the study population.

### A2.4 Balancing against the risks

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The risk of anxiety as noted above is outweighed by the potential benefits of this participatory research.

## A3 Other General Information –

### A3.1 Location of research – where the research will be conducted

NO –

YES – QUT

provide details:

In Townsville within a community-based centre where immigrant Maori and Pacific Island families meet and /or seek help upon resettlement in Townsville (Townsville City Council Multicultural Support Centre).

**A3.2 Is the QUT Human Research Ethics Committee (UHREC) the primary or only ethics committee reviewing this proposal?  
If not, please provide details.**

Yes

**A3.3 Estimated timeframes for the project, i.e. DD / MM / YEAR**

Data collection cannot commence until you have received formal written approval.

START OF PROJECT

18 January 2012

START OF DATA COLLECTION

20 April 2014

END OF PROJECT

20 January 2016

END OF DATA COLLECTION

20 October 2015

## SECTION B: PARTICIPANT OVERVIEW

**B1.1 Who will be approached to participate?**

Young Maori and Pacific Island parents and Maori and Pacific Island community elders who have resettled in Townsville within the past 5-10 years.

Child Health service providers including child health workers and community health workers working with immigrant Maori and Pacific Island families.

**B1.2 Approximately how many participants will be approached?**

There will be at least fifteen participants from the young parents and fifteen who are the elders of the community.

There will be at least fifteen further participants recruited from relevant child health service providers who are working with immigrant Maori and Pacific Island families within the primary healthcare setting in Townsville.

**B1.3 How will potential participants be identified and approached?**

Initial contact will be made through the handing out of recruitment flyers at a stall over a 5-day period during a multicultural festival. Where interest is expressed in taking part in the study, phone or email contact will be made with potential participants. The research will be introduced to potential participants and elders at other community

groups such as church meetings and at community social celebrations such as the marking of prominent anniversaries for example, Constitution celebrations.

An approach email will also be circulated to relevant child health service providers and community health workers. Manager of child health units will be contacted, and the research discussed. Permission will be sorted to email health professionals in these units to seek research participants.

**B1.4 How will the participants provide their consent to participate?**

Each participant will sign a consent form stating that they have understood what the research entails, that they have been well informed and agree to be study participants and that they may withdraw from the study without any penalty at any point.

are unable to  YES  X give informed consent? **B1.5 NO Will the study involve participants who**

If YES, please include details.

**B1.6 Will the potential participants be screened?**

No

**B1.7 Will participants be offered reimbursements, payments or incentives? Ensure details of any reimbursements, payments or incentives (e.g. gift voucher) are provided on the Participant Information Sheet.**

Yes, family and elder participants will be reimbursed with \$20 upon completion of attendance at a focus group and /or an interview. This amount is reimbursement for a participant's time and cost (petrol) to attend a focus group and/or interview.

**B1.8 Is there an existing relationship with participants?**

The researcher is a member of the community and is likely to have had some informal contact with some participants and with relevant child health service providers for example, an Indigenous Health Service provider based in Townsville.

**B1.9 Is it proposed to conduct a debriefing session at the end of the research (or at the end of each participant's involvement)?**

Yes, this will be held upon completion of the focus group discussions and interviews.

**B1.10 Will feedback, the outcome / results of this research be reported to participants?**

Yes, opportunities will be made to allow for this to occur during and after the focus group discussions and interviews.

The research outcomes will also be communicated to the community.

**SECTION C: DATA MANAGEMENT**

**C1 Future Use of Data**

**C1.1**  YES  NO Is it likely / possible that any of the data collected will be used by you, or others, for any research other than that outlined in this application? If yes, please describe below and ensure this is outlined in all the participant information sheets and consent forms generated under the clearance.

All non-identifiable data collected in this project may be used as comparative data in future Projects.

**C2 Procedures & Protection**

**C2.1 What data collection procedures will be utilised?**

ARCHIVAL RECORDS	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	QUESTIONNAIRE	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	FOCUS GROUPS	If you have indicated
OTHER INSTRUMENT	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	INTERVIEWS	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO		
OTHER INSTRUMENT	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	FOCUS GROUPS	If there is insufficient space, provide an additional separate document.			

