

CONSULTATIONS REPORT

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Acronyms

ABS Australian Bureau of Statistics

BCE Bilingual Community Educator

CESPHN Central and Eastern Primary Health Network

CGHiC Can Get Health in Canterbury

HERDU Health Equity and Research Development Unit

LGA Local Government Area

SACC School as community centre

SLHD Sydney Local Health District

STARTTS Service for the Treatment and Rehabilitation of Torture and Trauma Survivors

UNSW University of New South Wales

# Note to readers

This report is for CGHiC stakeholder use and not for wider distribution without permission from the authors.

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# Report Purpose

This report documents the methods and findings of consultations undertaken as part of the Can Get Health in Canterbury project (CGHIC). A brief analysis of the consultation data is represented by way of three tables and two diagrams in the results section, followed by a discussion for future considerations. The appendices include details the consultations as a separate document.

# Background to Can Get Health in Canterbury

The Canterbury Local Government Area (LGA) lies on land belonging to the Wangal and Bediagal (also spelt Bidjigal) people of the Eora nation, and is one of the LGAs within the portfolio of the Sydney Local Health District (SLHD) and the Central and Eastern Primary Health Network (CESPHN). Research positions the Canterbury LGA as the most socioeconomically disadvantaged area (lowest 20%) in the SLHD (SLHD and CESPHN, 2015). The population is culturally and linguistically diverse with 67.1% of people in the Canterbury LGA speak a language other than English at home, compared to 22.5% for the state (ABS, 2011). Of these, 16.6% reported poor English proficiency (ABS, 2011). CGHiC was established as part of the SLHD and Central and Eastern Sydney Primary Health Network (CESPHN) response to this, which aims to address health inequity in Canterbury by doing the following:

* Strengthen the capacity of the comprehensive primary health care system in Canterbury LGA.
* Contribute to reducing risks of inequity in health in the population of Canterbury by providing equitable access to high quality health care and contributing to strengthening social and physical environments that protect and promote health.

CGHIC was built upon a collaborative foundation with existing services, organisations and communities in Canterbury. This foundation was informed by a 6-month needs assessment phase to identify priority locations, population groups and health issues. This basis enables CGHIC to deliver a unique response to addressing health inequities in the Canterbury area, by supporting, strengthening and shaping a world class, person-centred primary health care system in Canterbury.

The 2014-2016 CGHiC priorities were developed through use of local census and health data, consultations (which are the focus of this report) and a decision-making process enacted through the CGHIC governance structures:

* Priority health conditions: 1) mental health, 2) vascular diseases that include renal, diabetes and cardio-vascular diseases, and 3) the behavioural risk factors associated with these (smoking, nutrition, alcohol use and levels of physical activity).
* Four priority population groups: 1) Arabic, 2) Chinese, 3) Bangladeshi, and 4) Rohingyan. Children were also identified as a priority area based on consultations and health data.
* Geographical priorities: Campsie, Lakemba and Wiley Park, which were selected based on having the highest socioeconomic disadvantage.

# Consultation Methods

CGHIC consultations took place between January and June 2014, with an additional phase of consultations undertaken in 2015 with Rohingyan people in Canterbury, through a UNSW medical student Independent Learning Project (ILP) supervised by the Health Equity and Research Development Unit (HERDU). Appendix 1 provides details of people and agencies that appear to have been consulted.

Aside from the ILP project, consultation methods listed below have been determined through review of consultation notes available through CESPHN documents, with details available in appendices where possible. Given this process, it is possible that the list of methods may be inaccurate or that some methods utilized omitted if no records of them were made. The content of the consultation notes included in the appendices is unedited.

