

Culturally and linguistically diverse peoples' knowledge of accessibility and utilisation of health services: exploring the need for improvement in health service delivery

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Abstract. With 28% of Australia's population having a culturally and linguistically diverse (CALD) background, the health system faces an increasing challenge to provide accessible and culturally competent health care. The view that all CALD communities are homogenous and solutions can be developed for the entire nation is detrimental. Despite available health services, CALD communities are reluctant to use them due to cultural differences, perceived racism and misunderstandings leading to the existing health disparities. Therefore, gathering data from four prominent CALD communities, such as the Sudanese, Afghani, Pacific Islander and Burmese communities in Logan, Queensland, about how they perceive and use health services can provide insightful information towards development of a service model that will better suit these CALD communities. The objective of the study was to examine the extent to which four prominent CALD communities (Sudanese, Afghani, Pacific Islander and Burmese) access and use health services in Logan, Queensland. Six focus group interviews using interpreters were conducted in English with Sudanese, Afghani, Pacific Islander and Burmese people. The results indicated that even long-standing CALD communities, such as the Pacific Islander people, were unfamiliar with health services and experienced difficulties accessing appropriate health care. Most wanted doctors to use traditional healing methods alongside orthodox medicine, but did not feel respected for their beliefs. Language difficulties impeded communication with health professionals who were hindered by ineffective use of interpreters. In conclusion, a clear role for bilingual community-based navigators was identified by CALD participants to address concerns about the health system, and to improve accessibility and health service usage.

Additional keywords: community-based navigators, culturally appropriate health service delivery, culture, ethnicity, focus groups.

Introduction

Australia has one of the most diverse migrant populations in the world, with over 3.5 million people living in Australia who were born overseas (ABS 1996). Logan, Queensland, has a total population of 173 272 people, with 25.3% of these residents born overseas (ABS 1996). Over 12% of its residents speak a language other than English and there are a sizeable number of refugees who have fled their own country due to political reasons.

The Australian health system faces significant challenges in providing accessible, culturally competent care to this growing population (Manderson and Allotey 2003). Strategies that reduce the language, cultural, social and financial barriers to health services for culturally and linguistically diverse (CALD) consumers are crucial to improving their health status. Despite numerous multicultural programs designed to address many of these barriers, CALD groups remain reluctant to engage with the health system, further increasing their health disparities (Manderson and Allotey 2003).

Utilisation rates of health and preventative services have revealed that CALD communities underutilise health services (Jenkins *et al.* 1996). A longitudinal study conducted by Kelaher *et al.* (1999) confirmed that lack of English proficiency acted as a barrier to health service usage. Kleinman *et al.* (1978) hypothesised that this underutilisation and lack of compliance with instructions could be due to a lack of congruence between explanatory models of disease. Thus, it is important to conduct qualitative research into CALD consumer's health beliefs, expectations, knowledge and health system experiences, as it may provide us with insights into these subtle differences.

Health, health care, disease and treatment are understood and experienced differently in different cultures. Refugees are a vulnerable group who have experienced pre-migration and post-migration stressors that impact on their health and wellbeing. This impact varies depending on their circumstances. Therefore, research in each culture is vital to realise the problems they face when managing their health and accessing services.

Some qualitative research have revealed that the traditional health and healing practices of Asian/Pacific Islanders conflicted with Western biomedical health care practices and, thus, acted as barriers to health care access. (Mayeno and Hirota 1994) A United Kingdom study (Watt *et al.* 1993) of the health care experience and health behaviour of Chinese immigrants found that the underutilisation and sometimes inappropriate use of health services was due to language/communication difficulties faced by many of the Chinese participants.

There is literature to support the view that attitudes, perspectives, health beliefs and health seeking behaviour are shaped by ones' ethnicity and culture. (Bates and Edwards 1992; Bates *et al.* 1995; Berger 1998; Payer 1998; Walker *et al.* 2005) Our study, thus, aimed to explore the perspectives of CALD people on health and illness, health services, accessibility and perceived barriers in order to obtain insights into possible solutions for low health service usage in these communities. This knowledge can translate into a better model of health service delivery and better health outcomes for CALD communities.

