

QUT Digital Repository:  
<http://eprints.qut.edu.au/>



This is the accepted version of this journal article. To be published as:

McCarthy, Alexandra and Shaban, Ramon and Stone, Cassandra  
(2010) *Fa'afaletui : a framework for the promotion of kidney health in an Australian Samoan community*. *Journal of Transcultural Nursing*.  
(In Press)

© Copyright 2010 Please consult the authors.

***Fa'afaletui: A framework for the promotion of renal health in an Australian Samoan community.***

Alexandra McCarthy RN, PhD  
Senior Lecturer, School of Nursing and Midwifery,  
Queensland University of Technology  
Building N, Room 356, Queensland University of Technology  
Victoria Park Road  
Kelvin Grove, QLD, 4059  
P: +61 7 3138 3850  
F: +61 7 3138 3814  
E: al.mccarthy@qut.edu.au

Ramon Shaban RN, M.Comm.Hlth  
Clinical Research Fellow, School of Nursing and Midwifery, Griffith University  
University Drive, Meadowbrook, QLD, 4131  
P: +61 7 3382 1271  
F: 61 7 33821277  
E: r.shaban@griffith.edu.au

Cassandra Stone RN, MNSc  
Nurse Practitioner – Nephrology Chronic Kidney Disease, Logan Hospital, QLD  
Cnr Armstrong and Loganlea Roads,  
Meadowbrook, QLD, 4131  
P: +61 7 3299 8241  
F: +61 7 3299 9123  
E: Cassandra\_stone@health.qld.gov.au

***Fa'afaletui: A framework for the promotion of renal  
health in an Australian Samoan community.***

Acknowledgements

Xxxx

xxxx

## ***Fa'afaletui: A framework for the promotion of renal health in an Australian Samoan community***

### *Introduction*

The state of Queensland, Australia, has a large Pacific Islander population, a significant component of whom are first- to third-generation Samoans (ABS, 2008). In our clinical experience, the Samoan community exhibit a disproportionate rate of kidney and related chronic conditions (such as obesity and diabetes) compared to the general population. This situation is also reported in other parts of Australia (McDonald & Russ, 2003) with large Samoan populations; as well as in New Zealand (Joshy, Dunn, Fisher, & Lawrenson, 2009; Sundhorn et al., 2008; Tomlin, Tilyard, Dawson, & Dovey, 2006) and the United States (Galanis, McGarvey, Quested, Sio, & Afele-Fa'Amuli, 1999; Pearson, 2008). This paper demonstrates how a culturally-sensitive framework, *Fa'afaletui*, guided a research project that aimed to increase our understanding of the factors contributing to these issues in one Samoan community in Queensland, Australia, and helped us to plan strategies that might ameliorate these issues.

### *Background to the study: The impact of westernisation on Samoan kidney health*

Samoa is considered one of the most conservative of the Pacific Island cultures and Samoans tend to maintain their collective cultural identity when they uproot to other countries (McDade, 2001). Nonetheless, emigration exposes even the most entrenched cultures to intense pressure to conform to other ways of living. Hence Samoan traditional legal, political, spiritual, educational and economic practices are consistently challenged upon emigration to westernised countries (McDade, 2001). Research has unearthed a range of adverse health outcomes associated with these challenges, as transplanted Samoan communities adapt to

different sociocultural and ecological environments (Ezeamama, Viali, Tuitele, & McGarvey, 2006; Levy-Storms & Wallace, 2003; McDade, Stallings, & Worthman, 2000; Pawson & Janes, 1981). In the US for example, transplanted Samoan communities have been studied for at least four decades with respect to their greatly enhanced risk of developing chronic diseases. Much of this risk is attributed to the adoption of a westernised diet, and appears to be compounded by a genetic predisposition to develop diabetes, obesity, hypertension and coronary heart disease (Ezeamama et al., 2006; Levy-Storms & Wallace, 2003; Ostbye, Welby, Prior, Salmond, & Stokes, 1989; Pawson & Janes, 1981).