* Invitation letter to participate in CGHIC consultations, sent by Tracey Wills in 2014 (Appendix 2), also translated into a Chinese language.
* Surveys, including translation into a Chinese language (See Appendix 3). Details of distribution and analysis were not recorded. Four survey responses were located on the CESPHN drive; some were in a Chinese language, others in English. English responses are outlined in Appendix 3.2.
* Focus group/s with GPs; details regarding these focus groups are undocumented, beyond a summary of GP responses. Appendix 4 contains a list of questions for GP Focus Groups.
* GP survey (Appendix 5); methods and details of administration and analysis not documented.
* Questions for “emerging leaders” (Appendix 6). Details undocumented regarding to whom, how, where etc these questions were asked although it is possible these were administered with Rohingyan people (see Appendix 7 for summary of consultation with “Rohingyan community leaders” and Rohingya groups in Appendices 8-9).
* The World Café method also appears to have been used for a women’s consultation but no details were documented. Notes suggest the World Café method was coordinated by Canterbury City Council, Women’s Initiative Network and Arab Australian Council (see Appendix 10 below).
* It also appears that numerous meetings and phone calls were made to complete consultations with health professionals and community organisation representatives. The CGHIC Annual Report 2014 provided by CESPHN indicates that these three questions were used to guide consultations:

1. What do you see as a barrier to accessing health services (and other relevant services) in your area?
2. What are your views on health (for community members)?
3. What are the main themes you come across in your work (for professionals)?

* In 2015, Ned Mereweather completed an Independent Learning Project (ILP) that aimed to identify key issues for Rohingyan people in accessing preventative and standard healthcare in the Canterbury area. Findings are available in his reports (Mereweather, 2015a, 2015b). His consultation methods included:
  + Consultation with agencies that support Rohingyan refugees and asylum seekers;
  + Consultation with Rohingya clients and case workers;
  + Observation functioning in the Canterbury Emergency Department;
  + Review of reports pertaining to asylum seekers and the health system.

# Analysis

The consultation notes were analysed according to thematic analysis, which involved two general steps: 1) review individual consultation notes to make sense of content for each note; and 2) review the consultation notes together to consider what is being said by those consulted as a group (Braun & Clark, 2006). A process of ongoing analysis ensured that themes could be refined (Liamputtong, 2009a, 2009b), with a mapping process according to two frameworks to represent the findings according to “service needs” and “health needs”[[1]](#footnote-1). Firstly, Levesque, Harris & Russell’s (2013) framework provided structure for analysis regarding to service needs, based upon their five dimensions of accessibility (approachability; acceptability; availability and accommodation; affordability; appropriateness) and five dimensions of abilities (ability to perceive; ability to seek; ability to reach; ability to pay; ability to engage). The second framework was the conceptual framework developed by the Commission on Social Determinants of Health (CSDH) (adapted from Solar & Irwin, 2007), which suggests interventions – such as those that the CGHiC partners work on together – could aim at taking action on (CSDH, 2008: 42):

* The circumstances of daily life:
  + differential exposures to disease-causing influences in early life, the social and physical environments, and work, associated with social stratification. Depending on the nature of these influences, different groups will have different experiences of material conditions, psychosocial support, and behavioural options, which make them more or less vulnerable to poor health;
  + health-care responses to health promotion, disease prevention, and treatment of illness;
* And the structural drivers:
  + the nature and degree of social stratification in society – the magnitude of inequity along the dimensions listed;
  + biases, norms, and values within society;
  + global and national economic and social policy;
  + processes of governance at the global, national, and local level.

While the consultations were focused upon the health and service needs of populations, many of those consulted made suggestions for ways to respond and improve the issues raised. During analysis, such suggestions were recorded alongside the issue or need with which it was raised. An inductive thematic analysis resulted in these solutions and strategies being grouped together as documented in Section 6.

# Consultation findings

The tables below provide a summary of issues raised, as well as an outline of CGHIC response/s to these issues and/or opportunity for CGHIC to respond. Documents on the CESPHN directory indicate that consultations were focused upon four language groups (English, Arabic, Chinese [language undocumented] and Bangladeshi) in three suburbs in Canterbury (Campsie, Lakemba and Wiley Park), reflecting a decision by the CGHIC Advisory Committee regarding priorities. This decision influenced the focus of consultations. The affected populations may have been self-identified, or identified by the health professionals and community organisations combined with health and demographic data.

## Service needs

Service needs in terms accessibility of services are summarized in Table 1. Service needs according to peoples’ ability to interact with services are summarized in Table 2. Figure 1 (below) provides a visual representation of service needs according to the Levesque et al (2013) framework.

