Literature Review on the Key Components of Appropriate Models and Approaches to Deliver Sexual and Reproductive Health Promotion to Pacific Peoples in Aotearoa New Zealand

Prepared for Ngaire Sandel
Portfolio Manager
Chronic Diseases
Public Health
National Services Purchasing
Ministry of Health

Prepared by Analosa Veukiso-Ulugia
Research Consultant

EXECUTIVE SUMMARY

A universal desire shared is that individuals, families and communities experience good health and wellbeing. However, there are various ways of defining what 'good health' looks like, according to the community under review. New Zealand is an ethnically diverse society, in which Pacific peoples make up 6.9 percent of the population. The achievements of Pacific peoples in New Zealand are well documented. However, it is also recognised that Pacific communities, particularly the youth population experience a number of socio-economic and health disparities compared to other ethnic groups living in New Zealand. One such area is that of sexual health.

Within the public health setting, statistics reveal concerning trends for the general population: the age of first sexual experience is lowering and for Pacific youth, the rates of teenage births are high, birth control methods are not consistently used and the rates of sexually transmitted infections are of concern. Although pregnancy and sexual activity may be an affirming and pleasurable experience, evidence overwhelmingly concludes that the exposure to such activities at a young age can have negative emotional, social, economic and physical consequences that extend into later years.

A number of key government agencies are tasked with developing strategies and interventions to assist in improving the health status of communities. It is well recognised that the issues facing communities differ and therefore, the need exists to understand and respond effectively to the experiences of these groups.

The purpose of this literature review was to identify key components of appropriate models and approaches to deliver effective sexual and reproductive health promotion to Pacific peoples in New Zealand. The findings reveal that there is no one model that specifically applies to the area of Pacific sexual and reproduction health promotion. However, there are two rich sources of information that can be further explored and developed to create a model that is appropriate. There is a well-established body of international literature that document the guiding health promotion principles and success factors necessary for sexual health programme development. The necessary characteristics of individuals working in this area have also been documented. There is also a growing body of New Zealand Pacific evidence, largely in the qualitative domain, that highlight important considerations when attempting to develop and implement such a programme as well as in the selection of health promotion staff.

The review outlines the current models and frameworks in the area of Pacific health. Although these models and frameworks may have been developed for a particular setting (i.e. Pacific mental health and Pacific family violence), their usefulness extends to sexual health promotion efforts. The opportunity exists for the frameworks and models to be adapted according to the needs of the community. These models demonstrate the unique

worldviews of Pacific peoples, where notions of 'holism', 'wellbeing' and 'relationships' prominently feature. Values inherent in across many Pacific cultures are also described. Central to the development of a sexual and reproductive health programme for Pacific peoples firstly requires an understanding of how 'sex' and 'sexuality' are viewed. The issues relating to specific populations such as Pacific youth and fa'afafine were identified within the review. Confidentiality was a consistent message raised by Pacific youth and the inability to talk openly about this issue.

A recurring theme within the literature is that sexual health is a highly sensitive issue for many Pacific communities; especially adults and grandparents. This is not a topic that is openly discussed for a range of reasons. A number of challenges are also identified within the literature. These include: the lack of information on rural and urban Pacific populations, the influence of cultural values and how this impacts on communication between youth and Pacific adults, and the involvement of churches as a setting for sexual health promotion activities.

However, despite these tensions, a growing body of Pacific evidence suggest potential pathways forward. Some are noted here:

- Involve Pacific peoples from the outset, the solutions need to be driven by Pacific peoples;
- Provide information in a way that is culturally sensitive and acceptable. For example, tailoring sexual health promotion messages that refer to 'healthy relationships' rather than on 'safe-sex' is likely to enable engagement with Pacific communities;
- Having an awareness of cultural protocols and etiquettes (it may be inappropriate to have a brother and sister, pastor and church member in the same group);
- Incorporate communication mediums that Pacific peoples respond to, such as ethnic radio stations, ethnic specific languages, drama and music;
- Co-ordinate and consolidate services that can maximise effectiveness for Pacific groups; and
- Undertake further research that documents the progress of current services tasked with delivering sexual health promotion services to Pacific communities.

The development of an effective model for Pacific sexual health promotion is an exciting opportunity. Experts in both Pacific and western settings agree that sexual health promotion activities need to incorporate community values in their design. The development of such a model will require an appreciation and merging of both the western theoretical knowledge base and Pacific knowledge's.

Contents

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1: BACKGROUND

Context

The Government's goal is that New Zealanders experience good sexual and reproductive health. The following objectives have been identified as pathways to achieving this goal:

- improved access to contraceptive information;
- reduced rates of unintended and unsupported pregnancy;
- reduced rates of sexually transmitted disease (STI); and
- delayed onset of sexual activity amongst Pacific youth and rangatahi (Ministry of Health, 2001, p. 19).

The Ministry of Health currently has a draft programme logic model to describe evidence-based approaches for sexual health promotion shown to be effective for the general population (Appendix 1). However there is little known about what effective services for Pacific people should look like. The Ministry of Health in its Sexual and Reproductive Health Strategy (2001) recognises that the issues facing communities differ and therefore the need to understand the experiences of these different groups exists.

Improving the health and social wellbeing of Pacific communities is a key priority for the New Zealand Government (Health Promotion Forum of New Zealand, 2012; Minister of Health and Minister of Pacific Island Affairs, 2010; Ministry of Health, 2002b, 2002c). It is widely recognised that Pacific communities, particularly the youth population experience a number of socio-economic and health disparities compared to other ethnic groups living in New Zealand. The current health issues facing New Zealand's Pacific youth, and youth in general, include high injury rates, including injuries and deaths from road traffic accidents, high rates of suicide and suicide attempts, and sexual and reproductive health problems (Ministry of Health, 2012).

The sexual health status of Pacific youth in New Zealand is concerning, especially given the high teenage birth rates[1] and low birth control methods utilised (Ministry of Health, 2002a, 2012; Paterson J, Cowley E, & Percival T, 2003). Available evidence also suggests that sexually transmitted infections are as much an issue for Pacific young people in New Zealand as they are for other ethnic groups (Craig, 2008). Findings from the Youth 2007 survey indicate that 45 percent of Pacific secondary school students have had sexual intercourse and that contraceptive and condom use were lower among Pacific students than NZ European students (Helu, Robinson, Grant, Herd, & Denny, 2009).

[1] Note: Recognising that Pacific fertility rates are also high (Craig, 2008).

Scope

The Ministry requested a review of literature that lists the key components of appropriate models and approaches to deliver sexual and reproductive health promotion to Pacific peoples in New Zealand. This may include but not be limited to include the following:

- specific considerations for youth;
- what key resources and skills would be required to deliver such a programme;
- what a successful programme should contain; and
- consideration of any differences between rural and urban populations.

This literature review explores both the conceptual and research based information related to sexual and reproductive health promotion to Pacific peoples in Aotearoa, New Zealand. The conceptual literature highlights the basic writings in the sexual health and health promotion field and presents the theoretical viewpoints. The research based literature illustrates studies that have been conducted in the area of Pacific sexual health.

This review begins with a background to the overall study. Chapter 2 explores Pacific views of sexual health and the terms associated within the general sexual and reproductive health promotion field. The objectives of sexual health promotion, the settings in which these occur and the approaches used are also presented. Chapter 3 discusses the Pacific health values, models and frameworks that are of relevance to the field of sexual health promotion. The general health promotion theories and approaches used are also discussed. Chapter 4 outlines the evidence on programme effectiveness and worker characteristics. Pacific commentaries on these areas of effectiveness are also provided. Chapter 5 concludes the review with a discussion of the challenges in addressing sexual health promotion services with Pacific communities and highlights the gaps in the literature.

Review Method and Limitations

An electronic search was undertaken of national and international material via university library databases and supplementing these with the more publicly accessible on-line databases such Google Scholar. Electronic searches were carried out under the term 'sexual health promotion', by Pacific ethnic groups and the word 'Pacific'. Due to the paucity of literature, the search terms were extended to include: Pacific sexual health, Pacific youth health, Pacific health, sexual health models, sexual health reviews, sexual health evaluation, sexual health frameworks, Pacific health frameworks and Pacific sexual health service/s. The electronic searches were supplemented by searching references listed in bibliographies and snowballing from cited references. Technical reports, government reports, policy manuals, grey literature and unpublished reports were also accessed.

The material accessed was limited to those published in the English language. A further limitation lay in the shortage of local New Zealand evidence-based material that demonstrated health outcome effectiveness for Pacific communities. The majority of the studies that demonstrate 'success' have originated from the United States. The inclusion of this material is deemed necessary as it enables a reference point for comparable studies.

Previous Reviews

Although there are no literature reviews that specifically explore the area of sexual health promotion for Pacific communities in New Zealand, four reviews have been undertaken that provide some context in relation to the broader areas of: Pacific Cultural Competencies in health (Tiatia, 2008), New Zealand Sexuality research (Jackson, 2004), engaging Pacific parents and communities[2] (Gorinski & Fraser, 2006) and Youth Development (McLaren, 2000).

Strategic Context

There are a number of national, regional and local strategic plans that inform discussions in the areas of Sexual health, Pacific health and Pacific youth. These include the New Zealand Health Strategy (Ministry of Health, 2000), Sexual and Reproductive Health Strategy Phase One (Ministry of Health, 2001), Statement of Intent 2010-2013 (Ministry of Health, 2010), HIV/AIDS Action Plan: Sexual and Reproductive Health Strategy (Ministry of Health, 2003), He Korowai Oranga: Maori Health Strategy (Ministry of Health, 2002a), Pacific Health And Disability Action plan (PHDA) (Ministry of Health, 2002b), Ala Mo'ui Pathways to Pacific Health and Wellness 2010-2014 (Minister of Health and Minister of Pacific Island Affairs, 2010), Pacific youth health (Ministry of Health, 2008) and Youth Health: A Guide to Action (Ministry of Health, 2002c).

The Treaty of Waitangi is also a central document that outlines the responsibilities of the crown and the relationship between the crown and tangata whenua. This document provides a framework for Māori to exercise control over their health and wellbeing. The underlying aspirations of health promotion can be seen in Te Tiriti o Waitangi (Health Promotion Forum of New Zealand, 2012).

This literature review focuses on models and programmes that may have significant impacts on the health of Pacific communities in New Zealand. There is a close relationship between Maori and the Pacific peoples in New Zealand. This relationship has been referred as a 'teina-tuakana' (Health Research Council of New Zealand, 2003). Therefore, in the spirit of 'Partnership' and 'Sharing', implicit in Te Tiriti o Waitangi, this review may contribute to Maori health and research outcomes by way of sharing cultural and intellectual taonga (treasures) for the joint improvement of Maori and Pacific health outcomes.