The traditional Samoan diet depended on fish and taro, but also contained a high proportion of fat in the form of coconut cream (Galanis et al., 1999; Ostbye et al., 1989). In the context of a subsistence lifestyle that incorporated a significant amount of exercise to counteract this level of saturated fat, a healthy body mass index could be maintained. A large survey of modernising Samoans in Samoa, however, has revealed a profound and consistent change in traditional dietary intake that is not accompanied by an equivalent increase in exercise levels (Galanis et al., 1999). Dietary changes include increased consumption of salted, processed foods containing a greater proportion of saturated fat; processed sugar and protein; and less complex carbohydrate and fibre (Galanis et al., 1999). This significant dietary shift is also underway in emigrant Samoan communities in the US (Pawson & Janes, 1981), Australia (McDonald & Russ, 2003) and New Zealand (Joshy et al., 2009; Simmons, Clover, & Hope, 2007; Sundhorn et al., 2008; Thompson, Simmons, Collins, & Cecil, 2001; Tomlin et al., 2006). As a result, alarming rates of obesity, hypertension and metabolic disorders such as diabetes are now reported. The tragedy is that all of these chronic conditions are largely preventable.

Apart from a cultural preference for a diet high in saturated fat, this situation is exacerbated by two other factors specific to Samoan culture that so far appear to have resisted westernisation. First, in traditional Samoan society, there are no social constraints against obesity (Ostbye et al., 1989); hence there is little pressure to maintain the western beauty ideal of slimness. Second, in traditional Samoan culture there appears to be no concept of prevention in relation to illness (Levy-Storms & Wallace, 2003), or risk-reduction in relation to health (Ostbye et al., 1989). Yet kidney disease can be prevented, or its progress decelerated, by practising good nutrition, exercising regularly and participating in opportunistic blood pressure and urine screening. The literature indicates that understanding the cultural situation, and then raising awareness of these strategies through culturally-specific education resources developed in partnership with those at risk, may be an effective means to reduce the incidence and progression of kidney disease in the Samoan community (Levy-Storms & Wallace, 2003; NASC, 2005; NCMHRIWD, 2009; Stewart-Withers & O'Brien, 2006). However to the best of our knowledge, Samoan culture had not been studied in depth in Australia. There was also no Australian program targeting these issues in this rapidly growing population; nor one that aimed to harness specific Samoan community resources within the Queensland Health District in which we worked to enhance their resilience to kidney disease.

We undertook a project that aimed to understand the issues contributing to renal health and illness in one emigrant Samoan community in Queensland, Australia, guided by the Samoan philosophical and cultural framework of *Fa'afaletui*. The objectives of the project were to first, develop an understanding of the factors contributing to this situation; and second, to work with the Samoan community to

plan sustainable, culturally-appropriate resources that enable them to make informed choices with regard to their kidney health.

*Framework of the study: Fa'afaletui*

To ensure successful outcomes, cross-cultural projects should be undertaken by way of concepts indigenous to the culture in question. *Fa'afaletui* is a research framework that enables the collection, sharing and validation of all of the different levels of knowledge within the Samoan community, and the weaving of these knowledges into consensus about a given problem that reflects the Samoan worldview and is acceptable to those concerned (Tamasese, 2008).

*Fa'afaletui* acknowledges the three perspectives fundamental to Samoan decision-making (Tamasese, 2008). If there is a problem to be solved, these three perspectives must be equally considered. The first two perspectives are those of the persons at the “top of the mountain” and the persons at the “top of the tree”, who bring long- and middle distance lenses to the issue. The third perspective is that of the “persons in the canoe”, who are closest to the “school of fish” i.e. who are most affected by the problem or who understand the micro-issues informing it, but who do not necessarily have the longer view that would enable them to account for all the issues contributing to a problem (Tamasese, 2008). The application of these perspectives enables a comprehensive assessment of a problematic issue to be made by the group as a whole, and a mutually acceptable response to be formulated.

Originally developed to enhance mental health service provision in emigrant Samoan communities in New Zealand, *Fa'afaletui* is considered sensitive and responsive to Samoan cultural norms in that context, and to provide a sound basis for research into health needs and the development of health services consistent

with Samoan lifeways (Koloto & Sharma, 2005; Tamasese, 2008; Tamasese, Peteru, Waldegrave, & Bush, 2005). We used *Fa'afaletui* as an organising framework that guided participant recruitment, data collection and data analysis in the project, as well as our plans for future resource development in partnership with the Samoan community. *Fa'afaletui* helped us weave together all of the knowledge and perspectives possessed by different groups within the larger Samoan community in question, and to reach a consensus about what is known and what should be done about the problem of chronic kidney disease.