Methodology

Focus group interviews are useful when engaging people who historically have had limited power and influence, such as ethnic minorities and CALD communities with lower literacy skills. (Bloor *et al.* 2001; Culley *et al.* 2007; Halcomb *et al.* 2007) We conducted six focus group interviews, with the help of credited interpreters, to ascertain the perceptions and attitudes of four CALD communities with regards to access to health services and their usage. (Bloor *et al.* 2001; Walker *et al.* 2005; Culley *et al.* 2007) Further, the focus groups facilitated the production of rich data that was cumulative and elaborative. (Halcomb *et al.* 2007) With the help of interpreters, we were able to ensure structure and direction to the discussions during the interview. This allowed us to elicit participants' different points of view so that we were able to get a clear picture of how each of these CALD participants thought and talked about their health in their everyday language.

Recruitment of participants

Participants were recruited from four prominent CALD communities living in Logan, Queensland. These were Sudanese, Afghani, Pacific Islander and Burmese people. These communities were selected following consultation and advice from the CEOs of two non-Government organisations (Multi-Link Community Services Inc. and Access Services Inc.) that predominantly serviced CALD communities in Logan. Following ethics approval (HSV02/07HREC), the sample was accessed through the local Multicultural Health Coordinator, who organised a meeting with the four CALD communities. With the use of accredited interpreters (people who are bilingual and who had completed formal training in interpreting), the purpose, objectives and data collection procedures were explained. Participants were asked to sign a written consent form with the help of the interpreter when they agreed to participate. The focus groups were run with six to eight participants in each group (a total of 42). Separate focus groups for males and females had to be held for the Sudanese and Afghani people due to cultural reasons. Each group was gender balanced, with average ages ranging from

28 to 60 years. Interpreters were used for all groups except for the Pacific Islander group who could speak English. The interviews were conducted in local community settings and were taped with the permission of participants.

Data collection and analysis

The researchers developed the focus group questions following consultation with ethno-specific health workers in the two non-government organisations and CALD community leaders (as identified by the Coordinator of Multicultural Health in Logan). We did this to ensure cultural relevancy in the way we framed the focus group questions, whilst at the same time obtaining the required information. Pre-prepared questions were asked about how participants came to be aware of health services, their pattern of accessibility and usage of such services, their perceived satisfaction with services they had used, their experience with interactions with service providers and/or health professionals, and their view about how services could be improved. All participants were asked the same questions.

Each of the six focus group interviews lasted about an hour. The researcher asked the questions through the credited interpreter who elicited the responses from the participants. One of the problems we encountered was that because the researcher was asking the questions using the interpreter, there were some translational problems during the focus group interviews. We found that at times the interpreters varied in their translation of our pre-prepared questions, leading to an uneven quality of the data across the six focus groups. According to Walker *et al.* (2005), working across various cultural groups can be fraught with problems such as ours, as concepts do not always have semantic or linguistic equivalence across languages or cultures. Participants' responses were recorded in English only due to cost and time constraints. The researchers acknowledge, however, that it would have been useful to have recorded the data in English and in the participants' own language, as reported by Knodel (1995), to overcome issues with translation following transcription. At the end of the interview, key points were repeated to the participants to check consensus.

The data was transcribed and content analysis was performed. This facilitated analysis of the data in the context of participants' attitudes on their awareness of health services, their pattern of accessibility and usage, their experience with interactions with service providers and/or health professionals, and their view about how services could be improved.

Results

Results revealed three common themes that ran through all four CALD communities. These were (1) unfamiliarity with health services and difficulty accessing them; (2) the need for doctors to accept traditional healing methods alongside orthodox medicine; and (3) language problems impeding effective communication with health professionals, highlighting the need for more effective use of interpreters. Although these themes emerged within each of the four CALD communities, they were experienced differently by each group, which was not surprising. All four CALD groups expressed the need for a bilingual community-based navigator to enhance their health service accessibility and usage.