[2] This review is in the context of the New Zealand education setting however the concepts are relevant to the population within the scope of this study.

Pacific Peoples in Aotearoa New Zealand

This history of Pacific peoples in New Zealand has been well documented (Macpherson, Spoonley, & Anae, 2001; Mauri Ora Associates & Medical Council of New Zealand, 2010; Ministry of Pacific Island Affairs, 1999). The term 'Pacific peoples' is often used to describe the diverse cultures of peoples from Polynesia, Melanesia and Micronesia (Macpherson, 2001). In New Zealand, the seven largest Pacific ethnic groups are Samoan, Cook Islands Maori, Tongan, Niuean, Fijian, Tokelauan and Tuvaluan (Statistics New Zealand, 2006).

In 2006, there were 265,974 people of Pacific ethnicity living in New Zealand. The largest Pacific peoples ethnic group was Samoan (n=131,103), followed by Cook Islands Maori (58,011), Tongan (50,478), Niuean (22,476), Fijian (9,864), Tokelauan (6,822) and Tuvaluan (2,625). The Pacific population is characterised as youthful. In 2006 the median age of Pacific peoples was 21.1 years, which is considerably lower than the median age of the New Zealand population overall (35.9 years). The characteristics of birth place have also shifted. Pacific peoples have changed from being a predominantly migrant group to a largely New Zealand-born population. Now almost 60 percent of Pacific peoples are born in New Zealand. For those who were born in Pacific countries and migrated to New Zealand, two in five arrived in New Zealand 20 or more years ago (Statistics New Zealand, 2006).

Language is an important component of Pacific culture. According to the national data collected from the 2006 census, the proportion of Pacific peoples who could speak more than one language (49 percent) was much higher than for the overall New Zealand population (18 percent). Around half of the people in the seven largest Pacific ethnic groups could speak the language associated with their ethnicity (Statistics New Zealand, 2006).[3]

There are many similarities between the Pacific cultures. These include core values, beliefs systems and extended family accountability. However, there are also significant differences between each Pacific group, such as language and cultural practices (Macpherson, 1996; Northern DHB Support Agency Ltd, 2010; Te Pou o Te Whakaaro Nui, Kingi-Uluave, & Olo-Whanga, 2010). Assimilation and acculturation processes have also had a significant impact upon Pacific families living in New Zealand (Le Va, 2009; Macpherson, 2001; Northern DHB Support Agency Ltd, 2010). An awareness of the history and the current realities will assist in the development of effective public health services.

[3] However, a person's ability to speak the language associated with their ethnicity was related to birthplace. For all of the seven largest groups, those born overseas were more likely to speak their own language than those born in New Zealand (Statistics New Zealand, 2006).

CHAPTER 2: SEXUAL AND REPRODUCTIVE HEALTH PROMOTION

This chapter begins with an overview of the way in which sexual health is understood within Pacific cultures. Traditional views of sexuality, some cultural roles and views of sexual violence are highlighted. The general terminology used within the discourse of sexual health promotion is identified and explained. Values necessary within the field of health promotion as well as sexual rights within international context are referenced. The review continues with a description of the objectives sexual health promotion including an overview of where promotion activities take place and the methods that are used.

Sexual health is multifaceted and difficult to define. As noted by Bogle,

> *'There have been a plethora of definitions, varying in breadth, depth and complexity, all trying to capture this multifaceted phenomenon'* (2006, p. 112).

Pacific Views of Sexual health

The discussion of sexual health within Pacific communities firstly requires an overall understanding of how health and wellness is viewed by these groups. Pacific health writers have proposed a number of frameworks for thinking through how Pacific health is conceptualized (Northern DHB Support Agency Ltd, 2010; Pulotu-Endemann, 2001; T. Suaalii-Sauni et al., 2009; Tuitahi, 2009). Although these frameworks are discussed in Chapter 3 of this review, it is important to note that in the area of health, the concepts of 'holism', 'wellbeing' and 'relationships' prominently feature (Minister of Health and Minister of Pacific Island Affairs, 2010; Northern DHB Support Agency Ltd, 2010; Percival et al., 2010a; Te Pou o Te Whakaaro Nui, et al., 2010).

> *'Pasifika world views and identities are based on a collective approach, with health and well-being relying on safe and balanced relationships. This is a holistic view of relationships. Within Pasifika cultural world views, considerable significance is placed on developing and maintaining relationships. A Pasifika world view and identity is described as being based on a collective approach, which is governed by a complex set of inter-relationships between their individuals, their families and their communities. These relationships are often upheld through adherence to a set of core values and practices. Western world views and paradigms usually centre on the notion of individualism' (Te Pou o Te Whakaaro Nui, et al., 2010)* p 14).

> *'Pacific definitions of health take as their starting point the state of wellbeing. For a Pacific person, wellbeing exists when their relationships with their environment, their God and other people are in a state of mental, physical, psychological, emotional and spiritual balance' (Percival et al., 2010b, p. 6)*.

The relationship between culture and sexuality has been documented (C. L. Fogel, 1990; Ministry of Health, 2001, 2003; Smith, 1990). Cultural norms often dictate what acceptable sexual behaviour is. Everyone has a sexual value system that is integral to their sexuality. Such a system defines sexuality as good or bad, appropriate or inappropriate, and intended for procreation or recreation or both (Bogle, 2006). Pacific writers have referred to the traditional ways of viewing sexuality and sexual identity (Finau & Percival, 2010; Hope, Rankine, & Percival, 2010; Percival, et al., 2010a; Powell, Rankine, & Percival, 2010; Pulotu-Endermann F.K & Peteru, 2001; Robati-Mani & Percival, 2010; Selu & Percival, 2010) and the roles people played,

> *'Fijian women embodied divine reproductive powers, as a daughter or sister made a new family line. In Samoa, as child bearers women were seen as sharing divinity with the gods'* (Tui Atua, 2007 as cited in Percival, et al., 2010b).

Unique gender identities

There are also unique and traditional forms of gender identities specific to some Pacific cultures. The review identifies two groups: the Fa'afafine and Fakaleiti.[4] Fa'afafine is a Samoan term and Fakaleiti is a Tongan term that refers to people who are physically male but who are said to 'have the spirits of women' or 'behave in the fashion of a woman' (Farran, 2010; Pulotu-Endermann F.K & Peteru, 2001; Sua'alii, 2001). There are debates within the literature whether these groups are distinguishable by sex or gender (Farran, 2010). What is consistent from the literature is that these groups are unique to the Pacific cultures and that they do not fit neatly into western categories of male, female, heterosexual, homosexual, bisexual or transsexual (Farran, 2010; Pulotu-Endermann F.K & Peteru, 2001). There are various aspects of being a fa'afafine or fakaleiti with differences observed in traditional and contemporary settings, being born in the Pacific islands and being raised or born in New Zealand (Pulotu-Endermann F.K & Peteru, 2001).

> *'Fa'afafine firstly denotes a Samoan and then a sexuality which must be seen in that cultural context. They are unique in their historical role as carers for and guardians or families or aiga, which are the foundation of Samoan culture or fa'asamoa… Many fa'afafine have had matai or chiefly titles bestowed on them by their aiga in recognition of their services. This is the highest form of recognition for any Samoan and underlies the recognition of their importance within that society*' (Pulotu-Endermann F.K & Peteru, 2001, p. 131).

[4] As noted by Farran (2010) there are similar groups found in the Pacific region. These include *Mahu Wahine* (Hawaii), *Mahu Vahine* or *Rae Rae* (Tahiti), *Whakawahine* (Maori, New Zealand), *Akava'ine* (Cook Islands), *Vaka sa lewa lewa* (Fiji), *pinapinaaine* of Tuvalu and Kiribati and *Fafafine* (Niue).

Intergenerational views

A number of studies undertaken with Pacific communities in New Zealand suggest that there are various generational perceptions of sexuality and reproduction. A further theme identified from the Pacific literature is that discussing sexual and reproductive health matters is 'taboo' (Anae et al., 2000a; Jameson, Sligo, & Comrie, 1999; Ministry of Health, 2008; Naea, 2008; Tupuola, 2000). Distinctions are also described between Pacific adults born in New Zealand and those born in 'Island villages'. Those born in the island nations are more resistant to listening or talking about sexuality and reproductive health issues (McClellan et al, 2000). Some writers refer to the 'deep conservatism' and '19th Century missionary attitudes' that 'mitigate against older Pacific people's willingness to talk about sexual and reproductive health' (McClellan et al, 2000).

> *'One stakeholder sums up the adult aversion to sexual and reproductive health promotion efforts in terms of personal denial "there's a good deal of denial going on, the programme is trying to turn around a culture that doesn't want to turn around"' McClellan et al (2000: 30).*

Sexual violence

Any experience of violence, including that of a sexual nature, is a matter of grave concern for a society. In New Zealand a recent qualitative study commissioned by the Ministry of Pacific Island Affairs entitled *'Pacific Pathways to Sexual Violence Prevention Research'* provided cultural insights relevant to communities tasked with developing sexual violence prevention strategies for Pacific communities in New Zealand (Percival, et al., 2010a). This project was undertaken with seven Pacific ethnic groups in Aotearoa New Zealand. A unique feature of this study was the involvement of researchers from each of the seven Pacific ethnic communities. The perspectives of communities from the Cook Islands (Robati-Mani & Percival, 2010), Fiji (Powell, et al., 2010), Niue (Kingi, Rankine, & Percival, 2010), Samoa (Peteru & Percival, 2010), Tokelau (Hope, et al., 2010), Tonga (Finau & Percival, 2010) and Tuvalu (Selu & Percival, 2010) are outlined in ethnic-specific reports. This study highlights the traditional views held in regards to violence:

> *'Violation against other people, and in particular family members, is viewed as a significant breach of the sacred relationships and thus of wellbeing' (Percival, et al., 2010a, p. 6).*

The implications arising from this sexual violence study are discussed in Chapter 5: Effectiveness.

Sexual Health Promotion

Sexual health promotion is defined as *'any activity which proactively and positively supports the sexual and emotional health and wellbeing of individuals, groups, communities and the wider public, and reduces inequalities in sexual health'* (Welfare & Lighton 2011; Department of Health, 2003).

The foundations for sexual health promotion can be traced to the Ottawa Charter. The Ottawa Charter identifies three basic strategies for health promotion. These are: advocacy - to create the essential conditions for health; enabling all people to achieve their full health potential; and mediating between the different interests in society in the pursuit of health (Health Promotion Forum of New Zealand, 2012). These strategies are supported by five priority action areas as outlined in Table 1.