### *Samoan history and culture*

A basic understanding of Samoa's politics, culture and history is necessary to undertake research successfully in this context, as these are embedded in *Fa'afaletui*. Samoa is a small developing island nation in Pacific Polynesia. It has a resident population of approximately 217,000 (Index Mundi, 2009), whose members speak one language and whose cultural tradition is relatively consistent across the country (Stewart-Withers & O'Brien, 2006). Traditionally the land, the resources and the political power are managed on a day-to-day basis by the *fono* or the village council, which vests ultimate political authority in the village Chief. This authority filters to the *matai* (the head of the extended family) and thence to the *'aiga* (the extended family or kin group) (Stewart-Withers & O'Brien, 2006). Within *Fa'afaletui*, these village-based authority figures provide the view from the 'top of the tree', and the family or kin group the view from near the 'school of fish'. Generally, each village unit managed its own affairs, and determined the roles and status of each village member; but villages were held together collectively by an overarching Council of Chiefs to whose authority they deferred in matters of more than local importance.



The Council of Chiefs can be seen as providing the view from the 'top of the mountain'.

The collective ethos of traditional Samoan culture acknowledges the concept of 'the individual' only in the sense that each individual contributes to the group, co-operates with group, is loyal to the group, conforms to group norms, respects the group and acknowledges their own and other's status and roles with the Samoan collective (McDade, 2001; McDade et al., 2000; NASC, 2005). Community, and due acknowledgement of the status and role of each member of the community, are key to Samoan culture. Strict protocols often determine what members of the community may say, the way in which they say it, the language they use, and the situation in which it may be said. There are also gender norms that must be observed, and issues that cannot be discussed across groups without the appropriate delegations from a higher level (Tamasese et al., 2005).

In addition, communication in Samoan culture is focused upon collaborative learning, with the art of storytelling highly valued (NASC, 2005). *Fa'afaletui* emphasises the necessity of participants to tell their story orally – survey research for example is not appropriate – and to enable the family members to tell their stories about the issue at hand as well. Embedded in these stories are Samoan cultural and normative values, which encourage the listeners to think critically about the knowledge and experience the story imparts, and how this knowledge can be used (NASC, 2005).

### Research design

#### Sampling and recruitment

The eligibility criteria for this study were:

- First, second or third generation Samoan community member

- Diagnosis of pre-renal or chronic kidney disease or identifies as family member of person so diagnosed
- Able to converse in English; and
- Able to give informed consent.

After ethical approval was obtained from the health service and the university, contact was initially made with a *matai*, who had previously expressed public concern about the rate of kidney failure in the Samoan community of Logan. Importantly, the *matai* was invested with the authority to speak for the community and refer us to the appropriate cultural informants. Snowball sampling techniques yielded a final sample of sixteen individuals participating in dyad or focus group interviews.

#### Data collection techniques

In keeping with Samoan cultural norms (Tamasese, 2008), no individual interviews were undertaken. They were conducted in the setting of the participants' choice, with one undertaken in a home setting and the remainder in the hospital setting. The interviews contained four separate dyads of husband and wife, or two separate focus groups of 3 and 5 participants each, comprising the person with kidney disease and their extended family members. The interviews were semi-structured, encouraging participants to tell their stories about life in Samoa before emigration, their concepts of health and disease, their knowledge and experience of kidney disease and the westernised health system, their current lifestyle practices, and the involvement of community and family in the care of a member with kidney failure. To maintain confidentiality, in all transcriptions and field notes participants were assigned a pseudonym and are referred to by that pseudonym in this report. Permission was obtained to audiotape and transcribe the interviews and to take

extensive field notes. The interviews were conducted by AM, an experienced qualitative researcher with clinical experience in kidney disease, and CS, who is a Nurse Practitioner in chronic kidney disease. The interviews lasted between 60 and 120 minutes each. They were constructed around stem questions that explored participants' health and lifestyle beliefs and practices pre- and post-emigration; their experience of kidney disease as a patient or a family member; family social, cultural and medical history; and perceived education and intervention needs with respect to kidney disease,

### Data analysis

The interview data and field notes were transcribed and analysed as soon as possible after each interview. Intensive data analysis was undertaken individually by AM with interim review provided by CS and RS. Analysis comprised the following discrete steps:

- 1) Simultaneously listening and relistening to the interview tapes, and reading and rereading the transcripts and field notes.
- 2) Ordering the data into manageable forms by sorting them into categories consistent with concepts in *Fa'afaletui*, such as levels of authority, cultural protocols, health, language, and the collective
- 3) Refining the concepts with further reference to the transcripts and field notes.
- 4) Examining the links between concepts and levels of knowledge, and weaving them together to arrive at an interim interpretation. This resulted in a description of the range of health beliefs and health behaviours of participants, and the possible sociocultural determinants of these. Consistent with *Fa'afaletui*, until validation was undertaken by senior community members and consensus was achieved, this interpretation was not finalised (Tamasese, 2008).

