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'*Hey, We Are the Best Ones at Dealing with Our Own*': Embedding a Culturally Competent Program for Māori and Pacific Island Children into a Mainstream Health Service in Queensland, Australia

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Abstract
Objective We present the results of one component of an external evaluation of Good Start Program (GSP), a community-based program for the prevention of chronic disease among Maori and Pacific Island (MPI) communities living in the state of Queensland, Australia.
Design An evaluation of the GSP was undertaken using a mixed methods approach. This paper reports on the qualitative component where interview and focus group data was collected, using Talanoa, a culturally tailored research methodology. Respondents included school students, community groups, teachers and parents, as well as the Good Start implementation team.
Result(s) The five broad themes that emerged from this evaluation related to (i) components of cultural-competence and (ii) perceived impact of the program. The views of all participants reinforced the importance of culturally appropriate programs and highlighted how the multicultural health workers (MHWs) contributed to the program's perceived success. The challenges in understanding restrictions of the mainstream health service framework were noted indicating the need for it to be flexible in incorporating culturally appropriate components if a program was to be embraced.
Conclusion The qualitative evaluation of the GSP suggests that culturally tailored programs, delivered by MHWs, have the potential to impact positively on community-level behavioural changes that improve health. These findings, supported by studies from other countries, contribute to the evidence that cultural-tailoring of programs is critical for ensuring that culturally appropriate initiatives are embedded in health care systems that support multicultural communities. Embedding includes the development of culturally appropriate policies, a culturally competent workforce and long-term funding to support culturally competent initiatives.

Keywords Māori · Pacific Islander · Culturally competent · Community · Evaluation · Strength-based approaches

Introduction

The prevalence of obesity has more than doubled in Australia in the past 20 years [1]. Studies in other Westernised countries such as the UK and USA indicate that the rise is slowing [2, 3], as is the case for adults in Australia [2, 4–7]. Trends for the prevalence of obesity in children are less consistent; in 2011–2012, 25.7% of children across Australia aged 5–17 years were either overweight (18.3%) or obese (7.4%). In Queensland, 27.5% of 5–17 year olds were classified as either overweight (18.2%) or obese (9.3%) in 2013, with no gender differences [8, 9].

Socio-cultural factors and higher socio-economic status (SES) are reported to have a protective effect on overweight and obesity among children and adolescents in many countries. Related factors include income; education; access (physical; affordability) to nutritious food; access to sporting facilities;

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health literacy commensurate with the dominant culture; outdoor environment and cultural norms of eating, exercising and ideal weight [5, 10, 11]. The report [9] found that in disadvantaged areas of Queensland in 2014, defined by SES, the prevalence of self-reported adult and child obesity was about 80 and 50% higher respectively than in advantaged areas [9]. An Australian study reported that the greatest predictors on childhood and adolescent obesity were ethnically based [2]. Age, sex, ethnic and socioeconomic disparities in the prevalence of obesity among children and adolescents have also been found in Global surveillance studies [5, 10, 12].

In this paper, we refer to migrants to Australia from the island groups of Micronesia, Melanesia, Polynesia and Maori and Pacific peoples from New Zealand as Māori and Pacific Island (MPI) peoples. In 2011, 279,248 MPI peoples resided in Australia, comprising 1.3% of the total Australian population [13]. The three largest MPI groups in Australia were Māori (46%; pop 128,430), Samoan (20%; pop 55,843) and Tongan (9%; pop 25,096) [13]. The MPI population is likely to be significantly higher due to both rapid population growth in Māori and Samoan populations and underreporting of Māori ancestry in the Australian Census [14]. The current MPI population is youthful with the majority being in the 0–24-year age group, compared to 25–49-year-olds being the majority for the overall Australian population [15]. The rapid growth of this youthful MPI population is predicted to continue both in Queensland [14] and Australia [15].

MPI communities in Queensland suffer disproportionally from obesity-related diseases [14]. Samoans, Tongans, Fijians and Australian South Sea Islanders (primarily from Vanuatu, the Solomon Islands and Papua New Guinea) showed higher rates of preventable conditions such as coronary heart disease, stroke, chronic obstructive pulmonary disease and type 2 diabetes than the overall Queensland population [14, 16, 17].

A range of factors appear to contribute to the greater prevalence of obesity-related diseases experienced in MPI communities relative to the non-MPI population in Queensland, including social and economic domains [14]. Acculturative stress and reluctance to seek help have also been linked to the lack of uptake of preventative health services [14]. Members of MPI communities in Queensland have indicated some contributing factors, including low levels of health literacy, such as low comprehension of the mainstream health system and health issues, and the cost of medical treatment. Maori FG members attributed to the lack of culturally tailored health promotion in Queensland [14]. Indigenous Fijians in Queensland also expressed a lack of confidence in the doctors and services provided [14]. Queensland-based Samoans suggested that a high reliance on their own community for care and support delayed or reduced their use of health services, especially preventive health [14, 18]. Collaborating with MPI communities, utilising strength-based approaches that embrace 'the skills, knowledge, connections and potential in a community' will enhance the ability of communities (individuals, families, neighbourhoods), to improve their health and wellbeing [19].