Table 1: Priority Action Areas for Health Promotion

1. Building healthy public policy	Putting health on the agenda of policy makers and at all levels within society
2. Creating supportive environments	Creating living and working environments that promote health and are ecologically sound
3. Strengthening community action	Making it easier for concrete and effective community action to take place as part of the health promotion process
4. Developing personal skills	Providing information and education for health and enhancing life skills
5. Re-orienting health services	Moving the health sector towards health promotion, beyond its responsibility for providing clinical and curative services

Social Determinants of Health

It is important to note how various factors influence health inequalities. It is well documented that health outcomes are influenced by economic, social and cultural determinants (Minister of Health and Minister of Pacific Island Affairs, 2010; Ministry of Health, 2008). To reduce inequalities in health resulting from these three determinants requires an acknowledgement of the roles these factors play, a comprehensive approach involving strategies both within and outside the health sector and a long-term commitment to confirm that interventions are improving the health of low socioeconomic groups (Minister of Health and Minister of Pacific Island Affairs, 2010; National Advisory Committee on Health and Disability, 1998).

Health Promotion Values

Health promotion action and practice are guided by core values and ethics (Health Promotion Forum of New Zealand, 2012). A recent report by the Health Promotion Forum of New Zealand (2012) identifies core values that are central to health promotion practice in Aotearoa New Zealand. These include: Te Tiriti o Waitangi; human rights; equity, determinants; interdependence; aroha; and integrity.

Working Definitions

Terms and working definitions associated within the general sexual health promotion field are outlined in Table 2. These definitions were developed out of a WHO-convened international technical consultation on sexual health in January 2002, and subsequently revised by a group of experts from different parts of the world.[5]

Table 2: Working Definitions in Sexual Health Promotion

SEX	Sex refers to the biological characteristics which define humans as female or male. These sets of biological characteristics are not mutually exclusive as there are individuals who possess both, but these characteristics tend to differentiate humans as males and females. In general use in many languages, the term sex is often used to mean "sexual activity", but for technical purposes in the context of sexuality and sexual health discussions, the above definition is preferred.
SEXUALITY	Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors.
SEXUAL HEALTH	Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.
SAFER SEX	Safer sex is a term used to specify sexual practices and sexual behaviors that reduce the risk of contracting and transmitting sexually transmitted infections, especially HIV.
RESPONSIBLE SEXUAL BEHAVIORS	Responsible sexual behavior is expressed at individual, interpersonal and community levels. It is characterized by autonomy, mutuality, honesty, respectfulness, consent, protection, pursuit of pleasure, and wellness.

[5] These working definitions are presented as a contribution to on-going discussions about sexual health, but do not represent an official WHO position, and should not be used or quoted as WHO definitions (World Association for Sexual Health, 2008).

Declaration of Sexual Rights

As noted by Sand fort (2006), a helpful concept in evaluating sexual health promotion activities is that of sexual rights, does an intervention promote or restrict such rights? International declarations and treaties such the Declaration of Sexual Rights (World Association for Sexual Health, 2008)[6] commonly outline rights relating to reproductive self-determination or to the protection from sexual abuse and discrimination (Sandfort, 2006).

Table 3: WAS Declaration of Sexual Rights

1. The right to sexual freedom.	Sexual freedom encompasses the possibility for individuals to express their full sexual potential. However, this excludes all forms of sexual coercion, exploitation and abuse at any time and situations in life.
2. The right to sexual autonomy, sexual integrity, and safety of the sexual body.	This right involves the ability to make autonomous decisions about one's sexual life within a context of one's own personal and social ethics. It also encompasses control and enjoyment of our own bodies free from torture, mutilation and violence of any sort.
3. The right to sexual privacy.	This involves the right for individual decisions and behaviours about intimacy as long as they do not intrude on the sexual rights of others.
4. The right to sexual equity.	This refers to freedom from all forms of discrimination regardless of sex, gender, sexual orientation, age, race, social class, religion, or physical and emotional disability.
5. The right to sexual pleasure.	Sexual pleasure, including autoeroticism, is a source of physical, psychological, intellectual and spiritual well-being.
6. The right to emotional sexual expression.	Sexual expression is more than erotic pleasure or sexual acts. Individuals have a right to express their sexuality through communication, touch, emotional expression and love.
7. The right to sexually associate freely.	This means the possibility to marry or not, to divorce, and to establish other types of responsible sexual associations.
8. The right to make free and responsible reproductive choices.	This encompasses the right to decide whether or not to have children, the number and spacing of children, and the right to full access to the means of fertility regulation.
9. The right to sexual information based upon scientific inquiry.	This right implies that sexual information should be generated through the process of unencumbered and yet scientifically ethical inquiry, and disseminated in appropriate ways at all societal levels.
10. The right to comprehensive sexuality education.	This is a lifelong process from birth throughout the lifecycle and should involve all social institutions.
11. The right to sexual health care.	Sexual health care should be available for prevention and treatment of all sexual concerns, problems and disorders.

Source: (World Association for Sexual Health, 2008).

[6] The World Association for Sexual Health (WAS) is an international umbrella organization representing sexological societies and sexologists[6] worldwide (World Association for Sexual Health, 2008). Sexology is the scientific study of human sexuality, including human sexual interests, behaviour, and function.

Objectives in Sexual Health Promotion

Various authors have noted the differences between sexual health promotion and sexual health education. The sexual health promotion literature identifies four main common objectives. These are 1) awareness raising; 2) information and education; 3) development of services and service providers; and 4) skills and capacity-building in individuals and communities (Bogle, 2006; Department of Health, 2003; C. L. Fogel, 1990). Activities associated with these objectives are outlined in Table 4. The traditional health information education model simply gives people information about their health. This has been shown to be a limited intervention which is unlikely to lead to either improvements in health or sustainable behavioural change.

Table 4: Objectives in Sexual Health Promotion

Awareness raising	• Increasing public awareness of sexual health issues • Increasing awareness of the importance of positive sexual and emotional relationships
Information and education	• Increasing access to sexual health information, support and advice • Increasing the levels of Sex and Relationships Education available to children and young people in particular and to the general population via lifelong learning strategies • To offer opportunities for adults as well as young people to access Sex and Relationships Education and support regardless of their age or ability
Development of Services and Service providers; and	• Increasing access to, and the effective use of, condoms and contraception • Increasing access to, and uptake of, psychosexual and sexual health support services • Supporting organisations, service providers and professional staff to play an active role in promoting sexual health
Skills and capacity-building in individuals and communities.	• Enabling particularly vulnerable individuals, groups and communities to take greater control over their sexual health • Offering individuals, groups and communities opportunities to gain key relationship skills such as negotiation, communication, assertiveness, saying 'no' and decision-making

Source: (Department of Health, 2003).

Sexual Health Promotion Settings

Sexual health promotion can be delivered at various levels, in various contexts and by people who come from a range of disciplines (Department of Health, 2003; Health Promotion Forum of New Zealand, 2012). A description of these settings is noted in Table 5.

Table 5: Sexual Health Promotion Settings

Setting	Example
Schools	School based and school-linked clinics. Sexual health classes, peer education projects,, service outreach sessions (such as health drop-ins run by School Nurses)
Informal youth settings	Youth centres, peer education projects, group work, service outreach sessions and sexual health projects.
Clinics and surgeries	Family planning clinics, school-based health centres, youth clinics, community gynecology, obstetrics and gynecology departments, primary care settings and other health services such as walk-in centres, mobile clinics, Accident & Emergency Departments.
Residential care settings	With young people in public care, people with learning difficulties, disabled people, older adults in residential care, people in prisons and young offenders' institutions, or in probation and bail hostels.
Further education, tertiary colleges, training colleges and universities.	This may be through work with Students' Unions, Peer Education projects, via provision of outreach sexual health services or dissemination of information materials and condoms.
Streets, parks and public sex environments.	Detached work takes place on the territory of the group being worked with – for example with young people congregating on garage forecourts or street corners, in parks and cruising areas used by men who have sex with men, or street-work with commercial sex workers. In these settings, information and support as well as outreach sexual health services and condom distribution can all be offered.
Pubs, clubs and recreation settings.	Similar detached work can be carried out to that described in the point above. Some pubs and clubs may be willing to have information displayed and to take regular condom "drop-offs" for customers.
Workplaces.	Information can be distributed and work-place policies agreed with employers, for example about the provision of staff training, sexual health service sessions or condom machines in the toilets.
Private and retail sector, shops and hairdressers.	Some sexual health promotion projects have successfully targeted shopping areas or hairdressers for dissemination of information, needs assessment surveys or piloting new materials.
Community centres, voluntary, community and faith groups.	Activities can be carried out with the voluntary sector or with community-based groups or Faith Groups.

Source: (Department of Health, 2003)

Schools

In New Zealand the health, education and social service sectors deliver components of sexual health promotion. According to the Adolescent Health Research Group (2003), school sexuality education is where young people most often get information about sexuality and sexual health. In New Zealand schools, sexuality education is one of the seven core subjects taught within the Health and Wellbeing curriculum. It aims to *'provide students with the knowledge, understanding and skills to develop positive attitudes towards sexuality, to take care of their sexual health and to enhance their interpersonal relationships, now and in the future'* (Ministry of Education, 2007).

Churches

There is a growing interest in the roles of Pacific churches as a venue for health promotion (Channing, Ualika, & Ha'unga, 2012; North, Mahony, & Schwalger-Teura, 2012; Pacific Health Branch - Ministry of Health, 2007). Partnerships between health organisations and Pacific churches have slowly developed facilitated by District Health Boards in the metro Auckland region (Counties Manukau District Health Board, 2008; Pacific Health Branch - Ministry of Health, 2007). Churches play a prominent role in the communal life of most Pacific people. According to national data collected in 2006, a sizeable majority, some 83 percent of Pacific peoples affiliate with a religion. This was higher than for New Zealand overall (61 percent). Ninety-seven percent of Pacific peoples that affiliated themselves with a religion identified themselves as Christians (Statistics New Zealand, 2006). The influence of Christian beliefs upon sexual behaviour is important to note for sexual health promotion activities.

Sexual Health Promotion Interventions

The delivery of sexual health promotion activities may employ a range of strategies. The various methods are outlined in the following Table.[7] An example of an intervention is the National Cervical Screening education campaign that used television advertisements as a form of communicating. The aim was to increase cervical screening amongst New Zealand women, with a particular focus on Maori and Pacific women who have lower screening rates (National Screening Unit, 2012).