### Findings

,Participants included eight people with kidney disease, and eight family members. Three of the participants were *matai*. Participants ranged in age from 19 to 74, with most in their fifties. Ten participants were first-generation Samoan emigrants and six were second-generation and Australian-born. Three of the Samoan-born participants had completed courses at post-secondary education level technical colleges. One second-generation participant was undertaking university level studies at the time of the study.

### Diet and exercise

All but one participant in this study reported dietary and exercise habits congruent with reports in the literature. That is, where it was undertaken, exercise was not strenuous. Typically it comprised a short and gentle walk with the grandchildren to school each day. Only one participant understood the need to increase heart rate during exercise to improve cardiovascular health, and the role of resistance activity such as light weights in promoting metabolism and weight loss. The diet of participants was primarily based on deep-fried corned beef, taro, fried mutton flaps, coconut cream and other sugary, fatty, salty, highly-processed items such as takeaway food. Visual assessment revealed that all but two participants (both 21 years old) carried excess bodyweight.

The exception to these dietary and exercise patterns was Levi, a 21 year old, second-generation youth worker. He had noted the impact of Samoan dietary practices on all community members and determined to do something about it by becoming a role model for his community:

Samoan diet is so bad, even me. When I am young I used to eat whatever my parents ate. Too much sugar and fat and salt. My dad was diagnosed with bad kidneys at 24. I don't want to be like him, so I lost my weight and ate better. I have lost 15 kgs and I feel better and now I tell everyone else. If our people can eat better ... they can get better and live. Our people can live longer, for our young ones.

*Fa'afaletui* emphasises that often, illness may be perceived by traditional Samoans as the result of a breach of a sacred relationship, or an act of irreverence or desecration that must be redressed through the appropriate cultural protocols (Tamasese et al., 2005). If that is indeed so, we were not skilled in eliciting any expression of that norm from our participants in relation to kidney disease. They described the renal problem to us as largely a result of the dietary impact of westernisation, perceiving it as the adoption of cheaper and more readily available high carbohydrate, low fibre, high salt western foods compounded by the continued traditional preference for taro and coconut cream. They described how it is lack of awareness of the role of diet and exercise in kidney health, rather than a conflict in beliefs about the development of disease, which appears to be contributing to this situation.

#### *The collective*

The concept of family in Samoan life appears to be relatively fluid, moving seamlessly from that of the immediate family to the wider family network, extended relations, friends, elders and unrelated Samoan community members. 'Family' appears to be based in social, rather than biological, relationships (McGrath & Edwards, 2009). Each family member expressed obligations to support and care for

other family members and each person understood their role and the function they fulfil within the family social structure. These obligations are embodied in the concept of *fa'alavelave*, where reciprocal love and concern are enacted by helping others in need (Stewart-Withers & O'Brien, 2006).

It appears that this collective philosophy, expressed as *fa'aSamoa*, has transplanted geographically to wherever first-generation Samoans have emigrated (Stewart-Withers & O'Brien, 2006). Certainly, the way that participants told their stories indicated that they saw little distinction between individual, family and community and they repeatedly emphasised the obligation that each had to the other. In our study, family members were extremely involved in caring for the person who received dialysis, always attending clinic with them, attending education sessions and helping them manage their regimen at home. Elders expressed concern for the well-being of younger members of their family, and younger community members often articulated fears for the health of their elders. One typical family organised a residency visa, modified their house and flew the matriarch of the family from New Zealand so that she could live with the family and be well-looked after. As one daughter, Mala, commented:

She means everything to us and we mean everything to her. So how could we let our kids not have their grandmother or their grandmother not have her kids?