Theme 1: Unfamiliarity with health services and access difficulties

Sudanese focus group

The Sudanese reported having reasonable knowledge about health services, as this information was provided when they first arrived in Australia. They described knowing how to call an ambulance and how to get to their GP or the hospital. They were aware of the process of how to access a specialist. Consequently, the Sudanese participants' views of the Australian health system were generally positive. They stated that health services were efficient and the doctors were well trained and friendly. However, most in the group highlighted some differences between the Sudanese and Australian health system. For example, they were concerned about the amount of blood that was taken for a blood test (three drops on a slide in Sudan as opposed to three or four vials in Australia). There was an expectation that a visit to a doctor would involve an injection, such as they experienced in Sudan (e.g. antibiotics and malaria injections). There was a sense among the group that if an injection was not given, then the GP had not satisfactorily dealt with their health issue. Thus, all Sudanese participants described the need for more information during their medical consultations so they understood what was happening. One Sudanese participant expressed his need for further information to the interpreter:

I worry why so much blood is taken . . . I worry they will sell the blood like in Sudan . . . people buy blood there. We don't understand what will happen when we go to see the doctor . . . we need information, we worry . . .

Afghani focus group

All the Afghani participants expressed a lack of knowledge of health services available to them, as highlighted by this discussion relayed via an interpreter:

We don't know where everything is [health services] . . . nobody knows. Sometimes it is word-of-mouth . . . also, we need to go with a male or with our teenage children who will miss school and we feel bad . . .

However, even when the Afghani participants (most of whom were refugees) understood health services to some extent, another barrier was that they often forgot their appointment times. Clearly, appointment times had little significance for this group of refugees as indicated by this statement made via an interpreter:

If we make an appointment, we always forget. We have to be reminded all the time!

Access to health services was especially difficult for the older Afghani participants. The children of these older Afghani participants had to accompany them to attend appointments with the doctor. This need arose from their view that they did not know where to go or how to get there and would not be able to interpret the discussions with the doctor. The consequence was that their children often had to miss school, which distressed them even further.

If I wanted to go to the doctor, my daughter has to cancel her day from school and then take me . . .

If the children were not able to miss school on that day, the Afghani women simply missed their appointments and, sometimes, had to go back on long waiting lists. This situation was problematic if their condition necessitated timely access to health services. As one Afghani participant reported via the interpreter:

And if my daughter didn't go with me, I would miss it [doctor's appointment]. Six months ago they made the appointment for me and then I'd have to wait another 6 months . . . this is not good for me . . .

Pacific Islander focus group

Participants reported a lack of knowledge about health services. They reported being unfamiliar with the health system, which led to difficulties in accessing appropriate health services. For example, this Pacific Islander participant commented:

Most people don't know of health services available to them . . . Unless you've been to the doctor and they tell you . . . the only time you are going to know where anything is, otherwise you're going to have to research yourself or ask somebody . . . you are in the dark.

In the focus group, participants reported mixed views on their experiences with health services. Some found their interactions with doctors to be positive, particularly when the doctors were from a similar cultural background to them.

When I came to Australia, it was only by word-of-mouth that I knew there was a doctor that was a New Zealander. I went to that doctor. My experience was good, because I expected what I'd expect from a New Zealander doctor and I got it.

Some, however, reported that their encounter with a health professional was not always positive in that there was little or no conversation between them during the interaction. This comment depicts this view.

Knowledge about health . . . I don't think we know enough about it . . . a few of us has diabetes . . . we eat a lot of taro [type of yam] . . . it's fattening. We don't know where to go to get help when we are sick or go for exercise for free . . . nobody tells us. The doctor does not even look at you sometimes . . . they are busy looking at the computer and just write a script.

Burmese focus group

The participants in the Burmese group reported that they did not have enough information about available health services. However, they were much more informed than the other groups about when to go to the GP, and when and how to call an ambulance. The interpreter reported on a discussion amongst the Burmese participants:

Yes, if they are sick – if their child is sick – they go to see normal doctor. They go to the hospital for emergency. When they arrive, the office [immigration] teach them when the emergency happen, they can call triple zero, but not [for] normal sickness.

The Burmese community, on arrival to the country, tended to be educated about how to access health services. However, community members expressed concern about whether or not new immigrants were able to take in this information, because so much was delivered in the early stages of their settlement. One Burmese participant explained this situation through an interpreter:

Maybe they can explain [the health system] to us, but when we just arrived we've got so many things to do so we got overloaded – we couldn't remember. That happened to us, because we just start with, you know, zero condition, and so we start learning, but straight away we've got so many information.