Mainstream western health services are usually based on a biomedical model which is often disease-focused and fails to encapsulate more holistic components of health. In contrast, the *Fonofale* model [20] of health is an example of a holistic model that encapsulates Pacific perspectives, including values and practices. It includes the interrelationship within and between family, culture, spirituality and health, incorporating the metaphor of a Samoan house to depict holism and continuity. The model, and similar pacific models such as *Te whare tapa wha* (Maori, Tonga, Cook Island) [21], resonate with socio-ecological models of health that recognise that individuals are embedded within multi-layered social systems, with dynamic interrelations between individual and environmental factors [22].

In comparison to the apparent disjunction between MPI concepts of health and the services currently provided in Queensland, the New Zealand health system has sought to improve the health of Māori and Pacific peoples by developing culturally appropriate services. Māori, as the indigenous people of Aotearoa/New Zealand, have established health initiatives to 'increase access, achieve equity and improve outcomes for Māori.' [23]. Other countries looking to develop culturally appropriate services can draw on New Zealand's experiences. New Zealand has considerable experience which can be drawn upon, including dedicated health policies, programs, research and services recognising the complex cultural, social and economic barriers that impact on MPI populations' ability to access and comprehend mainstream health messages and services [24]. Pacific health initiatives in New Zealand have empowered Pacific Island communities by increasing the Pacific health workforce, improving the responsiveness of mainstream providers and increasing the evidence base on Pacific people's health needs [24].

The availability of dedicated health workers has also been integral to improving the health of other communities in Queensland, including Aboriginal and Torres Strait Islander peoples [14]. However, in Australia generally and Queensland specifically, there has been limited experience in responding to the complex health needs of MPI populations (Queensland Health, 2008).

The development of culturally tailored health care delivery has been recommended for Queensland [14, 25, 26]. Cultural 'tailoring' is a deliberate response to important individual and subgroup variables such as attitudes and practices when designing and evaluating interventions, including research. Culturally tailored initiatives to improve nutrition and physical activity have been successful among disadvantaged communities [27]. However, ongoing education and long-term evaluation of community programs is required. The impact of such culturally tailored initiatives is potentially not seen until a number of years after implementation [24].

A culturally competent health care system '*acknowledges and incorporates the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs*' [28]. Neither cultural-tailoring nor cultural-sensitivity ensure cultural-safety nor equate to cultural-competence. Cultural-safety enables health beliefs and practices, which do not conform to the established western biomedical discourse, to be legitimately brought alongside these mainstream systems [29]. Cultural-competence extends understanding beyond simple awareness of cultural differences, encompassing behaviours, attitudes and policies that characterise a system/agency and that support effective work across cultures [30, 31].

The development and implementation of the Good Start Program (GSP) for MPI children was the Queensland Health response to the Pacific Islander and Māori health needs assessment [14]. The GSP, originally funded through a grant from the National Preventive Health Partnership Agreement (NPHPA) and subsequently Queensland Health, commenced in July 2011 with a commitment to improve the health and wellbeing of MPI children and their families. The program's key aims were to recruit and train a multicultural health workforce and develop culturally tailored activities, resources and training materials for MPI populations in Queensland. GSP activities have previously been described [32].

The development of the GSP responded to MPI communities living in Queensland being both diverse and complex. It was considered imperative that the GSP approach be multistrategic and that it embraced key strengths common to MPI communities, including their strong commitment to family, community and church [33], thus targeting significant community involvement. The MPI multicultural health workers (MHWs) were recruited from seven distinct MPI ethnic communities, based on their community connections rather than previous health care experience or health-related qualifications. Following in-service training, MHWs were responsible for delivering the GSP in their own communities. The GSP also employed a dedicated multicultural nutritionist who was a qualified dietitian/nutritionist from an MPI background.

We report here on the results of the qualitative component of an external evaluation of the GSP.

Methods

Design

The external process, impact and outcome evaluation of the GSP adopted a mixed method approach analysing both quantitative and qualitative data, as well as a range of GSP documents to gain additional insight into the GSP processes and approach. Interview and focus group (FG) data were collected from school students and other stakeholders, including community groups, school teachers and parents, as well as the Good Start implementation team. Purposive sampling was used to enable participants to be chosen based on cross section of ethnicities; length of time on the program or involvement with the program, range of ages and role of the stakeholder. The rationale was to ensure both depth and the diversity of participants contributing and in order to highlight common themes and to produce a 'thick description' of accounts related to experiences of the GSP [34]. It was not the intention to be able to extrapolate the findings of these interviews to the wider MPI community.

The Multicultural Health workers had representatives from seven communities: Cook Islands, Fijian, Fiji Indian, Māori, Samoan, Tongan and Papua New Guinean. Three other GSP staff interviewed were of non-MPI heritage as were two of the school teachers. The community stakeholders and students were of MPI heritage. Specific community groups were not recorded although it was noted they were predominantly Maori or Samoan.