C2.2 **NO** Have  YES  the data collection procedures approved by QUT or are they an academic standard instrument?

C2.3 **Provide brief details on prior approval or where instruments have been used previously, e.g. under a similar context to this proposal.**

The data collection procedures are standard methods that are commonly used in this form of research.

C2.4 **In what form will the human data be collected, recorded and stored? Place an 'x' in the table boxes below as relevant.**

Collected	Stored
-----------	--------

X	<input type="checkbox"/>	Individually Identifiable
---	--------------------------	---------------------------

<input type="checkbox"/>	X	Re-Identifiable or Potentially Re-Identifiable
--------------------------	---	--

<input type="checkbox"/>	X	Non-Identifiable
--------------------------	---	------------------

C2.5 **Data Ownership**  
 Researcher /QUT and Maori and Pacific community in Townsville

C2.6 **Protecting Confidentiality**  
 Confidentiality and anonymity of study participants will be assured using pseudonyms, the omission of any identifying features in any output of the research and access to the data restricted to the research team.

C2.7 **Data Sharing Arrangements (collaborative projects)**



### C3 Storage & Security

C3.1  YES **Records will be stored for the required period.**

QUT Retention and Disposal of Research Data (as outlined by Queensland State Archives):

<http://www.tils.qut.edu.au/initiatives/researchsupport/datamanager/planning.jsp#70>

#### C3.2 HARD/PAPER COPIES...

C3.2.1 **What is the location of storage (ie room and building location)?**

Hard copies will be stored in a locked filing cabinet in the principal researcher's (office).

C3.2.2 **How will access to the stored data be controlled?**

Be stored in a locked filing cabinet access managed by the principal (researcher).

C3.2.3 **Who will have access to the stored data?**

The principal researcher

#### C3.3 ELECTRONIC DATA...

C3.3.1 **Where is the location of storage and back-up (ie a secure computer/server)?**

On the QUT server

C3.3.2 **How will access to the stored data be controlled?**

The computer is password protected and only the principal researcher and supervisors will have access to the data

**C3.3.3 Who will have access to the stored data?**

The principal researcher and supervisors

**C3.4**  
N/A If applicable,

YES

NO

X

has Faculty approval been provided for off-site storage?

## Appendix 3 Timeline for Completion of the Research and Coursework

Timeline for Completion of the proposed Research	
Stage 2 Proposal Due Date	14/12/2013
Confirmation Due Date	25/01/2015
Final Seminar	24/12/2019
Expected Completion Date	24/07/2020

Timeline for Completion of Coursework		
Semester 1/2012	AIRS:	Completed
Semester 2/2012	HLN405	Assignment 1, 2, completed and Assignment 3 leading to a fully developed proposal where an in-depth exploration of a methodological area of knowledge and Stage 2 Proposal (Extension permitted to 14th November 2012)
Semester 2/2012	HLN 701	Shell unit /completed
Semester 1/2013		Ethics and organization sites and sampling
Semester 1&2/2014		Ethics Approval Obtained /Recruitment
Semester 1&2/2015	HLN711:	Data Collection/Advanced Qualitative Methods
Semester 1 & 2 2017		Data Analysis/Writing up Thesis
Semester 1&2 /2018		
Semester 1 & 2		Final Seminar/Writing Up Thesis/Thesis Submission 2019/2020/2021

## Appendix 4 Members of the Community Reference Group (CRG) for the Maori and Pacific Island Study

KT (not current)	Initial member/Townsville Maori Social Justice Elder	Maori
VN (current)	Head of Pacific Studies, Auckland University	New Zealander and Pacific Islander
WE (current)	Researcher	Pacific Islander
FT (current)	President of Townsville Samoan Catholic Community	Pacific Islander
S (deceased: 2014)	Townsville Maori Community Elder	Maori
JS (not current)	Townsville Social Worker	Australian

## Appendix 5 My Story

### My Story

In the early sixties, my twin and I were born on a tiny, small Pacific Island nation called Niue to a Niuean Samoan father and an Indigenous Fijian Irish mother. Our parents had met in Suva, Fiji Islands while our father was on a health scholarship to study to become the first Public Health Officer for Niue at the University of the South Pacific in Fiji. While in Fiji our father met our mother who at sixteen years of age was working as a waitress in a restaurant to support herself. Meeting our father was a 'way out of poverty' for our mother who had lost her own Mum when she was a toddler and had experienced an unstable upbringing in life being moved between families to families on a short-term basis.