Table 6: Types of Sexual Health Promotion Interventions

Types of Interventions	Examples and description
Media campaigns	National and local campaigns. Also via the press or the internet. The purpose of such campaigns is usually to raise public awareness and/or to target particularly vulnerable in terms of sexual health and HIV.
Sex and relationship education	Formal and informal education, youth and community settings. Give information and advice about causes and effects of sexual ill-health Explore myths, values and attitudes to enable informed decisions to be made Facilitate the development of skills required for healthy living
One-to-one work (Client-centred)	Individual one-to-one work in a sexual health services setting with service users. Or it may be done by non-clinical staff in community settings. Work with individuals on their own terms, addressing their sexual health issues, choices and actioins Empower client to take responsibility for his or her own sexual health
Group work	Particularly with vulnerable groups such as young people, teenage parents.
Peer education programmes	With parents and carers, young people and gay and bisexual men.
Arts work	Theatre, video making, Children's Express writing.
Condom distribution	Via Schools (school condom-availability programmes), Primary Care, youth workers, youth clinics, Family Planning Clinics, street-work with commercial sex workers or outreach work.
Production and dissemination of material	Leaflets, posters, video's, CD-ROMs, games and magazines to increase information and knowledge levels as well as stimulating uptake of services.
Publicising local sexual health services	And encouraging uptake of these, particularly by those who have not traditionally been service-users.
Outreach / Street work	Publicising and promoting sexual health services to groups, communities and individuals who might otherwise not be aware of them or confident enough to use them.
Community development approaches	Approaches which work with vulnerable and marginalised communities (e.g. gay and bisexual men, black & minority ethnic communities) to empower them and build capacity.
Targeted work with particularly vulnerable groups	With young women who may be abused.
Screening and testing	Example: for HIV and other Sexually Transmitted Infections.
Training courses and workshops	For staff to develop the necessary confidence and professional and

[7] This content originated from the following reports: (Bogle, 2006; Department of Health, 2003; D. B Kirby, 2003; McLaren, 2000) and were adapted for the purposes of this literature review.

	personal skills to enable them to deliver the work effectively.
Conferences and seminars	Which models of good practice can be shared and new research disseminated.
Informal dissemination	Updates, training resources, newsletters and new research disseminated.
Development of policies and strategies	Aimed to positively support sexual health and HIV prevention.
Research	Research into most effective practice. Also dissemination of research findings from both national and international studies.
Working with political heads	That will enable them to be fully aware of the complexities. Action to change the physical environment to enable the choice of healthier lifestyle, by use of legislation, public pressure, lobbying, advocacy and community involvement
Needs assessments	For example through surveys or seeking the opinions of service-users or non-users and via action-research projects.
Promotion of strong inter-agency working.	Sexual health promotion is most likely to be effective when initiatives are multi-agency. Therefore joint working, inter-agency support and opportunities for shared training all make a positive contribution.
Non-sexual programmes	Service learning programmes. Vocational education and employment programmes.
Youth development programmes	Growing and developing the skills and attitudes young people need to take part in society. Building strong connections and active involvement in all areas of life. Young people being involved and having a say in decisions that affect them, their family, their community and their country and putting into practice and reviewing those decisions
Education programmes	These include: parenting, life skills, contraceptive education, Abstinence-only; Sex and HIV education programmes.
Medical	Promote medical interventions to prevent or ameliorate sexual ill-health Encourage people to seek detection and treatment of sexual problems
Behavioural	Focus on clients attitudes and behaviour change to encourage adoption of healthier lifestyles to prevent sexual ill-health

The use of oral tradition and drama are additional examples of intervention methods. Family Life Education Pasefika Services (FLEP) is a Pacific sexual health education service based in the Auckland region, and incorporate drama and music into their service delivery (Ministry of Health, 2008). This form of delivery is consistent with writings on traditional Pacific methods of communication. Reflecting upon Samoan customs, Peteru & Percival (2010) note that

> *'Knowledge about Samoa's past was known through oral tradition which refers to stories, poems, songs and genealogies passed down through generations by word of mouth' (Percival, et al., 2010b, p. 56).*

CHAPTER 3: HEALTH MODELS & FRAMEWORKS

This chapter explores Pacific health models and frameworks that may be applicable to the sexual health promotion field. The chapter begins with an outline of the values shared by many Pacific cultures. A number of Pacific health models and frameworks are then identified and discussed. The chapter concludes with an overview of the general theories that guide sexual health promotion practice and an example of a sexual health promotion intervention.

For the purposes of this review, health models are defined as frameworks or structures that inform and shape health promotion work by providing a set of values, tools (knowledge and skills) and practice (Health Promotion Forum of New Zealand, 2012). These models and frameworks are valuable in that they enable policy agents and practitioners to understand what is culturally appropriate and effective for Pacific peoples, in order to improve and maintain their material, spiritual health and wellbeing (Te Pou o Te Whakaaro Nui, et al., 2010; Tiatia, 2008).

Pacific Values

Within the New Zealand public health context, core values that are common to Pacific groups and underpin relationships when working with Pacific peoples have been extensively documented (Auckland District Health Board - Pacific Family Support Unit, 2012; National Health Board, 2010; Northern DHB Support Agency Ltd, 2010; Percival, et al., 2010a; Te Pou o Te Whakaaro Nui, et al., 2010; Tiatia, 2008). These values these include:

- Sacred bonds (Tapu)
- Love and compassion (Alofa)
- Reciprocal service (Tautua)
- Respect and deference (Fa'aaloalo)
- Humility (Fa'amaualalo)
- Family (Aiga)
- Spirituality
- Honour
- Relationships

Explanations of the cultural significance of these values, how they are demonstrated and how they may be adopted into practice are outlined in the following documents (Auckland District Health Board - Pacific Family Support Unit, 2012; Health Research Council of New Zealand, 2003; Le Va, 2009; Northern DHB Support Agency Ltd, 2010).

One value consistently emphasised in the Pacific literature is the importance of family (Auckland District Health Board - Pacific Family Support Unit, 2012; National Health Board, 2010; Northern DHB Support Agency Ltd, 2010; Percival, et al., 2010a; Te Pou o Te Whakaaro Nui, et al., 2010; Tiatia, 2008). A Pacific person derives a sense of identity from

their family. Variation also exists in Pacific families and in traditional models of family leadership, values and practices. These factors must be taken into account when working with Pacific families (Northern DHB Support Agency Ltd, 2010).

As noted by the Northern DHB Support Agency (2010), this view aligns with the Maori perspective of Whanau Ora[8] and recognises that health and wellbeing are influenced and affected by the collective as well as the individual (Auckland District Health Board - Pacific Family Support Unit, 2012; Northern DHB Support Agency Ltd, 2010; Taskforce on Whānau Centred initiatives & Ministry of Social Development, 2010).

Pacific Health Models and Frameworks

A range of models and frameworks have been developed by Pacific health experts to try and understand, identify or learn about the various paradigms that exist. Some models and frameworks also have a dual function, in that it may explains a particular worldview and also present a process for undertaking a therapeutic relationship with Pacific clients and communities. An outline of the Pacific health models and frameworks is noted in Table 7.

Table 7: Pacific Models and Health Frameworks

Model	Developed by	Reference
Fonofale	Fuimaono Karl Puluto-Endemann	Samoan model (Pulotu-Endemann, 2001)
Kakala	Konai Helu-Thaman	Based on Tongan values (Te Pou o Te Whakaaro Nui, et al., 2010)
Tivaevae	Teremoana Maua-Hodges	Based on Cook Island processes (Te Pou o Te Whakaaro Nui, et al., 2010)
Papao	'Papao Group' consisting of key stakeholders within the Pacific mental health sector	(Fotu & Tafa, 2009)
Soifua Maloloina	David Lui	(Lui, 2007)
Te Vaka Atafaga	Kupa Kupa	Tokelau model (Kupa, 2009)
Fonua	Sione Tuitahi	Tongan model (Tuitahi, 2009)
Strands/Pandanus Mat		(Glover, Nosa, Watson, & Paynter, 2010)
Faafaletui	Carmel Peteru & Kiwi Tamasese	(T. Suaalii-Sauni, et al., 2009)
Seitapu	Fuimaono Karl Puluto-Endemann	(Le Va, 2009)

Given the inherent differences that exist within pacific communities, researchers agree that no single framework exists that can provide a cultural context for all the Pacific cultures (Glover, et al., 2010; Le Va, 2009). However, there are shared commonalities as evidenced in the following statement:

[8] Whanau Ora is an inclusive approach to providing services and opportunities to families across New Zealand. It empowers families as a whole, rather than focusing separately on individual family members and their problems (Taskforce on Whānau Centred initiatives & Ministry of Social Development, 2010).

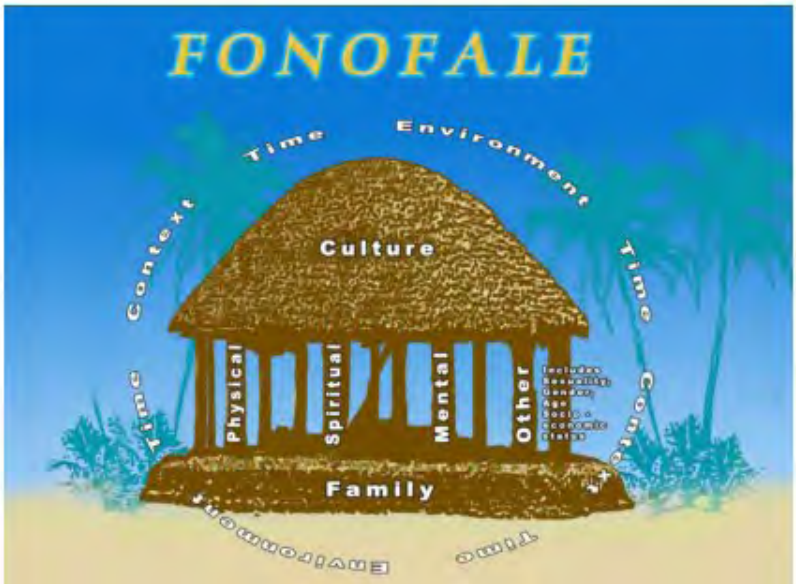
'These models and frameworks all point to the importance of focusing on the process of interventions and understanding of Pacific concepts such as the use of Pacific languages, spirituality, gender, familial and community responsibilities and intergenerational ethnic concepts of care. Similarly, many share an overall vision of achieving wellbeing, and strong and vibrant families and individuals' (T. Suaalii-Sauni, et al., 2009, p. 19)

For the purposes of this review, an outline of two Pacific models (Fonofale and Pandanus) and two frameworks (Seitapu and Pacific Conceptual Frameworks) are provided. It is important to note that though these models and frameworks may have been developed for a particular setting (i.e. Pacific mental health and Pacific family violence) their usefulness extends to sexual health promotion area for Pacific communities. The opportunity exists for the frameworks and models to be tailored for specific audiences, and that they are adaptable depending on workforce setting, population, service user needs and the service being provided (Le Va, 2009).