Talanoa, a culturally tailored research methodology [35], was used to collect interview and focus group (FG) data. *Talanoa* encapsulates informal communication between Pacific people and can be employed for individual interview and FG discussions. *Talanoa* meaning 'talk' or 'discuss' in Samoan, Tongan, Fijian and other Pasifika nations, is a Pasifika form of dialogue that brings people together to share views [36]. 'Talanoa removes the distance between researcher and participant and provides research participants with a human face they can relate to' [37]. This level of interaction assists in the establishment of rapport and a higher level of motivation among participants. Talanoa is a process based on respect and trust, principles that, among others, underpin Pacific cultural values, beliefs and worldviews [35]. The principles of *Talanoa* align with Maori beliefs and values [38]. Participants in a *Talanoa* group are able to either challenge or legitimate another participant's story and shared information.

A participatory approach was taken, with Good Start team members being consulted to ensure a culturally tailored research design. The interview guides were developed by the Principal Investigator (LS), the interviewer (NF) and in consultation with management and health workers of the Good Start program. They were not pre-tested. The interviewer (NF), is of Pasifika heritage (Samoan/Niuean/Tongan), which as an 'inside' researcher [39]; encourages rapport building and engagement with participants, as well as having in-depth knowledge of culturally appropriate etiquette and principles [40, 41]. The interviewer has experience in facilitating/conducting FGD's and 1–1 interviews from her postgraduate research studies and associated projects [42–44], most of these with Pasifika communities. The qualitative interviews and focus groups were undertaken in English between April 2014 and November 2014.

In-Depth Interviews

In-depth interviews were conducted by the evaluation team project officer with five community stakeholders, five teachers/teacher liaisons and the five members of the GSP management team, with dedicated interview topic guides being developed for each of the three groups. All interviews were conducted in English and lasted from 15 min to 1 h and 20 min.

Focus Group Discussions

To understand interpretations of students, parents and staff involved in the GSP, a series of 18 FG discussions were conducted with the following groups: two secondary school students and four primary school students, four parents (of primary school students), two community groups and six MHW groups. The school, parent and community groups were purposefully selected as described.

Additionally, a school stakeholder analysis was conducted and involved a list of all the current participating schools at the time of interviews (April 2014 to November 2014). They were identified by the GS Multicultural Co-ordinator, Multicultural Nutritionist and MHWs, and their contact details given to the UQ Evaluation Project Officer. School stakeholders from 15 schools were invited via e-mail, phone call or in person. Five responded with an interest to participate. An even representation across the sites was attempted. School stakeholders were teachers and teacher liaison officers, dealing specifically with the Māori and Pacific Island students in the school.

The MHW groups were with each of the three Multicultural Health Worker sites (Gold Coast, Brisbane and Cairns), and repeated.

Of the 10 community stakeholders identified, 6 responded with an interest to participate. In total, five community stakeholders participated in the evaluation research. An even representation across the sites was attempted and achieved based on the number of programs delivered at the specific sites. Attendance at GSP Family Nights and other community events were opportunistic for contacts and casual conversations. This led to a more formal group interview with one family whose members regularly attended a GSP Family Night.

As part of the [primary] school student FGDs, an interactive activity was also used to facilitate student discussion of their perceptions of and experiences with the GSP. Activities were adapted from the National Evaluation of The Children's Fund 'The Evaluator's Cook Book' [45] which provided resources for participatory evaluation exercises with children and young people.

Refreshments were provided for the FGD's by the interviewer, as well as introductions that included cultural backgrounds (including by the interviewer) allowed for a relaxed environment and for common ground to be established [46]. As well as establishing common ground, ground rules agreed upon before the FGD's allowed discussions to flow.

The focus group duration was between 10 min in lower primary students and 1 h and 30 min in adults.

Transcription and Analysis

The interview and FGD audiotapes were transcribed by an external transcription service (DAATS). All transcriptions were reviewed by the interviewer prior to analysis to ensure accuracy.

Reviewed transcripts from both the interviews and FGs were imported into NVivo version 10 (QSR International) and coded iteratively: ideas were labelled and grouped into themes as patterns emerged [47]. Interrater reliability of the emerging themes was undertaken whereby all transcripts were initially reviewed independently by at least two members of the evaluation team to determine the level of concordance with the same data. The independently assessed emergent themes were discussed at team meetings. There was wide agreement with only small modifications to terminology required. The emerging themes formed the analytical framework for more in-depth analysis.

The findings from the interviews and FGs were presented to the GSP team with the identity of sites and individuals being protected for confidentiality. This consultation acted as a form of validation and enabled refinement of new knowledge [48, 49]. Queensland Government, Children's Health and Hospital service, received the final comprehensive evaluation report.

Results

The five broad themes that emerged from this evaluation of the GSP all related to components of cultural competence: (1) engaging MPI communities in health services management and policy, (2) engaging with the MPI community, (3) developing the Māori and Pacific Island health worker workforce, (4) developing culturally competent services and (5) employing a strength-based approach. We use 'respondents' to refer to people who took part in either interviews or FGs and 'participants' to refer to people who took part in the GSP.

Engaging MPI Communities in Health Services Management and Policy

While Federal government funding enabled the GSP to be established in Queensland, senior health service management had difficulty recognising the value of a community-centred model. This was reflected in the difficulty getting approval for

aspects of the program and, at a later stage, getting ongoing program funding. At the time of this study, senior health service management personnel saw the activities under the GSP as outside their responsibility, while clinical service delivery, such as community-based child health checks and immunisation, was considered legitimate health service activities of the mainstream health services. A strategy since partially revoked.