During my childhood and school years on the Island of Niue, I remembered watching how my parents struggled to provide for us all nine children. Our father was the sole income earner and not only is he responsible for his large family he must look after his own siblings due to his own father deserting his young family on the Island by migration to New Zealand. It was during this setting in my young life that I learned two important lessons: one was that getting an education would change my position in life; the other one was that I am proud of my culture, proud of my parents for doing everything possible to give us opportunities despite their struggle, and proud of the person that I am and where I come from.

As soon as I finished high school, I begged my father to allow me to migrate to New Zealand to further my education and with great anticipation of what "the bright lights" of New Zealand would offer. I had not been successful with my education on the Island and I blamed having limited financial support and resources for this shortfall. Culture in part is also to blame because my father is obligated to share his earnings with the extended family because I remembered at times how we as young family members would sometimes have to go without school excursions, schoolbooks and school lunches.

Arriving in New Zealand at eighteen years of age and trying to resettle was harder than I expected. I was exposed to a variety of new people, new experiences and a new language, English. I learnt to speak English 'properly' despite learning to speak and to write English at high school back home because this was a requirement of me as an employee to 'communicate properly' with other fellow workers in my position as a quality officer in a manufacturing shoe factory. I was homesick and missed my parents but there was 'nothing' for me back home, so I set out to achieve what I set out to do and that was to further my education.

There was also an everlasting desire to please my parents and to pay them back for their hard work through becoming an educated and qualified daughter. There is a *Niuean* common proverb usually delivered as a form of blessing from a parent to a child (*tao e umu haau ke moho*), and when you fulfil and complete your work with diligence this will amount to you and your family (*monuina*) blessings. This also articulates the Niuean culture and meaning of (*lagomatai moe gahua fakalataha*) collaborative work with families and others in your community. The above is illustrated by McDonald and Rodriguez (2014) in their study with Pacific Island rugby players in New South Wales on, “how success for Pacific Islanders is not regarded as an individual accomplishment but instead is embedded within a complex genealogical and cultural narrative for the entire family and country of origin” (p. 238).

With the support of my partner (currently my husband of 30 odd years) I graduated with a Bachelor of Health Sciences (Nursing) early 1990’s, and worked as a child health nurse educator, researcher, and clinician within a community setting with Maori and Pacific Island families, non-government organisations, government health organisations, university and a Maori service provider in South Auckland. It was during this time that I gave birth to my three children, with the second child deceased being born as stillborn. Following we were blessed with our fourth child prior to our migration to Australia. At the same time, I was fortunate enough to be successful in my application for a Pacific Island health scholarship with the New Zealand Ministry of Health to further my studies. Post migration to Australia in 2005 I completed my post-graduate degree on external mode in primary healthcare nursing and a graduate diploma in community child and health nursing with Auckland Massey University.

I am a local qualified health professional of Pacific Island heritage (who has worked and has strong affiliations with Maori and Pacific Island communities in (Auckland, Townsville and in Brisbane). I am aware of some of the intricacies of specific cultural beliefs, norms and ethical requirements within the Pacific Island communities. What it means to be a cultural “insider” will assist with understanding spoken and unspoken “language” during interviews. One should also be aware of the paradox of being an “insider”, as being closer to the participants can lead to a much more personal relationship and a deeper understanding of the dynamics that might be at play during the research. Being a cultural “insider” has its advantages, indeed I am privileged and grateful particularly in terms of recruitment and the trust developed between the researcher and the participants. Conversely, a limitation for me is that I already have established ideas, opinions and knowledge in relation to the research problem, so the findings could consist of the knowledge and beliefs I have rather than the participants’ perspectives (Denzin 1994; David 2002). In such a case, measures were taken to maintain rigour in the research process and to avoid using pre-conceived knowledge, such as appropriately screening data and maintaining transparency of the processes involved in the project such as data management and ongoing feedback to the participants