The Fonofale Model

The Fonofale model developed by Fuimaono Karl Pulotu-Endemann is one model that is often quoted within the health literature (Agnew F et al., 2004; Auckland District Health Board - Pacific Family Support Unit, 2012; Minister of Health and Minister of Pacific Island Affairs, 2010; Northern DHB Support Agency Ltd, 2010; T. Suaalii-Sauni, et al., 2009; Te Pou o Te Whakaaro Nui, et al., 2010). The Fonofale model is particularly relevant to the area of Pacific sexual health promotion. This model incorporates the values and beliefs that many Samoans, Cook Islanders, Tongans, Niueans, Tokelauans and Fijians shared with Fuimaono Karl during workshops relating to HIV/AIDS, sexuality and mental health in the early 1970's to 1995. In particular, these groups all stated that the most important things for them included family, culture and spirituality.

Figure 1: Fonofale Model



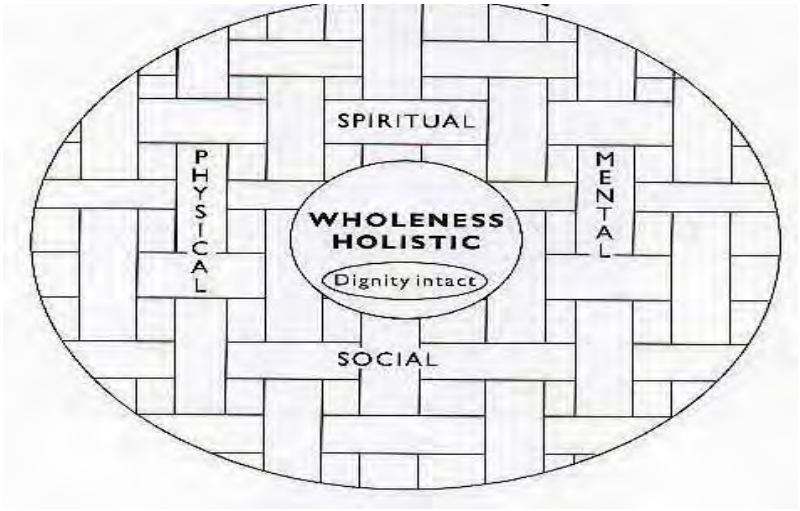
The concept of the Samoan fale or house was a way to incorporate and depict a Pacific way of what was important to the cultural groups as well as what the author considered to be important component of Pacific people's health. The Fonofale model incorporates the metaphor of a Samoan house with the foundation or the floor, posts and roof encapsulate in a circle to promote the philosophy of holism and continuity. The

Fonofale Model is a dynamic model in that the all aspects depicted in the model have an interactive relationship with each other (Pulotu-Endemann, 2001).

The Strands or Pandanus Mat model

This model utilises the Pacific metaphor of a pandanus mat (considered a cultural treasure in a number of Pacific cultures) to symbolise the interwoven nature of health and wellbeing (Glover, et al., 2010; Tamasailau Suaalii-Sauni et al., 2009). A central theme of this model is that of wholeness and that concept that effective healthcare and delivery requires a holistic approach that encompasses the dimensions of the four interweaving strands: physical, spiritual, mental and social elements of Pacific culture (Glover, et al., 2010; Northern DHB Support Agency Ltd, 2010).

Figure 2: Pandanus Mat Model



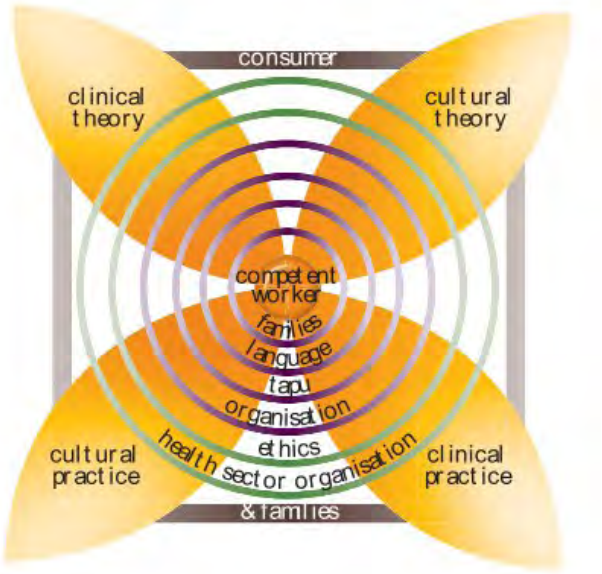
Seitapu Framework

The Seitapu framework developed by Fuimaono Karl Pulotu-Endemann recognises the importance of having both clinical and cultural competencies. This framework applies to the specialised provision of Pacific services (i.e. by Pacific for Pacific) within the mental health sector (Le Va, 2009). Recently the Seitapu Framework has been incorporated into 'The Real Skills framework'[9] resulting in the 'Real skills plus Seitapu framework'.

[9] The Real Skills framework describes the essential knowledge, skills and attitudes required to deliver effective mental health and addiction treatment services (Le Va, 2009).

Figure 3: Seitapu Framework

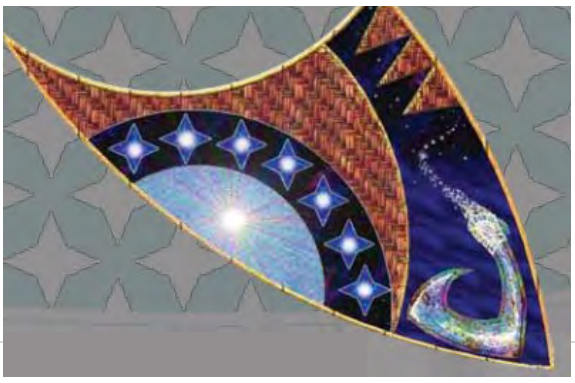
'The Real Skills plus Seitapu framework is intended to infuse Pacific knowledge, skills and attitude throughout the mental health and addiction sector… empowering services and people to become more responsive and accessible to Pacific service users. At the centre of the Seitapu model is the competent worker. The worker is placed at the centre rather than the consumer because what is under consideration is the mental health worker's competency, which will impact on the consumer and their families' (Le Va, 2009, p. 7).



Pacific Conceptual Frameworks

The Ministry of Social Development recently published a serious of ethnic-specific Pacific Conceptual Frameworks that defines and explains meanings of family and violence, and sets out the key concepts and principles that promote family wellbeing for seven ethnic specific Pacific communities in New Zealand - Cook Islands, Fiji, Niue, Samoa, Tokelau, Tonga and Tuvalu (Ministry of Social Development, 2012b). Four areas were acknowledged as important features in an education programme aimed at building and restoring relationships within families: fluency in the ethnic specific and English languages; understanding values; understanding the principles of respectful relationships and the nature of connections and relationships (Ministry of Social Development, 2012b).

Figure 4: Pacific Conceptual Framework Logo



Sexual Health Promotion Theoretical Frameworks

Sexual health promotion can be based on two kinds of theories or theoretical frameworks, and both theories/frameworks are required for effective sexual health promotion:

1. Theories that focus on a specific object
2. Theories that deal with how change can be accomplished (Sandfort, 2006).

Sandfort (2006) provides a useful example of how this may apply in practice. For effective HIV prevention, there is a need to understand why people who could protect themselves by using condoms do not do so. Even though it is important to understand why these people do not use condoms, it does not explain what to do next. For this step, theories that help to understand how to produce behavioural change are required.

There are several dominant models in the field of health promotion that have been developed to understand how factors can be changed to prevent or resolve an issue (Bowden & Manning, 2006; C. L. Fogel, 1990; Gorin & Arnold, 2006). As noted by Gorin (2006), these theories can be distinguished by the level at which they operate.

These theories include:

- Individual theories
  - Persuasion communication model
  - Goal-setting theory
  - Attribution theory
  - Self-regulatory theory
  - Stages of change
- Interpersonal theories
  - Social cognitive theory
  - Social support (network) theories
- Organisational change models and theories
- Community organisation models and theories
- Societal and Governmental theories

The PLISSIT Model

The PLISSIT Model for Sexual Health Interventions is an internationally recognised framework that guides sexual health assessment and intervention (Bogle, 2006; C. I. Fogel, Forker, & Welch, 1990). The model is based on principles of learning theory and uses a behaviour approach to the treatment of sexual problems (C. L. Fogel, 1990). As noted by Bogle (2006) by using this systematic framework, health professionals can develop skills in opening up discussions and progressing a conversation in a meaningful and sensitive way. A description of the various levels of intervention within the PLISSIT model is outlined in Table 8.

Table 8: PLISSIT Model for Sexual Health Intervention

Permission	Convey willingness to discuss sexual thoughts and feelings. Provide assurance that concerns or practices are normal. Permission is often sufficient to resolve what may become a major problem.
Limited Information	Provide information directly to concerns raised. Questions, sexual myths, and misconceptions may be addressed. This can result in significant changes in sexual attitudes and behaviours.
Specific Suggestions	Provide specific instruction/suggestions to help clients change sexual behaviour to achieve/restore sexual health. The client may need referral to an appropriate professional if knowledge and skills are lacking
Intensive Therapy	Provide highly individualised therapy, so referral to a specialist counsellor is necessary.

Source: (Bogle, 2006, p. 123)

CHAPTER 4: EFFECTIVENESS

This chapter summarises the available evidence-based literature and good practice guidance on promoting sexual health for Pacific communities in New Zealand. The chapter begins with a discussion on the measures of success or effectiveness within the sexual health promotion field. The components of a successful comprehensive programmes and education programmes are then explored. The key skills required by health promoters to deliver such a programme are also outlined. The chapter concludes with an outline of the considerations necessary for young people in the New Zealand context. Throughout the chapter commentaries from Pacific research studies are also highlighted.

What is success?

It is important to acknowledge that in the area of sexual health promotion the terms 'success' and 'effectiveness' may mean different things to different people. This review acknowledges the various "ways of knowing" that exist in indigenous and mainstream knowledge (Ministry of Social Development, 2012a) and draws from both qualitative Pacific research evidence and scientific studies undertaken in the area.

Evaluating a sexual health promotion programme is no easy task. A number of decisions that range from practice and theory need to be made (Sandfort, 2006). For example, identifying what the intervention is meant to accomplish. If, according to the stages of change model, an intervention is meant to move people from contemplating condom use to preparing for condom use, actual use is not the right outcome to assess. A further challenge within the sexual health promotion field is noting when effects should be assessed, and how long should these effects last. As noted by Sandfort, (2006)

> *'The answers to these questions depend on the complexity of the sexual health issue one tries to address. Some effects might occur directly after the intervention but subsequently fade out. It is also possible that initial effects will be positive and long-term effects negative. If sexual health interventions do not include support for maintenance of accomplished behavioral change, it is likely that the effects of an intervention will disappear' (Sandfort, 2006, p. 238).*

Given the diversity that exists within sexual health promotion efforts and the limited resources available, it is important to know whether sexual health interventions are effective, and if so, why. International reviews of sexual health literature identify five important sexual behaviours: initiation of sex, frequency of sex, use of condoms, use of other contraception, number of partners and/or sexual health outcomes (pregnancy, childbearing or sexually transmitted infections) (D. B Kirby, 2003). Many sexual health programmes are tasked with addressing one or more of these issues (Ministry of Health, 2001).