Table : Service needs according to accessibility.

|  |  |
| --- | --- |
| **What is the problem?** | **Who does it affect?** |
| ***Approachability (Transparency; Outreach; Information; Screening)*** | |
| Language barriers: difficulty in engaging parents, not enough interpreters | Rohingya, Chinese  Children, Bangladeshi  Arabic |
| ***Acceptability (Professional values, norms, culture, gender)*** | |
| No female representatives and/or professionals available. | Arabic, Rohingya, Women, Families |
| Incorrect interpreters provided (resulting in poor communication and bills charged to Medicare patients) | Rohingya |
| ***Availability and accommodation (Geographic location; Accommodation; Hours of opening; Appointments mechanisms)*** | |
| Long waiting times (paediatricians, speech pathologist, GDM, GPs, ED) | Families, Women |
| Dental health: Lack of affordable dental care; long waiting lists | Rohingya, Arabic |
| Lack of support for newly arrived resident/refugee (also creates burden on families) | Bangladeshi, Rohingya, Arabic, Families |
| ***Affordability (Direct costs; Indirect costs; Opportunity costs)*** | |
| Cost of accessing health services e.g. specialists | Women, Chinese,  Arabic |
| Lack of affordable and culturally appropriate preventative health services | Children, women, Chinese, Bangladeshi,  Arabic |
| Lack of safe, accessible environments to be healthy and active in | Women, Chinese,  Bangladeshi |
| ***Appropriateness (Technical and interpersonal quality; Adequacy; Coordination and continuity)*** | |
| Health professional communication (e.g. “not caring”  Language barriers: incorrect interpreters provided, incorrect bills charged to patients, difficulty in engaging parents, not enough interpreters | Rohingya, Chinese  Children, Bangladeshi  Arabic |
| GP lack of knowledge of referral pathways for free/bulk billing services, tests, bilingual workers, etc. | Rohingya / Refugee,  Arabic |
| Dissatisfaction with GPs, low ownership of GPs of their patients  (Note: Many were satisfied with their GPs) | Bangladeshi, Women |
| Low follow up attendance for child health | Bangladeshi |
| Poor health service identification of/response to delayed child development (especially GPs) | Children |
| Limited child developmental and screening advice provided to parents (especially by GPs)  Suspected high level of autism in children | Children, Chinese,  Bangladeshi |

Table : Service needs according to ability to access

|  |  |
| --- | --- |
| **What is the problem?** | **Who does it affect?** |
| ***Ability to perceive (Health literacy; Health beliefs; Trust and expectations)*** | |
| Health service navigation – lack of knowledge of how availability of and how to use health services; “too early” and “too late” paediatric presentations at ED | Rohingya,  Children/  Families |
| Mistrust of government and institutions (including health authorities) | Rohingya |
| Disability and associated stigma/fear of losing children if seeking help | Children/ General |
| ***Ability to seek (Personal and social values, culture, gender, autonomy)*** | |
| Reports of some mothers presenting at ED with sick child only once husband home. | Arabic, Rohingya, Women, Families |
| Cost and lack of support services e.g. child care, extra-curricular activities, empowerment, stress management | Children (school-aged), Women, Arabic |
| ***Ability to reach (Living environments; Transport; Mobility; Social support)*** | |
| Reports of some mothers presenting at ED with sick child only once husband home. | Arabic, Rohingya, Women, Families |
| Transportation to health services (particularly for sicker patients e.g. renal) | Women, People with a disability |
| Housing: High rent, Loss of social connections shifting for cheaper rent. | Families, Chinese |
| ***Ability to pay (Income; Assets; Social capital; Health insurance)*** | |
| Cost of accessing health services e.g. specialists | Women, Chinese,  Arabic |
| ***Ability to engage (Empowerment; Information; Adherence; Caregiver support)*** | |
| Limited health knowledge and education; desire to learn health information. | Rohingya, Chinese, Women, Arabic |
| Urban rental accommodation does not support positive parenting and child development | Children, Bangladeshi |

## Health Needs

Table 3 contains the health needs identified according to the CSDH conceptual framework. This framework is particularly relevant to the spirit of CGHIC, given its emphasis upon going beyond the immediate causes of disease to the ‘causes of the causes’; that is, the social, economic and political environments in which we live. Figure 2 provides a visual representation of the identified health needs.