Theme 2: the need for doctors to accept traditional healing methods alongside orthodox medicine

Participants in all four CALD groups reported that when a family member was sick, they first tried to apply traditional medicines from their country. If this did not work, they would seek a doctor, but this was as a last resort, particularly due to the expense. All four communities wanted doctors to recognise and consider their traditional healing methods.

Sudanese focus group

The participants in the Sudanese focus group reported that their health beliefs, cultural values and traditional health treatments were often overlooked by Australian health professionals. Health professionals were usually not willing to integrate traditional natural medicine with their treatments, but were also unwilling to recognise and respect traditional beliefs, often responding in negative ways to the participants. The Sudanese participants believed that if doctors used their knowledge of a client's culturally-specific health beliefs, values and alternative treatments to facilitate the medical consultation, this would inspire higher levels of trust in the Australian medical system. For example, one participant explained through an interpreter:

In Africa, they use herbs and roots as medicine and they think they get better. The other day, this lady went to the doctor for sickness and said she wanted some herbal medicine for her and she says the doctor just wrote a script and told her to go to the chemist. This upset her and she does not wish to go to this doctor again.

These behaviours resulted in the belief that the doctor was not caring and did not listen attentively. Medications prescribed by the doctor were sometimes perceived to be ineffective. An interpreter explained a discussion amongst the Sudanese participants:

They say the doctors should listen to them about their traditional remedies . . . not just ignore and give them Western medicine . . . some medicine the doctor gives does not work so they prefer to use natural remedies with Western medicine. They say some doctors are good and will listen to them with interpreter.

Afghani focus group

In the focus group, the Afghani participants stated a preference for traditional healers to be used alongside Australian doctors. They recognised that their resistance to using Australian health services impacted negatively on their health. For instance, some of the older participants indicated that when they were in pain, they self-medicated rather than going to a general practitioner. However, they acknowledged that this often did not work. They attributed their reluctance to the belief that the medication they would be prescribed would not work. Further, they did not wish to risk being admitted to hospital, because they would be separated from their family and would miss their own cultural food.

Our people we meet with resistance. My husband was very, very sick, so we tried home remedy first. He was rolling around, holding his chest, couldn't breathe. I'm ringing the ambulance and he's going 'no, no, no', and he's worried about whether the hospital medicine will help. But I rang an ambulance, as he needed to see the doctor . . .

All participants agreed that if a family member was seriously unwell, they would not try to fix it themselves, but would immediately seek a doctor or call an ambulance.

Pacific Islander focus group

Often the Pacific Islanders resorted to singing and dancing when they felt sick, as they believed that such activities would restore their health. They wanted health professionals to appreciate this belief. For example:

We have singing or cultural dancing in the community to get well. Sometimes people laugh [health professionals] when we tell them.

Burmese focus group

In the Burmese community, when talking about the process of managing health issues, participants expressed a preference for utilising traditional natural medicines first, particularly in response to simple colds and fevers, as highlighted by this comment through the interpreter:

We use wild rice and wild water – we use some kinds of leaves – we put it in hot water and drink the liquid. Normally, for colds and fevers, we use the natural products, but here, we have to depend on Western medicine. Some doctors don't go for that [traditional medicine].

Theme 3: Language problems impeding effective communication with health professionals, highlighting the need for more effective use of interpreters

Participants in three of the cultural groups (except the Pacific Islander group) discussed communication problems during health appointments, predominantly due to language barriers. For the Sudanese, Afghani and Burmese participants, an interpreter was necessary to facilitate communication with a health professional. As for the Pacific Island people, even though they could speak English, they reported they often experienced communication

problems, because they did not understand the medical terminology.

Sudanese focus group

The Sudanese reported that telephone interpreters were often used in GP clinics, but they perceived this process to be unsatisfactory. For example, participants explained that the consultation took longer and there was no attempt to establish any rapport between them and the interpreter (or even an introduction). They had to talk to a different interpreter every time they visited the GP, which hindered the development of an optimal health relationship. The interpreter for the Sudanese participants explained:

They say the doctor will ring the interpreter and the interpreter will talk with them and then the doctor talks with the interpreter, different interpreters every time . . . it is a three-way telephone conversation, which is not that useful . . . They prefer a face-to-face interpreter.