Within the public policy and health discourse, scientific evidence and methods of enquiry are often identified as useful measures of effectiveness (Gluckman & Hayne, 2011; Sandfort, 2006). Interventions that adopt an experimental evaluation design are noted as providing stronger evidence than other evaluations such as effect evaluations and process evaluations (D B Kirby, 2007; Sandfort, 2006).[10] Literature within the sexual health field commonly defines 'effectiveness' in the ability to change ones behaviour (D B Kirby, 2007).

Sexual Health Promotion Programmes

Comprehensive reviews of sexual health programmes have largely been undertaken with adolescent populations (Department of Health, 2003; D B Kirby, 2007). International research identifies that there are more than 500 risk and protective factors that influence the sexual behaviours of teenagers (D B Kirby, 2007). [11] Addressing the risk and protective factors that influence sexual behavior are strategies used (D B Kirby, 2007).[12]

Features of effective interventions

Literature suggests that multi-component pregnancy prevention programmes with a contraception education and access component have had the most success in delaying sexual onset or reducing the proportion of youth engaged in sexual activity, increasing the rates of contraceptive use, and in some instances, decreasing the proportion of adolescences who experienced a pregnancy (D B Kirby, 2007; Moore & Brooks-Gunn, 2003). The features of effective sexual health interventions are also outlined in a report by the Department of Health (2003). Effective interventions share the following characteristics:

- Incorporation of theoretical models of behaviour change, or components of these models, as a basis for intervention development and implementation.
- Provision of basic, accurate information about the risks of unprotected intercourse and methods of avoiding unprotected intercourse.
- Multi-faceted, including a number of components – such as skills development, motivation building and attitude change in addition to factual information. Information provision alone is insufficient to influence behaviour change. Personal and structural factors such as attitudes towards safer sex and condoms, motivation, the influence of significant others, wider social influences, as well as practical skills, all play an important part in the ability to change behaviour.
- Incorporate specific behavioural skills training, like how to use condoms

[10] Process evaluation that aims to gain an understanding of why an intervention did or did not accomplish the desired goals, Effect evaluations assesses the outcome of an intervention (Sandfort, 2006).

[11] Risk factors increase the likelihood of pregnancy or contracting a sexually transmitted infection whereas protective factors decrease the likelihood (D B Kirby, 2007) .

[12] Douglas Kirby is an international expert on the effectiveness of school and community programmes in the reduction of adolescent sexual risk-taking behaviours. He has authored over 100 articles, chapters and monographs on these programmes. His report entitled '*Emerging Answers 2007: Research Finding on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases'* was a comprehensive review of 115 programme evaluations identified the most effective approaches to preventing teen pregnancy and STDs.

- Based on a detailed understanding of background behaviours, beliefs and risk perceptions of the target population. Formative research can be useful in developing programmes which are appropriate to the target population in terms of age, gender, sexual experience and culture.
- Use of peer educators, particularly with adolescent audiences. Some adolescents may be more comfortable receiving sexuality-related information from peers rather than adults, and peers may also have added credibility because of their perceived recent experience of the issues under discussion.
- Emphasis on promoting condom use, rather than abstinence. Telling people not to have sex is unlikely to be an effective intervention.
- Of appropriate duration. It requires considerable time and multiple activities to change long established sexual risk-taking behavior (Department of Health, 2003).

Education Curriculum Programmes

As previously noted, sexual health promotion can occur in various settings such as schools. An international review of 83 studies measured the impact of curriculum-based sex and HIV education programmes on sexual behaviour and mediating factors among youth under 25 years throughout the world (D. B. Kirby, Laris, & Rolleri, 2007). Seventeen characteristics were noted as effective components within the education curriculum. Programmes were effective across a wide variety of countries, cultures, and groups of youth. The curriculum programme was replicated in other settings with positive findings demonstrated (D. B. Kirby, et al., 2007). These 17 characteristics are presented in Table 9 and can logically be divided into three categories, namely those describing: (1) the development of the curricula, (2) the overall design and teaching strategies of the curricula themselves, and (3) the implementation of the curricula. In the New Zealand context, an review of the quality of sexuality education programmes for students from Years 7 to 13 has been undertaken (Education Review Office - The Ministry of Education NZ, 2007a). An additional report published by the Education Review Office outlines how New Zealand schools can review their sexual education programmes with a description of best practice offered (2007b).

Pacific Viewpoints

Some of the effective characteristics identified in the general literature have also been identified as key components within Pacific sexuality studies (Anae, et al., 2000a; Naea, 2008; Tupuola, 2000). The need to be cultural competent strongly features in the general health literature: the ability to understand and appropriately apply cultural values and practices that underpin Pacific people's world views and perspectives on health (Auckland

District Health Board - Pacific Family Support Unit, 2012; Le Va, 2009; Te Pou o Te Whakaaro Nui, et al., 2010; Tiatia, 2008).[13]

Some authors identify the need for programmes to involve Pacific input at all stages: consultation, planning, implementation, monitoring and evaluation (Naea, 2008; Pulotu-Endermann F.K & Peteru, 2001; Tupuola, 2000). The use of language specific to the audience group is also an important pre-requisite. As noted by the Ministry of Social Development (2012b) *'language is identified as a crucial entry point to understanding traditional and contemporary worldviews of any one culture'*. Discussing issues such as sex, sexuality and reproduction with Pacific communities require an appreciation of protocols and etiquettes relevant to the particular cultural setting. It may be inappropriate to include in the same group, for example, brother and sister, older and younger siblings, mothers and daughters, or church leaders and non-church leaders (Jameson, et al., 1999; Ministry of Health, 2008; Tupuola, 2004).

Table 9: Effective Education Curriculum Programmes

The Process of Developing the Curriculum	The Contents of the Curriculum Itself	The Implementation of the Curriculum
1. Involved multiple people with different backgrounds in theory, research and sex/HIV education to develop the curriculum	***Curriculum Goals and Objectives***	1. Secured at least minimal support from appropriate authorities such as ministries of health, school districts or community organizations
2. Assessed relevant needs and assets of target group	1. Focused on clear health goals – the prevention of STD/HIV and/or pregnancy	2. Selected educators with desired characteristics (whenever possible), trained them and provided monitoring, supervision and support
3. Used a logic model approach to develop the curriculum that specified the health goals, the behaviors affecting those health goals, the risk and protective factors affecting those behaviors, and the activities addressing those risk and protective factors	2. Focused narrowly on specific behaviors leading to these health goals (e.g., abstaining from sex or using condoms or other contraceptives), gave clear messages about these behaviors, and addressed situations that might lead to them and how to avoid them	3. If needed, implemented activities to recruit and retain youth and overcome barriers to their involvement, e.g., publicized the program, offered food, or obtained consent
4. Designed activities consistent with community values and available resources (e.g., staff time, staff skills, facility space, and supplies)	3. Addressed multiple sexual psychosocial risk and protective factors affecting sexual behaviors (e.g., knowledge, perceived risks, values, attitudes, perceived norms, and self-efficacy)	4. Implemented virtually all activities with reasonable fidelity
5. Pilot-tested the program	***Activities and Teaching Methodologies***	
	4. Created a safe social environment for youth to participate	
	5. Included multiple activities to change each of the targeted risk and protective factors	
	6. Employed instructionally sound teaching methods that actively involved the participants, that helped participants personalize the information, and that were designed to change each group of risk and protective factors	
	7. Employed activities, instructional methods and behavioral messages that were appropriate to the youths' culture, developmental age, and sexual experience	
	8. Covered topics in a logical sequence	

Source: (D. B. Kirby, et al., 2007, p. 213).

[13] A detailed account of pacific cultural competencies is documented in Tiatia, 2008.

A number of New Zealand Pacific studies that explore sexuality have been undertaken with Samoan populations (Anae, et al., 2000a; Naea, 2008; Tupuola, 2004). Naea explored the views of Samoan women within New Zealand in regards to sexuality and school sexuality education (Naea, 2008).[14] This qualitative study identified the similarities and differences in the relationships between Samoan-born and New Zealand-born mothers and the impacts these relationships have on sexuality education. The study also identified strategies to reduce the cultural gaps between Samoan families and school based sexuality programmes. Some of the pertinent findings were:

- To increase the acceptance of sexuality programmes by Samoan families in New Zealand, health and education professionals needed to work together with families to ensure there are culturally appropriate and effective programmes which are ongoing;
- The need exists to educate Pacific people that it is okay to talk about sexuality.[15]
- The influence of culture and religion were very intertwined within many Samoan people who settle in New Zealand. Sexuality education programmes would need to have a cultural perspective that will raise Pacific students' awareness of the traditional values and beliefs of their parents, the challenges of being a migrant, acculturation and religiosity and the impact these issues have on their identity as a young New Zealand-born Samoan;
- The importance of Pacific people having access to good information and utilizing radio, music and drama in communicating this information. Pacific language radio stations are one medium;

Tupuola (2000) undertook a qualitative study with Samoan women in New Zealand exploring issues related to sexuality and being Samoan. Findings relevant to the development and implementation of sexual health promotion programmes include:

- The overall structure of programmes needs to be flexible, collaborative and a reflection of both Samoan and western principles and lifestyles;
- Crucial that the sex education programmes aim to empower the women themselves by including and involving them in the development, implementation and evaluation processes;
- The need for understanding of the various cultural views towards sex and sexuality. The term 'sexuality' must be defined by young Samoan women so that the services

[14] Women in Naea's study were categorized into three groups: 1) Traditional : Samoan women who had lived mostly in Samoa and have grandchildren; 2) Transitional women: women who came to New Zealand as young women, then married and had their children in New Zealand and; 3) Modern women: Samoan women who were born in New Zealand and who had children.

[15] Modern mothers discussed the need for Samoan parents, who hold traditional values and beliefs, to be educated on the importance of giving correct sexuality information to young people.

and programmes can begin from where the women themselves interpret and understand sexuality;
- Pacific community forums should be run by the youth themselves to educate health authorities and elders/aiga/parents in their respective communities about young people's perspectives on sexuality.