Health is considered a collective responsibility in Samoan culture. The mutual responsibility of family members to each other emerged as a consistent theme in our data. Leona, a senior woman, described how:

[Telling these stories] will help our people. They need to be told. They don't think so but they do. They got too much salt and sugar in their eating. Both young and old people. They say the old ones are too far too gone to get better, but if they do this [eat well and exercise regularly] they can live longer.

Given the intergenerational responsibilities expressed by all participants, it is worth considering Stewart-Withers and O'Brien's (2006) argument that establishing renal health or youth support groups within discrete sections of the Samoan community may be counterproductive. This is particularly so where support groups are established without negotiating with elders and family – it may lead to divisiveness and conflict and destroy what is already culturally in place (Stewart-Withers & O'Brien, 2006). Our experience in this project mirrors the observation that to work well, programs need to be supported by kinship connections, not destroy them (Stewart-Withers & O'Brien, 2006).

The collective responsibility of family members to each other in the context of health and illness also has ethical implications. Family members, including the *matai*, may need to know the details of the individual family member's illness from health professionals (NCMHRIWD, 2009). Tamasese et al note that confidentiality in health contexts has different meanings for Samoans, who do not necessarily subscribe to the principle of individual rights in health care (Tamasese et al., 2005). Tamasese argues that Samoan people should have their rights to confidential information extended as a matter of course to their families, otherwise the support network risks being marginalised (Tamasese et al., 2005). Similarly, McGrath and Edwards argue that the western concept of informed consent may have a different meaning in Samoan culture, as consent is not necessarily invested in the individual (McGrath &

Edwards, 2009). Hence practitioners may need to consider involving nominated family members in the consent process, irrespective of whether those family members have a biological relationship with the individual.

Most health teaching in western contexts isolates the individual from both their family and from the context in which that family operates. From the Samoan perspective, this may give the education little meaning (NASC, 2005). In terms of renal health education, emphasis on the relational aspects of health should be strong, for example, teaching the whole family to eat well and to exercise together. Recent research has also found that working with Samoan families to produce pictorial biological pedigrees, which identify blood relations who have developed conditions such as diabetes and kidney failure, and which visually represent risk, may also be helpful (McGrath & Edwards, 2009). Ideally, education and support would also take place in the local community setting, where people feel a sense of belonging (Tamasese et al., 2005).

Finally, the Christian faith has played a significant part in the westernisation of most of the Pacific Islands, including Samoa (NCMHRIWD, 2009). It now seems that where village-type structures are not possible after transplantation to other countries, the Christian church may assume a pivotal role in preserving cultural norms in emigrant Samoan communities (Stewart-Withers & O'Brien, 2006). Samoan churches have been referred to as 'urban villages', which help maintain traditional Samoan cultural networks by facilitating and providing a forum for regular community gatherings (Levy-Storms & Wallace, 2003). In the course of data collection we came to understand the significant role Christianity and the church play in this context. The following quote from Mary exemplifies this:



We can take these [stories] to our people when they come to Church, when they are all together. That is the only way we can get them together and make them learn about having a better diet. We can give them these stories and they can see what they need to do. It will be good for them.

All participants discussed their ties with the church, and we now consider it integral to our continuing work with the community to integrate a partnership with the local Samoan church into our kidney health promotion activities. In this project, we have learnt that important strategies such as oral group teaching through stories, and embedding notions of health and disease in natural contexts, may be transmitted by undertaking health teaching at church groups. This approach is entirely consistent with traditional medicine in Samoan culture, which passes on health teachings orally through extended kin-network systems (Levy-Storms & Wallace, 2003).

### *Discussion*

Once the first draft of this paper was written we presented the findings and our initial interpretation to a gathering of very senior Samoan community members drawn from the local and wider area. One attendee was a figure of great authority visiting from Samoa. We were encouraged by them to continue working with the community, and many opportunities have now been made available to us to do so.

An important lesson learned in this project is the extent to which, even in a westernised setting, the Samoan collective is bound by cultural protocols that ensure harmonious group function. These protocols, known as *tapu* (NCMHRIWD, 2009), govern how individuals of different status and different relationships relate to each other (Tamasese et al., 2005). They may be expressed overtly or be embedded in

communication processes. Communication protocols emphasise respect for others. They include knowing the structure of groups and acknowledging the key people in the right order; expressing appreciation for the opportunity to meet; acknowledging past interactions; and sharing some personal information about yourself that may have some connection with the group or with the purpose of the meeting (NASC, 2005). It is only once a connection is made by observing these protocols that the purpose of the meeting should be attended to (NASC, 2005).