…and the organisation [Qld Health] many times said, 'Hell—why, it's not Queensland Health work, it should be done by the community. … the big challenge is also to explain to the organisation that there is a massive value of having that, and the community organisation can do things, but I think having people from the community in government organisation, I think it's a totally different value … to get the organisation to have a better understanding of not only the culture but also the socioeconomic background of people in the community. (GSP Management 1).

The GSP management team also perceived challenges, sensing a dissonance in the management approach of MPI and non-MPI team members and feeling that there needed to be more of a marriage between the mainstream and MPI frameworks.

…I think even the cultural tailoring needs to be in terms of management as well. Their way of working with a Pacific team should be a Pacific way. It should be a marriage between Pacific way and western way. At the moment I find it's still very much western, and I struggle with that, and I find it frustrating at times and annoying. (GSP Management 3).

Part of the process in establishing a culturally tailored model therefore was development of cultural awareness and cultural competency within the GSP team, as well as with mainstream Health Service providers.

At the beginning, I know we kind of struggled to try and explain things … about cultural stuff. And, I think finally [management members] learned and we've sort of learned how to tell them (Tongan MHW).

The establishment of an MPI coordinator role within the GSP management team was fundamental to improving interrelationships between the mainstream Government Health Service and the MPI team. Respondents saw this appointment as a turning point for the program.

… especially with [the MPI? coordinator] coming on board, [there was] a bit more workforce education in regards to the management. Because they're not of our [MPI]culture, it's kind of hard for them to comprehend what do we mean or why are we wanting to do that. But [the MPI coordinator] is able to explain to them and give them a little bit more understanding. (Fijian MHW).

Respondents recognised the advocacy role of the GSP in promoting MPI health considerations to government bodies who in turn acknowledged the need for a program tailored to address the needs of the MPI community in culturally appropriate ways by funding the GSP.

The MPI coordinator and MHWs believed that the lack of multicultural representation in senior Government limited their ability to influence changes at that level. This was seen to be in stark contrast to New Zealand where Government services are bicultural and bilingual (Māori; English) at all levels.

acceptance because [in NZ] there's people of that descent high up enough to make change. Whereas here, in government, as far as [the MPI coordinator] goes, she's probably one of the highest multicultural, I mean [in] Queensland Health. If we had someone where Carmel [Carmel Peteru advises government in NZ] was, she'd have a lot more pull, more support. (Samoan MHW).

The MHWs described some community tensions in implementing a program tailored toward an MPI population, while operating within a mainstream health service framework and system which was seen as disconnected from MPI communities. The MHWs explained that it was difficult to apply MPI cultural norms in their work due to requirements to adhere to mainstream policies, protocols and assessments.

The GSP staff did however recognise the need to understand the health paradigms of both the mainstream and MPI communities in order to provide a culturally tailored service.

… part of our challenge is that we just have to try and build those relationships so that the same type of rapport that we have on the ground with our own people, we can have that same rapport in the system, because then we can speak to them [the health service] about the needs of our people and hopefully they'll listen, or we can also help them understand. So, we need to build rapport with both worlds for the sake of both worlds. (GSP Management 3).

Engaging with the MPI Community

The MHWs noted that as community insiders, they did not have the cultural barriers faced by staff in many mainstream organisations (e.g. Government and schools), affording them a 'head start' to implementing the GSP. This put MHWs in a position to help their own communities.

So, what comes to mind with being a health worker is probably being able to get into places where in our position [as community members], we wouldn't be able to get into and we have more pull because we have our [mainstream] Queensland health team beside us (MHW – Brisbane FGD).

The enthusiasm of the MHWs, their personal commitment to their work and their cultural connectedness to the communities was seen as a major asset to the program both by the program management and school students alike.

I might have the knowledge to do that, but I cannot run that group. Like, … I cannot get that many Islanders in a room doing that work, … no matter how much I know or how motivating I might be, I could not get that many people there, like,

I could not do it. Whereas our guys [the MHWs] can, because they are from that community, and these are people that they know and people trust them and they see—and … all of the health promotion research says you should use multicultural health workers, workers from that community. And, watching it in practice [that] is exactly what it is. (GSP Management 2).

The family approach taken by the program was received very positively by respondents, as was the general building of community relationships. Both approaches were seen as a good fit with the MPI culture.

Family is such a big thing and that's why, I think it's quite great 'cause the Good Start Program takes that family holistic approach, so absolutely—especially 'cause for us Pacific Islanders, it's all about family. (Samoan 2 Community Stakeholder).

Regarding the work with MPI children in schools, being an MHW from the same community was seen as a particular advantage due to the more immediate connection.

And it's great, 'cause the teachers in the schools do see that, they see that straightaway connection in there, 'You have so got to stay, we need people like you in our school because this part of the group has been left out and they need to find something to connect with and you bring that.' We bring that. So they are really excited, I think it's a great way for us to showcase our cultures and our different cultures in the Good Start Program…(Fijian 2 MHW).