A study entitled '*Tiute ma Matafaiaoi a nisi Tane Samoa i le Faiga o Aiga. The Roles and Responsibilities of Some Samoan Men in Reproduction'* (Anae, et al., 2000a) explored the knowledge and practices of both Samoan men and women in relation to reproduction. [16] This study adopted a qualitative design that included three research methods: focused life story interviews (n=40 w, n=40 m), key person interviews (n=21) and 5 focus groups (older men, older women, younger men, younger women) (Anae, et al., 2000a). This comprehensive study produced a number of findings relevant for the area of sexual health promotion for Pacific communities. A few are noted here:

- That there needs to be cohesion, coordination and consolidation of sexual health programmes to maximise effectiveness for Pacific groups;
- The forming of sexual health promotion and education packages. Framed under the umbrella of forming responsible family and peer "relationships" "general health", rather than on "safe-sex";
- 'Forming responsible relationships' needs to be promoted at all learning sites such as church, preschool, school, peer group networks; and
- Sexual health promotion and education packages need to address the different cultural nuances inherent within the different expectations of 'older' and 'younger' generations around forming premarital sexual and friendship relationships.

The implications arising from the Pacific sexual violence research (Percival, et al., 2010a) are similar to those raised in the previous discussion. [17] The study notes that:

- Key prevention messages and campaigns need to be targeted, given the differing rates of indigenous language use, church attendance and affiliation, and inter-marriage among Pacific ethnicities in New Zealand;
- Messages for each major ethnic community could be designed and developed by separate male and female working groups from these communities. This would ensure that key messages are culturally and linguistically accurate and that campaign materials are provided in the first language using culturally specific expressions;

[16] This study was funded by the Health Research Council of New Zealand. The objectives of this research are outlined in Appendix 2.

[17] Implications from the research project were categorized into 5 categories: policy development, service planning and delivery, pacific communities, workforce development and research and evaluation.

- Those working with Pacific families and communities incorporate Pacific protective practices, such as the brother-sister and male-female respect; and
- Resource ethnic specific and gender-based programmes that encourage Pacific communities themselves to dialogue about the best ways to prevent sexual violence and deliver their own solutions.

Effective Pacific Programmes

A review undertaken by McClellan & Guttenbeil (2000) entitled '*Final report for the comparative evaluation of the Pacific People's Regional Sexual and Reproductive Health Programmes'* presents the findings of a three-year comparative evaluation of regional[18] sexual and reproductive health regional pilot programmes for Pacific peoples in New Zealand. The review identified a number of issues related to: improving access, programme acceptability, programme effectiveness, resource efficiency, programme safety and future directions for Pacific sexual health activities.

The evaluators also identified training "messengers" who were conversant in their own indigenous languages as an appropriate method. In relation to programme effectiveness, the evaluations undertaken were of a formative and process nature; therefore only short-term impacts could be measured. Evidence of consumer and stakeholder satisfaction was demonstrated. However, as the programmes were in the early development phase, it was difficult for stakeholders to demonstrate outcomes of increasing sexual health knowledge and understanding of contraceptive methods including abortion and unplanned pregnancies (McClellan & Guttenbeil, 2000).

Use of drama

The use of drama and music are tools that enable the transmission of sexual health promotion messages. A recent mixed methods evaluation of a sexual health programme within New Zealand schools undertaken by Work and Education Research and Development Services (WERDS) revealed interesting findings for Pacific students that participated in the programme. Theatre in Education Trust (THETA) draws on an Applied Theatre approach to deliver sexuality education programmes to secondary students in New Zealand. 313 students were involved in the survey before and after the THETA Sexwise programme, of this 30 percent were Pacific students (n=94) and 41 percent were Maori (n=127). According to the evaluation conducted by WERDS, school teachers reported that the programme was culturally "very appropriate" for the students who saw it, particularly Maori and Pacific

[18] Four regions were considered in the evaluation: Northern (1) based in South Auckland Family Life Education Pasefika Trust; Midland (2) Hamilton Cook Island Association – Te Rapakau and South Waikato Pacific Island Health Committee (SWPIHC); Central (1) Train the trainer's education programme entitled the Making Waves project – situated in the Nursing Studies Department of the Whitirea Polytechnic, Porirua. Joint effort / partnership of four provider organisations: Hutt Valley Health, the Sexual Health Services of Wellington's Capital Coast, the Union Health Services and Whitireia Community Polytechnic and Southern (3) Christchurch – Crown Public Health, Dunedin 'Tangata Pasifika Social Support Services (TPSSS) and Southland 'Southern Public Health (SPH)' - establishment of a Pacific Health Unit.

students. Survey results revealed that Maori and Pacific students reported knowing more about sexual and relationship topics after the THETA Sexwise programme than they had done before the programme. In terms of accessing information, the preferences of Maori and Pacific students shifted focus after the Sexwise programme from traditional sources like friends and whanau to organised clinical services like Sexual Health Clinic (SHC), School Nurse, GP, School Counsellor and Family Planning (Work and Education Research & Development Services, 2011). It is important to note that the student survey results were based on a smaller sample of the total Pacific participants (37/94).

International Pacific studies – Developing Pacific health promotion interventions

Two international studies document success in developing health promotion programmes that are deemed culturally appropriate with Pacific communities. '*Creating Project Talanoa'* (McGrath & O.Ka'ili, 2010) presents a model for applying cultural concepts in the development of a risk reduction intervention for US Pacific adolescents. These risk factors included: risky sexual behaviour, substance abuse, and interpersonal violence. The qualitative exploratory study involved the identification of key cultural values (love, respect, family, tapu), a review of existing evidence-based prevention interventions and consultation with key stakeholders. The intervention, 'Project Talanoa' was then developed around four constructs: (1) cultural identity and pride, (2) teen health, (3) peer relations, and (4) family ties. The findings revealed that it was culturally appropriate, well-liked by the participants, supported by parents and others in the community, and found to be feasible. The authors note that additional research is needed to test it for effectiveness (McGrath & O.Ka'ili, 2010).

Aitaoto, Braun, Dang, & So'a (2007) explored the cultural considerations in developing church-based programmes to address one area of health promotion - reducing cancer health disparities among Samoans in the United States. Within the targeted community (Samoan churches), church-based programmes were welcome if they incorporated fa'aSamoa (the Samoan way of life) including a strong belief in the spiritual, a hierarchical group orientation, the importance of relationships and obligations, and traditional Samoan lifestyle.

Characteristics of Workers

The previous discussions centred on programme effectiveness. Central to the delivery of the 'message' is the 'messenger'. The Health Promotion Forum of New Zealand (2012) have developed a set of competencies to identify and define the behaviours, skills, knowledge, and attitudes that health promoters need to work effectively and appropriately with Māori and other peoples, communities, and organisations in New Zealand. Other writers have outlined the key characteristics for those working in the area of sexual health promotion (Bogle, 2006; Department of Health, 2003; Smith, 1990).

The skills and knowledge required in sexual health promotion include:

- a broader and more holistic philosophy of care (that explores the psychosexual aspect of sexual health;
- knowledge and understanding of female and male sexual anatomy and physiology;
- human psychosexual development;
- understand how the psychological, sociocultural and socio-political processes have on sexual health; and
- need specific attitudes, skills and confidence to discuss sexual matters without embarrassment, within professional boundaries, and knowing when and to whom to refer for expert therapy (Bogle, 2006).

These attitudes and skills require the worker to have:

- enhanced self-awareness. Self-awareness enables individuals to discriminate between their own problems and those of others;
- possessing sex-positive attitudes. The need to consider one's own attitudes towards sex and sexual activities, in order to avoid judgemental and discriminatory practice;
- respect and acceptance of the sexual values and beliefs of each individual;
- ability to demonstrate genuine interest in a person and their sexual issue;
- ability to convey understanding in a language that a person may understand;
- ability to discuss a person's feelings and sexual relationships in a sensitive manner;
- ability to create an environment for open and effective communication (Bogle, 2006); and
- being free of cultural prejudice and bias. If a health worker wants to work effectively with different groups of people, he or she must overcome cultural bias and learn to see health and beliefs from a patients perspective (Smith, 1990).

Pacific Viewpoints

Engagement – Relational connections

Literatures pertaining to Pacific communities identify the importance for relational connections (Finau & Percival, 2010; Health Research Council of New Zealand, 2003; Le Va, 2009; Percival, et al., 2010a; Peteru & Percival, 2010; Te Pou o Te Whakaaro Nui, et al., 2010). Examples of how this can be demonstrated are documented in the report entitled *'Talking therapies for Pasifika peoples: best and promising practice guide for mental health and addiction services'* (Te Pou o Te Whakaaro Nui, et al., 2010). Some of the important factors in this engagement process involve:

- respect of cultural values,
- the need to build rapport,
- attitude,
- 'va' – space,
- attitudes that convey genuine interest and respect,
- a spirit of service,
- humility,
- being non-judgemental,
- respectful,
- displaying compassion and flexibility.
- face to face interactions (Le Va, 2009; Te Pou o Te Whakaaro Nui, et al., 2010).

Matching

The issue of client-worker matching has also been identified as a key issue in Pacific sexual health writings. One view is held is that programmes delivered to Pacific communities be delivered by ethnic specific facilitators, both men and women, who cover the range of ages in the population (Anae et al., 2000b). However, others note that this may be problematic in the area of Pacific sexual health promotion. Pacific youth have raised concerns about participating in forums led by older Pacific leaders or accessing services with ethnic specific workers (Matenga-Ikihele, 2012; Ministry of Health, 2008; Tupuola, 2000).

Tupuola (2000) questions the effectiveness of the context and procedures taken by both the Pacific communities and health educators to educate young Pacific women about sexuality. She notes that it is crucial to acknowledge the different power relations between Samoan youth and elders in New Zealand.

> *'It is unrealistic to expect that young Samoan women can speak in the presence of adults or to publicly discuss matters of sexuality with ease. The gatherings tend to reinforce the authoritative and hierarchical social structures of fa'a Samoa (Samoan culture). In general, there is an unspoken expectation at these meetings for youth, in particular young women, to listen and defer to the perspectives and*

decisions of those in authority – the older and elite members of the communities… Many young women feared the loss of privacy, especially as many of the educators are renowned members of their church, ethnic communities and neighbourhoods, possible relatives and family friends' (Tupuola, 2004, p. 62).

Matenga-Ikihele (2012) undertook a qualitative study exploring perceptions of sexual health among adolescent Niuean females who were born in New Zealand. She found there was a clear preference for the young women to use services that did not consist of Niuean health workers.[19] One of the reasons for this is the fear of breaching confidentiality. This issue is also raised in similar studies with Pacific young people.