and the research team (Collet, 2008). The key is to ensure that this research was carried out in a more respectful, ethical, reciprocity, mutual and beneficial manner, seen from the point of view of Maori and Pacific Island peoples. Hence the use of the *Talanoa* methods, a narrative enquiry developed from the Pacific people's oratory tradition, and despite challenges along the process the researcher successfully elicited information from twenty- nine Maori and Pacific Island people about their experiences when accessing health services in Townsville.

In 2005 after 15 years of working with Maori and Pacific Island families in South Auckland and becoming highly dissatisfied with government policies impacting on low socio-economic families (including my family) I decided to migrate with my young family to Townsville in Queensland in search of a "better" life. Townsville is a regional city in North Queensland situated between Cairns and Mackay and the tropical lifestyle has promising appeal and sentiments given my husband and I both hailed from the same tropical and cultural upbringing.

In the early days of resettlement in Townsville, the goal posts around settlement were continually shifting as were the questions we had about how to make it work for us. As recent immigrants, where do we go to seek help in obtaining assistance when looking for a job or accommodation, resettling children into school or to link with people from the same background? The social isolation was dismal, yet my husband and I have had to continue because there were three other people dependent on us to make the move a "successful" migration.

However, it was not until halfway into the time of resettlement that I recognised the significance of culture and how it was becoming a centrality in my life in two respects. Firstly, as a low-income migrant and a woman, the experience of poverty encompassed cultural alienation, loss of family connection and low social status. Secondly, my work with Indigenous people within the community revealed the cultural dominance of economically powerful groups and the relative powerlessness of Indigenous people to assert important cultural values and beliefs when accessing healthcare (Puzan 2003; Davies & Papadopoulos 2006; Azzopardi & Gray 2010; West, Usher and Foster, 2010). Sadly, the health status for "Australian Indigenous people is an example of how a marginalised and dislocated group is powerless to historical and social factors such as unemployment, threats to cultural identity and social disadvantage" (Azzopardi & Gray, 2010, p. 105). These experiences also rekindled memories of working with Maori and Pacific Island families from low socio-economic backgrounds in South Auckland and Aboriginal and Torres Strait Island families in Queensland, New South Wales and Alice Springs Northern Territory Australia. Their willingness to share their understandings, thoughts, feelings and their worlds has made me more inquisitive. There were experiences of being overwhelmed and struggling with new concepts

of trying to be informed of “how to work” with Indigenous Maori families in South Auckland and in Australia. There were times of struggle at seeing some of the experiences of some of the families and their stories of poverty and powerlessness at the hands of the government and social welfare system. I came away struggling with my feelings of turmoil yet strengthened by the words of a local *kaumatua* (Maori elder/New Zealand) in his farewell speech to me on my last day at work by saying, “I give you this *tohunga* (greenstone) because you persevere and became part of us but by leaving it shows that you are now ready to move on having being able to recognise some of the causes of struggles of our families, therefore use your experiences here as a foundation for you to continue to develop in your journey”.





## Appendix 7 Original Flyer

Townsville Maori and Pacific Island  
Families (Mouíolaola/Whanau Ora) Study



You are invited to participate in this  
Research ..... Let's talk about ways to help  
Maori and Pacific Island Families!

## Appendix 8 Ethics approval

From: QUT Research Ethics Unit

Sent: Monday, 10 February 2014 12:15 PM

To: Leonie Cox; Carol Windsor; Wani Erick; Wani.Erick@atsichsbrisbane.org.au

Cc: Janette Lamb

Subject: Ethics Application Approval -- 1300000821

Attachments: UHRECSTANDARDCONDITIONSOFAAPPROVAL-

HUMANRESEARCH.DOC

Dear Dr Leonie Cox

Project Title: An exploration of perceptions of Maori and Pacific Island families, elders and child health providers in Townsville about how to make child health services more relevant and culturally safe

Ethics Category: Human - Low Risk

Approval Number: 1300000821

Approved Until: 10/02/2016 (subject to receipt of satisfactory progress reports)

We are pleased to advise that your application has been reviewed and confirmed as meeting the requirements of the National Statement on Ethical Conduct in Human Research.