Key to this engagement was the trust associated with being part of the community. The ability of the MHWs to identify with the culture of GSP participants leading to a level of trust and understanding that primarily revolved around the MHWs being 'of their own kind' and therefore having a connection on a variety of levels.

Same colour skin, same framework understanding, same jokes, same humour, same everything and so we've been able to just really overcome a lot of barriers just because .. we share the same value or cultural background (Samoan MHW).

This community trust opened doors that the MHWs believed would not have been possible for non-MPI health workers in the mainstream health system.

[Trust is] a big thing with the MPI. When you trust someone they open – they'll give you their shirt off their back, and that's just how us as people—that's how we roll. (Samoan 2 MHW).

Being both part of the community and a member of a government health program was, however, not always a comfortable position for the MHWs. Challenges sometimes arose in reconciling their personal values and community relationships with their roles as a government employee. There were frequent reminders of the need to comply with the rules of the mainstream health system, as well as reminders from the community of past experiences of inequitable research relationships. For example, the MHWs sometimes felt that they were letting their communities down when program changes needed to be made after they had already agreed to something. This fed into concerns about community perceptions of having programs 'done to' them rather than 'working with' the community to develop their own solutions.

We've already said yeah, we're coming into put in a sense of [cultural tailoring into the] school curriculum and then next week 'oh sorry, we can't come back in 'cause we're all doing this or we've got something else on.' So it's more like our people are used to—and I've heard this over the many terms—our people are used to government running programs and then pulling out. So they're used to people just coming in just quickly doing something and then getting out just to get stats. (MHW – Brisbane FGD).

A number of respondents discussed the need for program sustainability. The focus from senior health service management lay in 'skilling up' the mainstream health workforce to deliver GSP, rather than embedding a culturally competent program and workforce within the mainstream health service. Funding challenges were linked to the short-term nature of the GSP; respondents felt that lack of funding challenged the program's sustainability.

…hopefully we can work ourselves into maybe getting some more funding and actually make a proper sustainable plan for the future with our community and the members and the leaders and whoever else. (Samoan 2).

Some participants related sustainability to the trust that had been built between the GSP and MPI communities.

If there's a possibility of it not going forward next year after we've invested so much into it, and not just us, our community have trusted us to come on board with us too (Samoan 2).

Respondents described how the GSP sessions were focused on providing a positive, safe environment in which MPI people were able to openly share about health-related experiences and concerns, and in this way, become better informed.

I think that's the problem in this community, admitting [that] they have a sickness. At the moment, people don't like to talk about it and I'm hoping that Good Start [can] make it ok for people to be open [and discuss it]. (Fijian Community Stakeholder).

From the GSP management perspective, the genuine engagement of the GSP with the MPI community was considered to be one of the most significant achievements of the program.

For me, that's one of the main achievements; …to get community people genuinely interested in having their health back on their agenda. And also, that they are coming back for the right reason. And so, they see the value. And, it's also to create something where the community see the value of using the service which, I think, again, it's something really difficult to create. (GSP Management 1).

Developing the Māori and Pacific Island Health Worker Workforce

In 2011, the development of the MPI multicultural workforce in Queensland was unique to the GSP. Members of the GSP management team discussed challenges in MPI workforce development, particularly the wide disparity in educational level, knowledge and experience relating to nutrition and physical activity. However, members of the GSP management team also acknowledged the enormous expertise, benefits and value that MHWs had brought to Queensland Health and discussed their future contributions to this and other related work.

... one of the big challenges of the Good Start [Program] is also that I think we started with a team with massive differences in terms of education background, in terms of knowledge on nutrition, physical activity, in terms of capacity to learn, in terms of computer skills, so it has been quite [a] big challenge to get everybody to a certain level. ...the team now (...) are really confident in what they are doing. (GSP Management 1).

Defining the fundamental skill set for a MHW required an iterative process. While the initial chief criteria were for health workers to be of Māori or Pacific Island descent, it became apparent that other criteria were necessary. In particular, MHWs needed to be interested in the subject area as well as wanting to work with the community, being strong facilitators and having skills in basic IT and administration.

We need Pacific for Pacific but we need to have skill sets… there's a certain criteria that's important because just getting the job because you're PI and not having the necessary skills or capacity to get those skills can be problematic for the project as well, but I think defining what skills as well as Pacific Islander as well as networks, yeah, it's important for a really good team. (Māori MHW).

There was a perceived need to incorporate the 'Pacific Way' in developing the leadership skills and other future aspirations of the MHWs.

So, I think to have an effective community model, it also starts internally within the way that the, in that Pacific way it would be ... things that really help build their leadership, ... help encourage them, ...bringing [together] other Pacific health role models or leaders that are doing amazing work. (GSP Management 3).

Religious practices and spirituality was perceived as essential for the successful tailoring of services to MPI communities. Whilst incorporating religious aspects into the GSP activities was considered by the MHWs to be culturally appropriate, this attitude was not necessarily shared by those working within the mainstream health service who felt that the program needed to be both non-political and non-religious. This belief from mainstream health workers may explain in part the dissonance in the management approach from the non-MPI team members discussed earlier.