Table : Health needs

|  |  |
| --- | --- |
| **What is the problem?** | **Who does it affect?** |
| ***Material circumstances*** | |
| Lack of safe, clean, affordable, accessible environments to be healthy and active in (e.g. playgrounds for children, safe running paths, community sport groups, recreation facilities) | Women, Chinese,  Bangladeshi |
| Transportation – to health services and in general | Women, People with a disability |
| Urban rental accommodation does not support positive parenting and child development | Children, Bangladeshi |
| Housing: High rent, Loss of social connections shifting for cheaper rent. | Families, Chinese |
| ***Social cohesion*** | |
| Support as newly arrived resident/refugee | Bangladeshi, Rohingya, Arabic, Families |
| Stigma and/or fear of losing children due to disability | Children/ General |
| Social isolation | Rohingya/ refugees,  Chinese, Women,  Bangladeshi |
| ***Psychosocial factors*** | |
| Mental health issues from: Stigma; stress from domestic violence; stress from lack of family safety in country of origin; pressure to provide financially for family; anxiety and depression when a new arrival. | Rohingya  Women  Chinese, Bangladeshi, Arabic |
| ***Behaviours*** | |
| Tobacco use | Arabic |
| Nutrition and obesity/weight management | Children, Bangladeshi, Arabic, People with a disability |
| Gambling | Chinese |
| Delayed child development: Speech issues; autism | Children, Bangladeshi |
| ***Biological factors*** | |
| Poor general health | Rohingya |
| Women’s health | Rohingya |
| Diabetes, Gestational diabetes | Bangladeshi |
| Vitamin D deficiency | Arabic, mothers |
| Oral health | Rohingya, Arabic |
| ***Social position*** | |
| Domestic violence (related to mental health support) | Rohingya, Chinese,  Arabic |
| “Self-determination” – want to learn to advocate on own behalf | Arabic |
| No family in Australia - causes stress and difficulty in parenting | Women, Bangladeshi, Rohingya |
| ***Education*** | |
| Limited health knowledge and education; desire to learn health information. | Rohingya, Chinese, Women, Arabic |
| Need knowledge about positive parenting | Bangladeshi |
| Child development: Delayed child readiness for school; tutoring and homework support required. | Children  Chinese |
| Language – limited English skills and/or illiterate.  Home duties prevent their access to English classes. | Rohingya, Chinese,  Bangladeshi, Arabic,  Women |
| Limited if any school education; illiterate. | Rohingya |
| ***Occupation*** | |
| Lack of qualifications and/or recognition of qualifications by Australia | Rohingya, Women |
| Unemployment | Chinese, Rohingya men, Women |
| ***Income*** | |
| Lack of income leads to a range of mental health problems in not being able to provide for the family. | Chinese |
| Lack of financial resources prevents access to some health services due to affordability. | Arabic, Rohingya |
| Lack of income prevents access to transport. |  |
| ***Gender*** | |
| Women not allowed to answer the door when husband not home/unaccompanied | Women, Arabic, Bangladeshi |
| Role of women restricts mothers taking children to ED until husband home in evening | Mothers |
| ***Ethnicity/Race*** | |
| Racism and discrimination – in general community and in health services | Newly arrived people, asylum seekers/refugees |
| ***Policy (macroeconomic, social, health)*** | |
| Australian Government health policies created stress and anxiety for many groups (e.g. co-payments) | Chinese, Arabic |
| Sudden departure to offshore detention (makes access to local services and building relationships difficult) | Rohingya |
| ***Cultural and societal norms and values*** | |
| Avoid exercising in front of men | Women |
| ***Health care system*** | |
| *Reference to service needs diagram* |  |



Figure : Service needs identified through the CGHiC consultations 2014.