When we get there, we don't have no interpreter . . . we can speak, but we don't know how to say all the details – so this is the main barrier for us.

Afghani focus group

The Afghani participants explained through the interpreter the importance of community-based interpreters who understood the local community and could maintain a degree of consistency over time. Access to personal assistance from someone of the same cultural background was seen as the most important and appropriate solution to the communication difficulties experienced in their community. The current approach to interpreters (i.e. impersonal, inconsistent and telephone-based) was seen as a significant barrier to using medical services that actually exacerbated communication difficulties. The interpreter speaking for the participants stated:

They say they want somebody from their own culture who can speak the English to go with them to see the doctor . . . maybe someone they can trust and who can ask the questions for them with the doctor . . . this way no need to take their school children with them to see the doctor.

Burmese focus group

The Burmese highlighted the need for an interpreter from the same culture to be available to support their GP and hospital visits, but also to follow up on levels of comprehension. As the interpreter explained:

Yeah, they said they like their own interpreter to take to the hospital or to the doctor, that way more easy for them and the doctor.

Having information about health and social services published in other languages was considered to be important, but did not replace the personal assistance of an interpreter. Participants expressed more enthusiasm about having access to information videos or interactive media. This type of resource was also viewed as a long-term language improvement tool.

If in Burmese language that way we find the video with Burmese language – and so, straight away we can learn and remember. If we see the pamphlet, which are all Burmese language with the contact number and address, we know what is happening, so we can go to that.

Bilingual community-based navigators

There was strong support among all four CALD groups for a bilingual community member who could work with CALD communities and support them to navigate the health system. Participants expressed the view that the navigator should live and work in their community. They stated that such a resource would greatly improve their knowledge and access to health services in their local community. One young Afghani woman summed up this view.

So if we got the opportunity for our family, like for my mum, for example, but not only my mum but for all ladies, I think it is much better for us if there is someone there that can help, to take them to the doctor and care about everything and make it better.

They also considered that this person could act as an advocate for health in their community, providing support to access health appointments:

It is a very good idea. Because then there'll be communication between this person and our people. They will know if they are sick and they are able to talk to this person and get information . . . People will feel comfortable knowing that there are their people that we can go and ask.

All participants stated that any person who adopted this navigator role should have a satisfactory personal background, a good attitude, be knowledgeable, be able to be trained in how the health system worked, be bilingual, be culturally aware and be able to build relationships in the community.

I'd like to know his [community member assigned to support the community] personal background and attitude . . . and for him to know more of our cultural background . . . someone that would be willing to learn and provide information . . . You've got to have the heart to want to help other people, but you're also giving them the knowledge by giving them the training, so they have to be able to build relationships . . . A person with an open mind and knows what the community wants. This person helps between our people and the health people . . . they are the 'go between' if you like . . .

All participants also supported the need for both male and female workers within their communities to promote men's and women's health respectively. The Pacific Islander participants believed that the workers could be affiliated with a cultural health centre where bilingual doctors were also employed. The Pacific Islanders maintained that a cultural health centre should be free and could provide a range of services and information, such as immunisation, women's health, exercise and cooking classes, as highlighted by this comment:

That is what would be really great, like a cultural community centre, like with different doctors . . . we can all

go to and there's a doctor there, health promoters, and all that . . . If we do have a centre and have once a week for our people, for someone to do exercise and it's free of charge, and I'm sure all of them will come.

Discussion

The themes highlight the profound ways in which cultural differences influenced the experience of health service usage in four CALD communities and their willingness to utilise these services as supported by Mayeno and Hirota (1994) and Watt *et al.* (1993). Even long-term residents from the more established Pacific Islander community expressed greater levels of comfort when accessing doctors from a similar cultural background. For refugees, such as the Sudanese, who were exposed to intensive information on arrival to Australia, the information provided raised their awareness about how to use health services, but not about fundamental cultural differences between the Australian health system and that of their countries of origin. Specific cultural differences, such as different orientations to time (as with the Afghani people), different expectations (as with the Burmese people) and fear about different practices in their own country (as with the Sudanese people), were shown to influence the experiences of the participants. This concurs with Manderson and Allotey (2003) and Kleinman *et al.* (1978), whose research showed that cultural differences impact on the way people conceptualise and manage their ill health and in the manner in which they engage in health seeking behaviour.