The ethos of mutual responsibility has several implications for renal health professionals. Even in westernised situations the nominated heads of each extended village and family are figures of the utmost importance. Any researcher or clinician operating in this context should be aware that to be successful, research and practice initiatives must be filtered through a system of community elders, that is then circulated to other layers of the community and back again up the strata, until consensus about the initiative is produced (Tamasese et al., 2005). It is also useful to understand how the *matai* is responsible for the general smooth running and wellbeing of the family. The *matai* is a figure accorded great respect, and will often play a key role in building trust and rapport between the health service and Samoan family members. These consultative processes may take some time, but it is helpful to take that time – to establish who you are, the basis of your relationship, to consult appropriately, and to hear the stories of family members – before any other tasks are undertaken, because it can have an enormously beneficial impact on subsequent interactions (NASC, 2005).

Community workers may also observe more overt expressions of *tapu*. For example upon entering a Samoan home, shoes should be removed and left at the door. Once inside, the visitor should take a seat before speaking, and understand

that it is considered insensitive to stand in the presence of other people while they are seated (NCMHRIWD, 2009; Tamasese et al., 2005). Offering or receiving hospitality in the form of food is also appropriate (NASC, 2005). For health workers new to working with the Samoan community, many cultural protocols that are useful in this context are summarised in the Pacific Cultural Competencies Framework (NASC, 2005) developed in New Zealand.

### *Language*

Language emerged as a significant issue in our study, both in the collection and analysis of data and in developing written resources for the community that were useful to them. All but two of the participants were first generation immigrants and while first-generation participants' spoken English was generally moderate to good, written English was often problematic. The second-generation participants were schooled from a young age in English and were more conversant with westernised communication media. Similarly, in other countries language problems, particularly in interactions with first-generation emigrants, remain a significant barrier to the provision of preventative and other health services to Samoans (Levy-Storms & Wallace, 2003; NCMHRIWD, 2009; Tamasese et al., 2005). Guided by *Fa'afaletui*, we are now developing a multifaceted strategy to overcome this.

The strategy recognises that westernised mass media and English-language written resources are usually not effective in encouraging older Samoans to undergo screening and other risk-reduction practices (Levy-Storms & Wallace, 2003), although they may be effective in delivering messages to second- and third-generation community members. Hence negotiations are currently taking place to enable our clinical team member to appear on the local Samoan-language radio station to talk about kidney health, and the importance of diet and exercise in

promoting it. We also hope to negotiate workshop appearances at Samoan community church gatherings to impart these messages in person. In addition, in consultation with the participants we have produced a brochure and poster, decorated with important Samoan motifs and culturally significant visual messages chosen by the participants, for distribution throughout the wider community. Written in grade 6 level English, the materials give simple advice on the health-promotion and risk-reduction practices essential for kidney health, and most importantly, give the names and contact details of local service providers. We are now in the process of translating these materials into the Samoan language, to make them even more culturally relevant. Ongoing support has been obtained to ensure the continued updating and production of these resources, which the team would like to share with other health professionals to adapt to their local Samoan contexts.

#### *Limitations of the study*

The first limitation of this study is the use of snowball sampling, which means we might not have accessed key informants with valuable stories to tell. As researchers new to this field and as non-Samoan community members, however, this technique was the only way we could gain initial entrée into the field. With the knowledge and community networks we have developed as a result of this study, more comprehensive qualitative sampling techniques can be used in the future.

The second limitation of this study is that, despite great efforts, we could not find a Samoan focus group facilitator or data analyst for the life of the study. Hence language barriers were often encountered, and the clarification and normative background provided by a Samoan speaker would have resulted in richer focus group data and analysis because of their greater understanding of Samoan cultural norms (Tamasese, 2008). To overcome this limitation, we did find an accredited

Samoan translator with whom to seek clarification on points of language and meaning, and also took our findings back to representatives of each different level of authority within the community. Our interpretations of the data were revised to reflect their perspectives and were subsequently validated by them. Nonetheless, the inclusion of a Samoan team member would have resulted in richer data and more nuanced analysis.