I can therefore confirm that your application is APPROVED.

If you require a formal approval certificate, please advise via reply email.

CONDITIONS OF APPROVAL

Please ensure you and all other team members read through and understand all UHREC conditions of approval prior to commencing any data collection:

> Standard: Please see attached or go to

[www.research.qut.edu.au/ethics/humans/stdconditions.jsp](http://www.research.qut.edu.au/ethics/humans/stdconditions.jsp)

> Specific: None apply

Decisions related to low risk ethical review are subject to ratification at the next available UHREC meeting. You will only be contacted again in relation to this matter if UHREC raises any additional questions or concerns.

Whilst the data collection of your project has received QUT ethical clearance, the decision to commence and authority to commence may be dependent on factors beyond the remit of the QUT ethics review process. For example, your research may need ethics clearance from other organisations or permissions from other organisations to access staff. Therefore, the proposed data collection should not commence until you have satisfied these requirements.

Please don't hesitate to contact us if you have any queries.

We wish you all the best with your research.

Kind regards

Janette Lamb on behalf of the Chair UHREC Research Ethics Unit | Office of Research | Level 4 88 Musk Avenue, Kelvin Grove | Queensland University

of Technology

p: +61 7 3138 5123 | e: ethicscontact@qut.edu.au | w:

[www.research.qut.edu.au/ethics/](http://www.research.qut.edu.au/ethics/)

## Appendix 9 Figure 4: Demographics of MPI Participants in Townsville

Service Users	Participants	Age	Ethnic Background
Young Parents	CD	21	Fijian
	LI	40	Niuean
	CW	38	Niuean/European
	MD	44	Fijian
	ES	39	Solomon Islander
	PS	45	Niuean
	MA	34	Samoaan
	JG	26	Samoaan
Youth			
	B5	21	PNG
	FT	20	Samoaan
	VS	29	Maori
	KT	30	Niuean
Young Focus Group			
	TT	29	Niuean/Fijian
	LT	36	Niuean
Community Elders			
	TM	61	Maori
	OD	65	Fijian

	HW	54	Fijian
	SC	50	Fijian
	EV	54	Niuean
	FT	48	Samoaan
Elders Focus Group 1			
	EV	48	Fijian
	CK	54	Aboriginal/Samoan
	AJ	58	Fijian
Elders Focus Group 2			
	JP	45	PNG
	CP	51	PNG
	TP	44	PNG
	MP	54	TSI/PNG
	MT	50	TSI

## Appendix 10 Child Health Service Providers

Child Health Service Providers/Townsville/Brisbane	Participants	Age	Ethnicity
Queensland Health RN	M (Withdrew from study)	45	Papua New Guinea/European
Child Health Worker	E	56	Samoan
MPI Child Health Nutritionist	K	31	Maori
Community Development Office	R	38	Niuean
Queensland Health Midwives			
	J (QLD Health Midwife)	51	European
	H (QLD Health Midwife)	45	Torres Strait Island (TSI)
Queensland Government	E (Youth Justice Health Worker)	39	Solomon Island
	M (ECHW early child health worker)	28	European



	C (ECHW	55	Australian TSI
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# Appendix 11 Original Flyer