The theme of using traditional healing methods alongside Western medicine was consistent across all four groups, irrespective of time in Australia, demonstrating the importance of health professionals working collaboratively with cultural beliefs and practices rather than rejecting these notions. When participants experienced rejection, they were left with little or no confidence in the services and were less likely to access health care, as shown with the Sudanese group in our research. Similarly, Smith (Smith 1999) argued that social institutions that deal with CALD people must provide health services that are culturally safe. Culturally safe services have been defined as those where there is no assault on a person's identity caused by the fact that service delivery methods or processes are alien to the person's culture (Ramsden 1990). It has been argued that equity as a concept cannot deliver inclusion for culturally diverse people, as it promotes 'sameness' (Eckerman *et al.* 1992), a notion that automatically favours the dominant culture. To provide culturally safe services, it is necessary to embrace the 'difference' created by culture, and be willing to understand and accept all aspects of that culture (Morgan *et al.* 1997), while still acknowledging that communities and individuals will differ enormously (Ariotti 1999; Maher 1999).

With respect to one's health beliefs, the trust people place in a service will also be affected by the extent to which it is based in their local community and driven by the needs of that local area (Morgan *et al.* 1997). People are generally wary of anyone who speaks on their behalf, especially when they do not come from the local community. This was evident in our research when interpreters were used via telephone in three of the four CALD communities. Clearly, participants viewed this interpreter arrangement to be less than satisfactory. Participants voiced the

opinion that they preferred to take a bilingual person whom they knew and trusted and who was from their own community to interpret for them in person. From this, it can be inferred that access to personal assistance from someone of the same cultural background was seen as an important and appropriate solution to the communication difficulties experienced by these communities.

Participants in this study strongly supported the need for the navigators to be selected by the community and to be local people of good standing in the community. They would form a bridge between the community and the health system, but remain based in the community sector, thus creating a link. Evidence suggests that this community-based 'navigator' or 'natural helper' approach can gain entry into marginalised CALD communities in a more efficient manner than any other type of health worker (Bishop *et al.* 2002). It is likely that their modes of operating will be more culturally appropriate and they will therefore be able to promote healthy behaviour change more effectively (Eng and Smith 1995). In terms of its ability to produce health outcomes, a systematic review (Lewin *et al.* 2007) recently identified sufficient evidence to conclude that the natural helper or navigator approach may promote greater uptake of prevention strategies, such as immunisation, screening and health monitoring. Most importantly, this approach has been found to build capacity and strengthen existing community systems for the longer term (Brach and Fraser 2000).

Conclusion

Our research explored the pattern of accessibility and utilisation of health services in Sudanese, Afghani, Pacific Islander and Burmese communities in Logan, Queensland. Three themes emerged, culminating in the suggestion by participants that a bilingual, community-based, navigator service should be developed in their communities. It was envisaged by participants that these navigators would be able to respond appropriately, supporting people to navigate the health system, educating health professionals and building the capacity for future health promotion within the community. By virtue of their increased presence, service providers would become more aware of cultural issues and processes. We believe that these proposed outcomes need to be the focus of future research in the Logan area. One of the major limitations of the findings was the use of only four CALD groups (Brach and Fraser 2000). Furthermore, the problems with translation of data with ethno-specific interpreters had resulted in unevenness in the quality of the data collected. Nevertheless our findings do provide some insight into why access and usage of health services may be problematic for other similar CALD communities. Future research, using other CALD communities, need to be conducted to improve access and usage of health services for all of these communities. As Brach and Fraser (2000) reported, only culturally competent health systems can translate into better health outcomes via the impact they have on (1) improved communication, (2) increased trust in the health system, (3) greater knowledge about services, and (4) expanded cultural understanding within the health system.

Conflicts of interest

None declared.

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