Given that spirituality is an integral component of health in Māori and Pacific communities, for example in the *Te Whare Tapa Whā* (Māori) [21] and *Fonofale* (Samoan) models of health [20], the disconnect between health and religion was one of the reasons given as to why the MPI community believed that mainstream health workers were not able to adequately engage with the community and were less successful in influencing health behaviours.

I remember [a MHW] had a problem. [Management] didn't understand why she did a karakia[1] *at the beginning of everything. So, she actually approached me and said,* "*Look, [management] said,* "*we're not a Christian [service], we're an apolitical and areligious, so you can't be doing the prayer*". *And I said, well, did you explain to him what a karakia was? Because in Māori, karakia is not necessarily Christian based.* (Māori Community Stakeholder).

Developing Culturally Competent Services

The MHWs tailored the program's health information, making it culturally appropriate, making it both comprehensible and acceptable by the MPI communities. For example, the GSP nutritionists ensured that professional development presentations and resources were culturally appropriate, as in the case of taro leaf [50], a cultural adaptation of the Healthy Eating Pyramid [51]. Respondents discussed the need for an intimate knowledge of MPI communities in order to tailor the program to be culturally appropriate.

...that whole cultural tailoring is the fact that someone from that community has intimate knowledge about the ways of that community; the dietary practices, the spiritual practices, the way we parent, the way we decide [how] we cook food and shop. So, if someone knows that intimately, then they can take that information and then take the stuff that Queensland Health is giving them, put it together and then deliver it in such a way that makes complete sense. (Fiji Indian MHW).

The use of the relevant MPI language was seen as an important component of cultural competence.

When they ran the nutrition education part, the kids would listen and they used language that was familiar with them and they could understand. So, the thing is, a non-Pasifika, [non] Māori person can deliver the program but I'm not sure how effective that would be. (European School Teacher).

An overwhelming strength of the GSP from the perspective of the participating school students, stakeholders and staff was the MHWs themselves. This related

[1] Karakia are *prayers* or *incantations*. They are generally used to ensure a favourable outcome to important events and undertakings such as tangihanga (*the ritual of farewell to our deceased*), hui (*meetings*), unveilings etc.; however, they can cover every aspect of life. http://maori.otago.ac.nz/reo-tikanga-treaty/te-reo/karakia

specifically to their ability to connect with the students and the community as a whole in culturally appropriate ways, their implementation and facilitation skills and their role modelling.

The school students discussed how they enjoyed the program content as a result of the MHWs' culturally relevant facilitation skills, in particular their open, friendly and informal approach which they saw as supportive and fun.

They're really friendly; like they help, they are always supporting you, telling you what to do, like always there and encouraging you. (GSP High School Student 2).

The community stakeholders noted how barriers disappeared as a consequence of having MHWs deliver the program. They explained that they respected the MHWs and saw them as empowering the community to take charge of their own health.

...the Good Start program is an opportunity for us to go "hey, we're the best ones at dealing with our own". And, this is how we can—this is why and these are the results when you match people with their people. (Māori Community Stakeholder).

Employing a Strength-Based Approach

Respondents discussed the participatory approach during Professional Development sessions for the MHWs, where the assets and strengths of MPI team members were acknowledged and utilised.

A strength-based approach was taken whereby the positive assets of the MPI community were embraced and a deliberate effort was made to distance the program from the negative stereotypes of the community.

…you have to provide a positive and a safe environment for our people to be able to tell [their] stories and not feel condemned, 'cause often, the media hammers our people so badly. It only focuses on the negative, and there's so many more positive things that outweigh that, and then people start to feel like they can't talk about things or they feel isolated, and that's something they get into more trouble with. (Samoan 1 Community Stakeholder).

The 'no shame' and 'no mocking' ground rules within the GSP also contributed to building confidence in young MPI people and equipping them to engage beyond their MPI peers and community.

...they're ...ground rules, like 'no mocking', 'no shame'; these [mocking and shame] are all crippling things in our culture. The mocking keeps our people sheltered, the shame keeps our people sheltered [secluded], and so, we'll deliberately put that in the program setting just for the session, but we've seen an impact on that resulting in their results [academic performance] at school. (Tongan MHW).

This environment, together with the informal discussion approach to delivering information during the GSP cooking sessions, helped families instigate dietary changes.

The wider benefits experienced by those participating in the GSP included building cross-cultural relations within school and community groups, for example MPI and Indigenous (Aboriginal and Torres Strait Islander) students. Participants also felt that the GSP has provided motivation and support on a number of levels. People felt motivated by the MHWs' personal achievements in making positive changes for their own health—'walking the talk'—and being positive role models (champions), as well as by other members within the GSP. This provided motivation for ongoing attendance at activities, demonstrating the importance of community champions.

The school (student and adult) participants in particular talked about their increased self-esteem and confidence due to the GSP, partly through interacting with peers with whom they otherwise would never have engaged. Both students and adult participants shared that they enjoyed the cultural aspects of the program such as the incorporation of hip hop and cultural dance and role plays using cultural dance, singing, chanting and acting.

I learnt so much from Good Start, like, being around people, meeting people and not being ashamed of myself. And now, I'm like outgoing, out there and laughing out there, and it's all from the Good Start. (GSP High School Student 2).