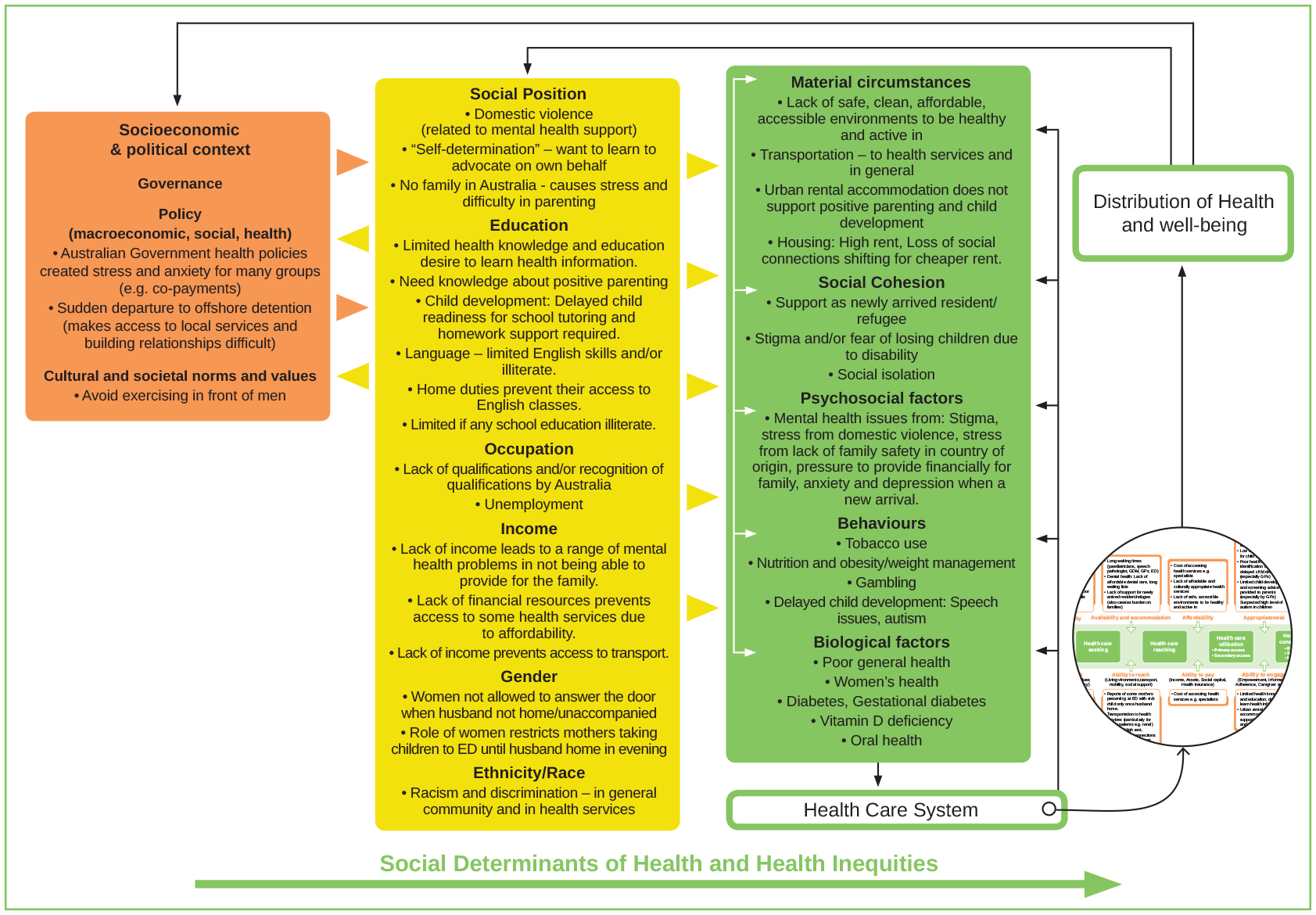


Figure : Health needs identified through the CGHiC consultations 2014.