A third limitation is that *Fa'afaletui* was developed for the New Zealand political context, meaning that, despite its apparent utility in this study, it might not be a good fit to this or other Australian contexts. The sociodemographic profiles and political situations in Australia and New Zealand are reasonably similar, but differ in one important respect. Australia considers itself a multicultural nation – one whose health policies extend equal standing to all of the discrete cultural groups that comprise its population. Hence recent Australian policy does not privilege one group over another, they are accorded equal consideration in health service decision-making. New Zealand's official approach to other cultural groups and to health service provision is bi-partisan, based on the treaty of Waitangi. It recognises the independent sovereignty of its Maori Indigenous population, which, like the Samoan population, is of Pasifika. Although some have argued that the protection of Pacific Ocean-origin minorities against the “tyranny of the majority” is still not well-developed in New Zealand policy (Palmer, 2005), in practice New Zealand probably has a better understanding of the needs of its Samoan citizens and has more experience and willingness to implement culturally-appropriate health services for them than Australia. This is exemplified by the Pacific Cultural Competencies Framework (NASC, 2005) (NCMHRIWD, 2009) that informs health service provision in that country, and which has no equivalent in Australia. This argument is further supported

by reports of successful Samoan health initiatives in the areas of mental health (Bush, Chapman, Drummond, & Fagaloa, 2009; Masoe & Bush, 2009).

Hence, while our experience of *Fa'afaletui* in this Australian context appeared to be a good fit for this exploratory study, wider political system issues may render the framework void in this context in the future. The region in which we undertook the study is experiencing rapid population growth. This population is exceptionally culturally diverse, relatively socioeconomically-disadvantaged and exhibiting extremely high rates of renal and other chronic diseases in all cultural groups (ABS, 2008). In short, services do their best to address the health needs of each cultural group equitably and appropriately, but they are stretched and likely to become more so. This has implications for the development or enhancement of services specifically for the Samoan group in this region, when other groups have similarly specialised needs and equal rights to health service provision.

#### *Conclusion and implications for further research*

*Fa'afaletui* provided a useful framework for this study and enabled us to develop a novice understanding of the complexities of the problems we explored. Our engagement with the Samoan community has inspired us to learn more, and to continue working with them. The most important lesson learned was the potential benefit of taking the message to the community in a form that is relevant for them. The usual expectation is that messages are best communicated 'in the clinic'. Using *Fa'afaletui* to guide data collection, data analysis and the production of resource materials and strategies, we now know that the message about promoting kidney health will be more effective if it is disseminated where the community are, in a language and a context they understand.

The implications of this study are threefold. First, we need to establish collaborations with Samoan champions who will partner with us in developing and implementing interventions to help reduce the development and the burden of kidney disease. Second, we need to establish collaborations with other researchers more experienced in the Samoan health context, who can help us develop a research framework based on *Fa'afaletui* that is a good fit with the Australian situation. Third, we then need to scope cost-effective, culturally-relevant strategies that translate well into the Australian health and political context and enable the Samoan community to assume greater control of their health and well-being.

References

- ABS. (2008). 2006 Census of Population and Housing (Publication. Retrieved 27 July, 2008, from Australian Bureau of Statistics [ABS]: <http://www.abs.gov.au/>
- Bush, A., Chapman, F., Drummond, M., & Fagaloa, T. (2009). Development of a child, adolescent and family mental health service for Pacific young people in Aotearoa/New Zealand. *Pacific Health Dialog*, 15(1), 139-146.
- Ezeamama, A. E., Viali, S., Tuitele, J., & McGarvey, S. T. (2006). The influence of economic factors on cardiovascular disease risk factors in the context of economic development in the Samoan archipelago. *Social Science and Medicine*, 63, 2533-2545.
- Galanis, D. J., McGarvey, S. T., Quested, C., Sio, B., & Afele-Fa'Amuli, S. (1999). Dietary intake of modernising Samoans: Implications for risk of cardiovascular disease. *Journal of the American Dietetics Association*, 99(2), 184-190.
- Index Mundi. (2009). Samoa Population: <http://www.indexmundi.com/samoa/population.html>.
- Joshy, G., Dunn, P., Fisher, M., & Lawrenson, R. (2009). Ethnic differences in the natural progression of nephropathy among diabetes patients in New Zealand: Hospital admission rates for renal complications, and incidence of end-stage renal disease and renal death [Electronic Version]. *Diabetologia*.
- Koloto, A. H., & Sharma, S. (2005). The needs of Pacific women when they are victims of family violence. *Social Policy Journal of New Zealand*, 26, 84-96.
- Levy-Storms, L., & Wallace, S. P. (2003). Use of mammography screening among older Samoan women in Los Angeles county: A diffusion network approach. *Social Science and Medicine*, 57, 987-1000.