In summary, the views expressed were predominantly from respondents from MPI backgrounds; however, across the themes identified, the views of all participants reinforced the importance of culturally appropriate programs and recognised the contribution of the MHWs to the program's perceived success. The challenges in understanding restrictions of the mainstream health service framework were noted by GSP management as well as by the MHWs who indicated the need for the mainstream health service to be flexible in incorporating culturally appropriate components if a program was to be embraced. Table 1 provides a summary of the emergent themes and key findings.

Discussion

Looking firstly at the broad, organisational context of the mainstream health service, whilst the GSP evaluation suggested significant areas of success in the development and implementation of the program, there were also substantial obstacles in doing so and ultimately in ensuring long-term sustainability of the program. The views of the participating students, stakeholders and GSP staff were that the GSP team had been able to successfully develop a multicultural health worker workforce, together with culturally tailored programs, resources and training materials using a strength-based

Table 1 Emergent themes and key findings from the evaluation of the GSP

Theme	Key findings
Engaging MPI communities in health services management and policy	• Senior health service management had difficulty recognising the value of a community-centred model.
	• Some dissonance in the management approach of MPI and non-MPI team members
	• Marriage between mainstream and MPI frameworks required
	• Cultural awareness and competency required for non-MPI staff
	• Advocacy role of GSP in promoting MPI health considerations to government
Engaging with the MPI community	• MHWs did not have the cultural barriers faced by staff in many mainstream organisations.
	• Cultural connectedness of MHWs seen as a significant asset
	• Trust of the MHWs key component of engagement with the MPI community
	• Some conflict for the MHWs reconciling their personal values and community relationships with their roles as a government employee
	• Program sustainability seen differently by senior management and the MPI workforce and stakeholders
	• GSP provided a safe environment for the MPI participants.
Developing the Māori and Pacific Island health worker workforce	• The wide disparity in educational level, knowledge and experience relating to nutrition and physical activity was initially challenging.
	• Defining the fundamental skill set for an MHW required an iterative process.
	• Religious practices and spirituality was perceived as essential for the successful tailoring of services to MPI communities.
Developing culturally competent services	• Respondents discussed the need for an intimate knowledge of MPI communities in order to tailor the program to be culturally appropriate.
	• The use of the relevant MPI language was seen as an important component of cultural competence.
	• The MHWs were seen as an overwhelming strength of the GSP.
Employing a strength-based approach	• A strength-based approach was taken whereby the positive assets of the MPI community were embraced and a deliberate effort was made to distance the program from the negative stereotypes of the community.
	• The ‘no shame’ and ‘no mocking’ ground rules within the GSP also contributed to building confidence in young MPI people.
	• The school (student and adult) participants in particular talked about their increased self-esteem and confidence due to the GSP.

approach. The MHWs in particular noted that there were significant health service and policy barriers that impeded their progress. A key obstacle was the struggle for legitimacy within the health service, their program being seen by senior management as misplaced and more suited to delivery by community organisations rather than MHWs working within a mainstream service. This reflected an organisational strategy, since partially revoked, to out-source community-based health promotion activities to the non-government sector, or to focus on the provision of training and resources to other government sectors (e.g. Education Qld) to replace direct service delivery. Significant effort was required by the MHWs to determine how to communicate upwards within the mainstream government health service. This increasing communication between MHWs and mainstream service providers was attributed to the appointment of a multicultural coordinator to the management team, with greater interaction/dialogue in the interface between the mainstream and MPI frameworks.

Opportunities for views of the MHW team to be communicated upwards to senior management within the broader health service were limited and were seen as inadequate. The lack of multicultural representation in the senior level of Government was perceived to be a serious limitation to their ability to communicate and influence changes at that level.

Some respondents contrasted this perceived lack of cultural representation in senior government with the more equable cultural representation in NZ health services, which they saw as culturally competent.

At the implementation level of the GSP, a key action area of the program was community and stakeholder engagement in order to improve the health outcomes in MPI communities. The current evaluation has found that the ability and success of the GSP in reaching into the community, including hard-to-access members, was primarily a consequence of having a dedicated MPI multicultural workforce and the assets they bring to the program. The MPI team played a vital role in engaging the community, communicating information, cultural tailoring of services and supporting the development of community-based solutions to address the high burden of obesity-related chronic disease. Capturing the different levels of social, emotional and cultural awareness of students at primary and high school levels is an example of the complexity of the GSP catering to the range of needs and understandings of their participants. The GSP's effectiveness in changing participating students' health-related knowledge and some attitudes and practices has previously been reported [32]. There was a real sense that the success of the program was due in part to the cultural connectedness of the MHWs and being able to relate personally to the struggles of the MPI community. A further key to this engagement was the trust associated with being part of the community, enabling community access that may not have been possible within the mainstream system.

The holistic nature of the GSP which encompassed spiritual concepts of health and wellbeing in the community was also considered a significant strength of the program. It encapsulated shared holistic health paradigms that include physical, spiritual, mental and social wellbeing [20, 52, 53]. Given that spirituality is considered an integral component of health in Māori and Pacific communities, the GSP approach was seen as a good fit with the target MPI community. The disconnect between health and spirituality was another reason given as to why respondents believed that mainstream health workers would not be able to effectively engage with the community to the same extent as MHWs.