# Possible ways forward

Whilst the consultations did not explicitly seek to generate knowledge about solutions (the focus of consultations was upon health issues and needs), some suggestions were made. To honour those contributions, the suggested solutions are outlined below and grouped by theme. It is recommended that CGHiC stakeholders consider and discuss these solutions as part of its 2-year planning phase currently underway, as part of ensuring CGHiC meets the needs of the communities it serves. Note that there is not necessarily consensus that the strategies below are suitable for progressing, in part because the relevance of some strategies for 2014 does not apply in 2016.

## Strengthen the cultural safety[[2]](#footnote-2) of health care services and institutions

* Canterbury Hospital staff to participate in training and support regarding:
  + Cultural awareness and cultural competence, such as the training provided by NSW Refugee Health Services or the National Centre for Cultural Competence.
  + Appropriate use of translators, including how to communicate with patient when using.
  + Self-reflexivity including understanding of the mainstream culture including biases, assumptions and worldviews that the majority of health workers bring.
* Engage community leaders and community groups intended to benefit from programs in design and delivery of those programs, including representation on CGHIC governance structures.
* Provide health professionals with training and information regarding alternative cultural views regarding disability.
* Health services could “employ bilingual staff” (especially female) including BCEs.

## Develop partnerships for supporting healthy environments

* Establish partnership with Canterbury-Bankstown Council to address environmental, safety and waste concerns: link to Council Environmental Management Plan, particularly in relation to strategies regarding health and safety, and community waste management.
* Identify beautification projects to link to, e.g. “The Clean Up Riverwood project”.
* Identify community garden initiatives to link to and support.
* Work with City of Canterbury Environmental Management Plan 2012-17: strategy to Develop and encourage an accessible transport network that caters for the needs of pedestrians, cyclists, public transport and motor vehicle users. Consider whether Canterbury-Bankstown Council will develop a new plan.
* Extend community education component of Kids Don’t Fly in partnership with rental agents/strata managers.
* Build partnerships to improve housing design, planning/design guidelines, local area planning in the longer term.
* Develop links with Sydney Alliance advocacy for affordable housing.
* Develop a link to the NSW Multicultural Problem Gambling Service.

## Support locally-run, safe, affordable, accessible healthy lifestyle activities

* Support establishment of women’s walking groups, women-only gym classes – ideally free.
* Support GPs to refer to nutrition and healthy lifestyle initiatives relevant to the CGHiC population groups and areas.
  + Develop a directory or similar of information for GPs regarding Arabic community and health prevention programs.
  + Publicise the CESPHN mapping document of healthy lifestyle GP referral programs on the CGHIC website and distribute through newsletter.
* Identify physical activity options for school-aged children and support access by CGHiC priority groups.
* Advocate for equipment in parks that can be used in poor weather conditions including rain or hot sun.
* Partner with schools to make healthy lunch/food options available for children.
* Identify and promote physical activity options for school-aged children.
* Deliver nutrition information in relation to traditional cooking and foods using local produce.
* Train community members in Eat Well and Tell and pay to deliver to others.

## Create partnerships to support community mobility and transportation

* Partner with Canterbury Council
  + Link to Canterbury Council Bike Shed (free bike, education on bike maintenance).
  + Support cycling as a transport strategy.
* Support women to obtain a drivers license (who want one).

## Deliver health information in partnership with communities

* Utilise BCE program to support new communities and arrivals, online and offline.
  + Embed parent education in BCE positions to work with other parents about child development.
  + Provide information regarding stress management and empowerment.
  + Provide information regarding micro businesses and other courses.
  + Deliver additional women’s health education courses.
  + Deliver additional oral health care education courses for Rohingya communities.
  + Provide diabetes management information.
  + Provide health relationships and healthy parenting information, with sensitivity to domestic violence.
  + Establish a mechanism in BCE program to identify and respond to community priorities. The Community Navigator role in CGHiC (Feroza Yasmin) is an example of how this might be achieved.
* Provide child-care for community education and events.
* Work with NSW Resourcing Parents Website to ensure resources available in other languages.
* Provide women’s health service information in CASS weekly column in local Chinese newspaper.
* Identify Arabic and Rohingya speaking people to be trained as facilitators of FICT program by STARTTS, and as BCEs for the new SLHD BCE program.
* Explore delivery of DV/mental health workshops for men, who are depressed.
* Utilise radio for delivery of health messages for Arabic community.
* Provide information and support to Rohingyans to access health services.