Conference

Presentation

2019 Pasifika Medical

Association (PMA) “The

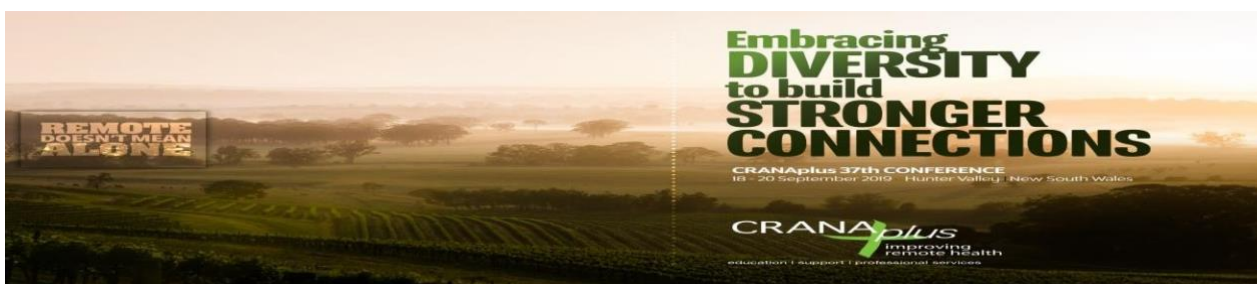
Rising tide”



Keynote Speaker (Power-point) Niue



- "Currently, you really need to do an in-depth health services"
- "Niueans needs to have a voice" - community members to develop a based training for mental health
- Give specific recommendations as to how and what can be done to improve services by Niueans and the trust
- with a view on building up existing strengths culturally safe and with
- Enhanced data collection about ethnicity (the actual list of Niuean "hidden" due to being identified as others)



Queensland Maori Pasifika Families and Child Health Service Providers talanoa (narrate) about culturally safe service delivery



**2017**

**Multilink**

**Organization and Stakeholders Health Forum, (Power-point) Brisbane, 2017**

*2016 Pasifika Women's Alliance Domestic Violence Forum, (Keynote Speaker) Northside Brisbane*



Talanoa or Getting people to open up



*Queensland*

2014 National Talanoa Pasifika Health and Education Conference, (Power-point), Cairns QLD



## **Appendix 12 Accepted Abstract at 2019 PMA Conference, Niue & 2019 Crana Plus Conference Newcastle NSW**

### Title

Queensland Maori, Pasifika Families and Child Health Service Providers narrating (talanoa) about culturally safe service delivery; an exploration on why a lack of uptake of child health services

### Authors

Erick, W and Windsor, C

### Abstract

A Queensland Health report identified Maori and Pacific Island groups in Queensland as two priority groups due to social disadvantage. One key performance disadvantage among Maori and Pacific Island communities in Queensland was disengagement from child and family health services. A qualitative study was undertaken, to explore this issue, drawing on a theoretical lens which combined Decolonization, Ecological and Cultural Safety methodologies and Talanoa methods. Interviews were conducted with twenty-nine Maori and Pacific Island Families in Townsville and eight Child Health Service Providers in Brisbane and Townsville to produce greater insight into the conceptualization of culturally safe health service delivery.

A combination of Charmaz's constructivist methods and Bronfenbrenner's ecological model underpinned data analysis. Power dynamics, socio-contextual realities or positionality, identity versus cultural norms, deficit discourse and cultural disconnection were key categories that depicted health service delivery to Queensland Maori and Pacific Island Families. The theoretical framework shifted the focus from service users (Maori and Pacific) to examine child health service providers' experiences in their work with Maori Pacific Island families. The interpretive analysis unearthed misconceptions within service delivery, particularly a predisposition to assume that health care delivery that engaged a transcultural approach was a culturally safe approach.



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22 May 2019

Ms Wani Erick  
Townsville  
Australia

Fakalofa atu ma Wani.

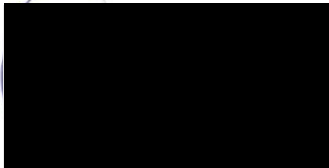
Thank you for your abstract on disadvantage among Maori and Pasifika families in Queensland and apparent disengagement from child and family services.

Participants at the MPA come mainly from NZ and Pacific Islands where these issues are relevant and outcomes are of interest.

I am pleased to advise you that your abstract is accepted for the PMA. When the programme is finalised, I will advise you of the date, time and place for your presentation.

We look forward to seeing you at MPA.

Kind regards,



**Colin Tukuitonga**  
Convenor, PMA2019

Pacific Community (SPC) Headquarters: Noumea, New Caledonia. Regional Offices: Suva, Fiji;  
Pohnpei, Federated States of Micronesia; Port Vila, Vanuatu. Country Office: Honiara, Solomon Islands.  
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