- Masoe, P., & Bush, A. (2009). A Samoan perspective on infant mental health. *Pacific Health Dialog, 15*(1), 148-155.
- McDade, T. W. (2001). Lifestyle incongruity, social integration, and immune function in Samoan adolescents. *Social Science and Medicine, 53*, 1351-1362.
- McDade, T. W., Stallings, J. F., & Worthman, C. M. (2000). Culture change and stress in western Samoan youth: Methodological issues in the cross-cultural study of stress and immune function. *American Journal of Human Biology, 12*, 792-802.
- McDonald, S. P., & Russ, G. R. (2003). Burden of end-stage renal disease among indigenous peoples in Australia and New Zealand. *Kidney International, 63*(S83), S123-S127.
- McGrath, B. B., & Edwards, K. L. (2009). When family means more (or less) than genetics: The intersection of culture, family and genetics. *Journal of Transcultural Nursing, 20*(3), 270-277.
- NASC. (2005). Pacific Cultural Competencies Framework. Retrieved 24 July, 2009, from [home.xtra.co.nz/hosts/gm-piass/PCCFwork.doc](http://home.xtra.co.nz/hosts/gm-piass/PCCFwork.doc)
- NCMHRIWD. (2009). *Real Skills Plus Seitapu: Working with Pacific Peoples*. Auckland, New Zealand: National Centre of Mental Health Research Information and Workforce Development [NCMHRIWD].
- Ostbye, T., Welby, T. J., Prior, I. A. M., Salmond, C. E., & Stokes, Y. M. (1989). Type 2 (non-insulin-dependent) diabetes mellitus, migration and westernisation: The Tokelau Island Migrant Study. *Diabetologia, 32*, 585-590.
- Palmer, G. (2005). The Treaty of Waitangi - Where to from Here? Looking Back to Move Forward, *Presentation to the Te Papa Treaty of Waitangi Debate Series*. Te Papa Museum, Wellington, New Zealand.

- Pawson, I. G., & Janes, C. (1981). Massive obesity in a migrant Samoan population. *American Journal of Public Health, 71*(5), 508-513.
- Pearson, M. Z. (2008). Racial disparities in chronic kidney disease: Current data and nursing roles. *Nephrology Nursing Journal, 35*(5), 485-489.
- Simmons, D., Clover, G., & Hope, C. (2007). Ethnic differences in diabetic retinopathy. *Diabetic Medicine, 24*, 1093-1098.
- Stewart-Withers, R. R., & O'Brien, A. P. (2006). Suicide prevention and social capital: A Samoan perspective. *Health Sociology Review, 15*(2), 209-220.
- Sundhorn, G., Metcalf, P. A., Gentles, D., Scragg, R. K. R., Schaaf, D., Dyal, L., et al. (2008). Ethnic differences in cardiovascular disease risk factors and diabetes status for Pacific ethnic groups and Europeans in the Diabetes Heart and Health Survey (DHAH) 2002-2003, Auckland New Zealand. *The New Zealand Medical Journal, 121*(1281), 28-38.
- Tamasese, K. (2008, 22nd-25th September, 2008). *Achieving wellbeing with Pacific peoples, families and communities: Considerations of gender, culture and socioeconomic contexts*. Paper presented at the Creating Futures: Research, Practice and Policy for Indigenous, Rural and Remote and Island Peoples, Cairns, Queensland, Australia.
- Tamasese, K., Peteru, C., Waldegrave, C., & Bush, A. (2005). Ole Taea Afua, the new morning: A qualitative investigation into Samoan perspectives on mental health and culturally appropriate services. *Australian and New Zealand Journal of Psychiatry, 39*, 300-309.
- Thompson, C. F., Simmons, D., Collins, J. F., & Cecil, A. (2001). Predisposition to nephropathy in Polynesians is associated with family history of renal disease, not diabetes mellitus. *Diabetic Medicine, 18*, 40-46.

Tomlin, A., Tilyard, M., Dawson, A., & Dovey, S. (2006). Health status of New Zealand European, Maori, and Pacific patients with diabetes in 242 New Zealand general practices. *The New Zealand Medical Journal*, 119(1235), 1-12.