## Promote mental health of CGHIC priority groups

* Continue roll-out of mental health first aid training.
* Support establishment of playgroup for women with mental health issues.
* Develop and deliver community workshops regarding the benefits of treatment for the community.
* Provide links to Transcultural Mental Health counselling line.
* Draw upon bilingual mental health resources from Transcultural Mental Health where available, and partner to support cultural appropriateness of mental health activities.

## Support emerging communities, particularly refugees and asylum seekers, to access local health and other services

* Support GPs to provide appropriate health care and identify child health and development issues:
  + Deliver a refugee health CPD event: Present information to GPs of services available for referral; inform of refugee Health Pathway tool.
  + Develop GP Sheets (quarterly, bi-annually, etc) to inform GPs of local mental health, bulk billing, etc matters and updates in relation to refugees and asylum seekers.
  + Develop Canterbury mental health collaborative plan.
  + Arrange for links to Transcultural Mental Health Services GP program.
  + Work with GPs to identify barriers and solutions to identification of child development issues.
* Partner with local organisation (e.g. SACC, Good Beginnings) to deliver parent education and build parent confidence in using health services.
* Support and mentor the Canterbury Hospital health equity *Learning by Doing* group, via HERDU.
* Link with services that support newly arrived residents and refugees, to identify ways CGHiC can support access to and benefit from health services, For example:
  + Link with Canterbury libraries to provide information to library clients.
  + Strengthen the partnership with SSI (e.g. Child and Family team), STARTTS, Refugee Health Services and Multicultural Health Services.
  + Link to early childhood services for parent education regarding where and ways to access health services.
* Provide support for refugees and asylum seekers to access education.
  + Link to Metro Migrant Resource Centre delivery of STEP (homework support program [tutors]).
  + Navitas to restructure training for Rohingyan men to provide additional English hours.
  + Link with AMES to promote access free English classes for newly arrived migrants, refugees, humanitarian entrants.
  + Provide free childcare to support mothers to access English classes.
* Provide support to access employment.
  + Train community members (especially women) to deliver Eat Well and Tell, which Active Canterbury Together delivered with TAFE to provide partial qualifications to community members. Pay to deliver.
  + Identify Arabic and Rohingya speaking people to be trained as facilitators of FICT program by STARTTS.
  + Employ Chinese, Rohingya men in BCE program (amongst others).
  + Provide strategies on ways to use overseas qualifications in Australia to gain employment.

## Support the building of community groups and networks

* Support and promote community festivals and events for social interaction and connection.
* Support communities to “be more neighbourly” to new arrivals.
* Link with key stakeholders and promote relevant programs.
  + Link with STARTTS Families in Cultural Transition program.
  + Continue partnership with SACC, which has helped people to build connections.
  + Partner with 4Cs (community development) women’s program.
* Seek ways to support advocacy by Arabic community to “put pressure on politicians to see what people are really suffering from”.
* Support Tripoli Mena (if they still want this) to invite local MP to their Arabic group to discuss their health issues.
* Establish a network of Bangladeshi parents to collaborate with Bangladeshi community and health and education professionals to take action to increase the proportion of Bangladeshi children who meet developmental milestones appropriate to their age group.

# Strengths and Limitations

## Limitations

There are limitations to the study presented in this report. For example, only documents located on the CESPHN file directory were included in this analysis, which carries with it three limitations.

Firstly, in the case that additional consultation was undertaken but not documented and saved on the CESPHN directory, those consultations are unavailable for inclusion.

Secondly, the line of questioning for the consultation was not always documented or clear, which is important given that the questions asked shape the kinds of responses provided in the consultation. Further, the consultation notes are the *interpretations* of the CGHiC staff undertaking the conversations.