Furthermore, as the family is the most basic social unit for Pacific families, with children being enmeshed in wider family groups [54], the family approach taken by the program was received very positively by the stakeholders, as was the general building of community relationships.

The use of culturally tailored resources such as the 'taro leaf' [50] also aided the implementation of the GSP. However, this excellent tool would not have been effective on its own, with the content alone not being considered the most important aspect of the GSP, but rather the culturally centred communication skills brought by the MHWs when facilitating the program. It was not a matter of changing the mainstream health messages for MPI community, rather the method of delivery. Delivery of culturally tailored content within a mainstream service considered to be unlikely to achieve the same level of engagement or success. It was an almost unanimous voice that having the program delivered by the MPI MHWs, and being culturally specific, was essential to its appeal and success. Employment of MPI MHWs being seen as critical to the success of health promotion, and health care delivery, in MPI communities by the participants.

The need for positive and supportive environments to enable the MPI community to celebrate their culture and discuss their issues was seen as paramount. The no shame approach, a strong determinant of behaviour in Pacific communities [54–56], proved a safe environment for engagement with the program. MPI participants emphasised the need to be away from negative cultural stereotypes and judgement and felt this could only be achieved with health workers from within the MPI community. For Samoan [56], Tongan [55] and other Pacific societies, the avoidance of shame is a powerful determinant of behaviour [54]; therefore, the no shame and no mocking ground rules set by the MHWs were vital for the school student engagement in particular.

The strong collaboration between the MPI multicultural health workers in the GSP and stakeholders within the community, community groups and schools helped to achieve the wide reach of the program within a relatively short period of time; approximately 30 months. The significant support and advocacy from within the GSP management team as the program developed enabled the implementation of a culturally tailored approach.

Overall, the qualitative data strongly suggests that the GSP was effective in engaging community members and changing attitudes to and knowledge of health. These changes have the potential to increase the ability of MPI communities to make positive nutrition and physical activity behavioural changes in ways not previously available. The culturally tailored program responded to the important cultural variables within the MPI community [31] and has provided a structure within which the community has been able to negotiate the meaning of health, together with the capacity to actively engage and make positive lifestyle choices that are sustainable because their relevance is clear. This approach has been found to contribute to the success and sustainability of programs [31, 57]. Additionally, as recommended from other obesity-related interventions in minority ethnic communities [58, 59], the MPI staff have implemented a strength-based approach, celebrating the culture of the community and building on the assets available within the community, rather than focusing on cultural influences seen as 'barriers' to overcome. They have also been able to provide the bridge between the mainstream framework and the 'Pacific way', enabling the community to increase their mainstream health literacy and engage with the health service in ways not previously possible.

To further progress positive changes in health and wellbeing within these MPI communities, the contribution of the political processes which shape access to resources, including those for promoting health, also need to be addressed [29]. This includes mapping local policies and how they interact with Māori and Pasifika health and wellbeing, further identifying priorities to improve access to health care for Māori and Pasifika and investigating how context (e.g. the physical environment, access to social, economic and cultural capital) interacts with processes of migration to influence health outcomes for Māori and Pasifika young people living in Logan city.

A key question remains about the sort of system changes required for this health service, and others, to become culturally competent services. Cultural-competence requires a health service that moves past tokenism and short-term program funding models that see programs such as GSP 'helicoptered in' followed by a lengthy period of uncertainty regarding ongoing funding. Mainstream policy continues to treat communities such as MPI as a 'special case', cultural differences being seen as an anomaly by health services. Instead, there is the need for programs like GSP to be embedded as an ongoing component of an integrated health service, which is sensitive to the cultural differences in MPI communities. Embedding requires the establishment of structures and processes to support culturally appropriate health programs, including evidence-informed decision-making practice [60] for the development of policies that reflect the needs of community members and long-term funding for programs that are culturally relevant. It also requires the active promotion of an organisational culture that values and acts on the contributions of MPI at all levels of the health system.

Conclusion

The GSP was a federal- and state-funded initiative, in response to a Health Needs Assessment, to address the health and wellbeing of MPI communities, children and their families in Queensland. The program included the recruitment and training of MHWs and the inclusion of an MPI coordinator as part of the program management team. Qualitative evaluation of the GSP suggests that culturally tailored programs delivered by MHWs have the potential to impact positively on behavioural changes that improve health and are sustainable because participants understand the cultural relevance of the interventions. Given that these findings are supported by studies from other countries, it is critical that culturally appropriate initiatives are embedded in health care systems that support multicultural communities. Embedding includes the development of policies, a culturally competent workforce and long-term funding to support culturally competent initiatives.

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Compliance with Ethical Standards

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Ethical Approval and Informed Consent Informed consent was obtained from all individual participants included in the study. Additional informed consent was obtained from all individual participants for whom potentially identifying information is included in this article.

Three ethics committees approved the evaluation of the GSP: Queensland Health (ref: HREC/13/QRCH/150), the University of Queensland (ref: 201,400,196) and Education Queensland (ref: 550/27/1439).

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