Finally, being subject to interpretation is a matter for all research, given that the researcher is the ‘research instrument’ (O’Reilly, 2009). No member-checking process was undertaken through this report’s development, nor did it appear to have happened when the consultations took place. This report does not argue that member-checking ensures the ‘validity’ of the data; the idea that member-checking can ensure a pure representation of a participant’s story, or truth, is flawed (Sandelowski, 1993). Rather, the “problem of speaking for others” is relevant here, as connected to representation and its potential impacts on the individuals being represented (Alcoff, 1991). As such, the appendices will not be made public beyond the CGHiC stakeholders and all attempts have been made to de-identify data incorporated into the main report.

A further limitation is that while different community and health stakeholders were consulted, various issues were raised by each of those groups which could not be considered according to voice, due to the time constraints of this analysis. This means that details of issues pertaining to particular groups have not been documented, beyond the summaries outlined in Sections 5.1 and 5.2.

## Strengths

While there are limitations to this analysis, there are strengths to conducting an analysis in the manner outlined above. Firstly, this report has shown the usefulness of the two frameworks for making sense of extensive consultation data, so that consultation can inform action. Initially, when the consultation notes were collated there were almost 70 pages of data. Lengthy amounts of text can be unwieldly and impractical for typically busy stakeholders who must understand and act upon its contents.

Secondly, the two frameworks used together enabled the analysis to look beyond health services to other processes and issues that underpin health. This broader focus is important, given that strengthening health equity requires going beyond a focus on the immediate causes of disease (CSDH, 2008).

Thirdly, the methodical process used for the analysis and interpretation means that the logic underpinning this study, including its findings, is transparent. In other words, this report reflects data transparency, analytic transparency and production transparency (Moravcsik, 2014). Transparency of all relevant research processes is important for rigour in qualitative research (Mayrick, 2006).

# Discussion and Conclusion

This report’s analysis of the 2014 CGHiC consultation data enabled the concerns, issues and ideas raised by health professionals and community groups to be made available in an accessible way to CGHiC stakeholders and decision-makers. Doing so is important for preventing consultations as being tokenistic (Arnstein, 1969) and instead move towards community-informed action[[3]](#footnote-3). More specifically, the use of the two frameworks for this analysis (Levesque et al., 2013; CSDH, 2008) enabled the communication of the service and health needs of the four community groups to a wider range of decision-makers in the SLHD and CESPHN, making effective use of the CGHiC consultations and reducing the need to conduct further consultation before action had been taken in the short term.

The analysis demonstrated a sound understanding of access issues across both individual and organisational factors as well as across the SDOH framework. This suggests that when asked about health issues people see this as more than access to health services but also as involving action across the social and economic environmental factors. Some of the potential changes required will take time, but action that builds on the consultation in a way that expands people’s choices to improve their future development is key to achieving health equity (Rifkin, 2003).

This report has provided an overview of the methods undertaken and findings from the consultation that informed the establishment of CGHiC in 2014. An analysis of these findings according to service needs and health needs, according to two relevant frameworks, enabled the communication of those findings. The consultations identified a number of possible strategies for CGHiC to consider going forward, recorded above for the purposes of consideration and discussion amongst CGHiC stakeholders. This report therefore serves the purpose of documenting the 2014 consultation phase of CGHiC, and analysis of those findings presented in a manner that will support CGHiC to meet the needs of the communities with which it works.

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1. The mapping according to “health needs” and “service needs” was in part in response to the CESPHN planning process requirements. [↑](#footnote-ref-1)
2. This report acknowledges the multiplicity of terms regarding the reflexivity required to work across cultures including cultural competency, cultural awareness, cultural empathy, cultural humility, cultural respect, cultural safety, cultural security and so on. While each term has its strengths and limitations, this report uses the concept of cultural safety in recognition of its interrogation of power relations and racism, including its requirement that cultural safety is judged by the recipient of a service (not the provider) (Taylor & Guerin, 2013). The suggested solutions are a step towards the direction of cultural safety. [↑](#footnote-ref-2)
3. This report acknowledges that the terminology of community-informed can mean different things to different people, including that ‘community informed’ could imply an even lower level of participation than consultation, rather than more (Arnstein, 1969). In this report, we use this term to reflect recent conversations as part of the CGHiC review process, to reflect that CGHiC is informed by community priorities and perspectives (Ward et al., 2016). [↑](#footnote-ref-3)