Participants in the Pacific Youth Health Project reported that talking to a Pacific health worker was unsafe, and going to the family doctor or to a Pacific health service or worker was not an option, because they might be seen by somebody connected to their family or church. Overall, they were averse to any option that risked their parents finding out they were sexually active (Leger 2005 as cited in Ministry of Health, 2008:20)

A report by Te Pou o Te Whakaaro Nui (2010) presents a guide on working with Pasifika individuals and families. In this area of matching, they discuss that:

'It is important not to assume that culture is unimportant to all Aotearoa/New Zealand-born Pasifika peoples, as many are often still raised in families where Pasifika values, beliefs and traditions are strongly held and practice. Be guided by the person you are seeing'. (Te Pou o Te Whakaaro Nui, et al., 2010, p. 21).

Role of Family Members

An interesting finding from the Pacific sexual health literature is the role that family members play as educators in sexual health matters (Anae, et al., 2000a; Matenga-Ikihele, 2012). Matenga-Ikihele (2012) expresses an important role that Niuean women have, with mothers and sisters commonly identified as key educators in the transmission of sexual health information. This is important to note in developing sexual health promotion programmes.

[19] The objectives of her study were to explore sources of sexual health education and to identify the barriers that prevent young Niuean women accessing appropriate sexual health education, information, treatment and health services.

Working with Youth

In New Zealand a number of government documents have identified important considerations when working with young people of all ethnicities, including Pacific (Ministry of Health, 2002c, 2008; Ministry of Youth Affairs, 2002). The Youth Development Strategy (Ministry of Youth Affairs, 2002) places an emphasis on how policies and programmes are designed and provided for the betterment of young people.

A recent report from the Prime Minister's Chief Science Advisor entitled *'Improving the transition: reducing social and psychological morbidity during adolescence'* explored ways to improve the outcomes from young people in their transition from childhood to adulthood (Gluckman & Hayne, 2011). A number of the report findings are pertinent to this discussion of sexual health promotion activities for Pacific communities in New Zealand. These include:

- the young people of New Zealand reflect the changing ethnic mix of our population. While the issues and their solutions are generic across all of our population, *programmes must be developed and delivered in culturally appropriate ways to the very different communities that now make up young New Zealand.*
- an appreciation of the developmental stages. Puberty and adolescence represent a critical period of transition from childhood to adulthood, from reproductive immaturity to maturity, from dependence to independence. There is a need to understand life-course stages and adopt an interdisciplinary approach;
- the period of adolescence are strongly influenced by culture and sociological factors;
- remediation in adolescence is not likely to be as effective as prevention. There is growing evidence that prevention and intervention strategies applied early in life are more effective in altering outcomes and reap more economic returns over life course than do strategies applied later.

A report entitled *'Te Remu Tohu: A Framework for Youth Health Workforce Development'* presents a framework for the future development of the youth health workforce in New Zealand (Kekus et al., 2009). This report identified that 'sexual health concerns' was one of the six key health issues experienced by young people aged 15-24.

The key themes that emerged as being priority areas for development and consideration included:

- coordinated and holistic care;
- accessible and appropriate care; and
- characteristics of the Youth Health Workforce.

The characteristics of health services and the youth health workforce were also noted. Health services should be:

- accessible 24/7, online and via text;
- confidential;
- one stop shops;
- youth friendly;
- remove barriers related to cost/transport; and
- provide more access to health information and services.

The workforce should be:

- skilled;
- diverse;
- youth friendly, non judgemental, approachable; and
- should genuinely like people (Kekus, et al., 2009, p. 25)

Pacific Youth

The previous discussions have outlined the views and experiences of Pacific youth in relation to sexual health matters. For the purposes of this review, it is important to reference the Pacific Youth Health paper (Ministry of Health, 2008). This paper presents a framework for understanding poor Pacific youth health outcomes, including unintended pregnancy and sexually transmitted infections. The paper also collates the available information and evidence about Pacific youth health in New Zealand. The determinants of youth health: biology, culture, education, employment, housing are discussed. Risk factors such as diet, physical inactivity, smoking, alcohol and drug use, sexual activity and poor help seeking; poor health outcomes: chronic disease, injuries, unintended pregnancy, STIs and overweight and obesity are identified. Relevant interventions to improve youth health are also presented.

The paper acknowledges that New Zealand-educated Pacific youth have greater exposure to other value systems and are more likely to question traditional values that are not common or widely accepted in New Zealand society. The report recognises that cultural, family, community and church networks can serve as a protective factor for Pacific youth, but there are also challenges:

> *'the challenges of bridging two cultures can result in the isolation of youth from support structures at vital times' (Ministry of Health, 2008, p. vii).*

The development of sexual health promotion interventions need to be cognizant of these issues specific to Pacific youth.

CHAPTER 5: CHALLENGES AND KNOWLEDGE GAPS

This chapter discusses a few of the challenges and gaps identified within the literature. The following issues will be discussed:

- Rural and Urban populations
- Cultural values
- Reaching Pacific adults
- Pacific Health promotion settings

Rural and Urban Population Differences

A consideration of the differences between rural and urban Pacific populations was requested in the literature review brief. As noted by Robson, Purdie & Cormack (2010) the concept of 'rurality' and 'urbanicity' are complex with various measures utilized. For the purposes of this review, population size, accessibility to urban services, and peripherality (or remoteness) are important features in defining what a rural and urban area is.

At the time of the 2006 Census, 2.5 percent of the total Pacific population lived in rural areas.[20] A sizeable majority of Pacific peoples, some 67 percent of Pacific peoples (177,933 people) lived in the Auckland region. Thirteen percent lived in Wellington. An outline of the urban and rural distribution of Pacific ethnic groups is depicted in Table 10. However, there is very little information available on the ages of the Pacific groups living in rural areas.

Table 10: Rural/Urban Distribution of Pacific Ethnic Groups

Usual residence	Samoan	Cook Islands	Tongan	Niuean	Tokelauan	Fijian	Total Pacific	Total NZ
	Percent							
Auckland urban area	66.4	58.8	78.1	77.1	26.5	57.7	65.8	30
Hamilton urban area	1.7	2.5	2.4	2.3	0.8	4.1	2.2	4.6
Wellington urban area	15.7	11.1	4.3	6	49.7	9.5	12.4	9
Christchurch urban area	4.7	2.5	2.1	2.2	1.4	4.6	3.6	9
Dunedin urban area	0.8	1.3	0.8	0.5	1.2	1.3	0.9	2.8
Other main urban areas	5.6	10.7	5.5	4.6	11.5	10.8	7.1	16.6
Total main urban areas	94.9	86.7	93.2	92.7	91.1	88	92	71.8
Secondary urban areas	1.8	5.5	2.7	1.8	5.4	3.3	2.9	6
Minor urban areas	1.6	3.9	2.2	2.5	1.7	4	2.5	8.1
Total urban	98.3	96.1	98.1	97.1	98.2	95.3	97.5	86
Rural centres	0.3	0.9	0.5	0.6	0.3	0.8	0.5	2
Other rural areas	1.4	3	1.5	2.4	1.5	3.9	2	12
Total rural	1.7	3.9	1.9	2.9	1.8	4.7	2.5	14
Total	100	100	100	100	100	100	100	100

Source: (Statistics New Zealand and Ministry of Pacific Island Affairs, 2010, p. 19)

[20] Main urban areas are centred on a city or major urban centre, with a population of 30,000 or more. Rural centres and other rural areas are areas not specifically designated as 'urban'. They include towns of fewer than 1,000 people (Statistics New Zealand and Ministry of Pacific Island Affairs, 2010, p. 19)

Anecdotal evidence suggests that the sexual health issues facing Pacific communities in rural New Zealand areas differ from those in the urban areas, such as Auckland. A report by Robson (et al; 2010) entitled *'Unequal Impact II: Māori and Non-Māori Cancer Statistics by Deprivation and Rural–Urban Status 2002–2006'* provide some insight how rural–urban status and its relationship with deprivation may impact on health in different ways. These include:

- Exposure to risk and protective factors for health is likely to vary by rural–urban status however this is measured;
- Rural–urban status can impact on access to health services. For example those living in rural areas may be less likely to access health services
- Deprivation status. Three types of deprivation have been recognised: resource deprivation (low income, housing), opportunity deprivation (lack of availability of services such as health, recreation) and mobility deprivation (higher transport costs, inaccessibility of jobs, services, facilities)

However, as the findings from this literature review would attest, there is currently very little research exploring the rural and urban population differences. This is an area that warrants further research.

Cultural Values

A consistent theme from the Pacific literature was the strong influence of traditional cultural values and the inability for young Pacific peoples to learn and speak openly about matters relating to their sexuality. Tupuola (2000) in her study with young Samoan women found that many are hesitant about discussing taboo subjects in the presence of adults, particularly as they see it violating Samoan principals of fa'aloalo (respect) and ava (reverence).

This inability to speak openly about sexual health matters has a flow on effect in regards to the sexual health knowledge and attitudes of Pacific young people. As noted by participants in a Pacific Youth Health Project (Leger cited in Ministry of Health, 2008), the youth reported that although sexual health was a primary concern for sexually active Pacific youth, their knowledge is limited because it is a subject they are not allowed to talk about. Members in this group considered it culturally inappropriate to talk to their parents about sexual health (Ministry of Health, 2008). This is further evidenced in the study undertaken by Matenga-Ikihele (2012) with Niuean adolescent females living in Auckland. A key finding was the lack of knowledge these females about contraceptive methods, sexually transmitted infections and sexual health services.

Reaching Pacific Adults

A key issue facing sexual health promotion services in New Zealand is the potential disinterest of adults. This may be attributed to traditional Pacific cultural values. This is evidenced in research undertaken by McClellan (et al, 2000). Regional health programmes

found it difficult to get Pacific adult communities to address sexuality and reproductive health as a health issue and secondly to attract and engage adult audiences. Some of these difficulties were attributed to barriers internal to the services themselves, however, adults not wanting to discuss sexuality matters were also identified (McClellan & Guttenbeil, 2000).

Pacific Health Promotion Settings

The importance of church in the lives of many Pacific peoples is consistently noted in the Pacific literature. A number of health organisations are working with Pacific churches as a venue to promote health messages (Channing, et al., 2012; North, et al., 2012; Pacific Health Branch - Ministry of Health, 2007). However, there are mixed views in regards to involving churches as a venue for sexual health promotion (Anae, et al., 2000a; Tupuola, 2000).

Research undertaken with Pacific youth revealed that religion had a strong influence on the messages Pacific youth were allowed to receive about sex (Ministry of Health, 2008). Church denominations are guided by their ethos that may dictate the types of messages delivered to its members. Therefore, encouraging an open and frank discussion about matters related to sexual health, such as contraception methods, may well be in violation of church teachings. There is anecdotal evidence that youth groups within Pacific churches utilize components of sexual health promotion and prevention messages in their sessions. However this is not well documented or published. The role of church as a venue for sexual health promotion is one that needs further attention.

Deficiencies in the literature

In addition to the challenges noted, a number of deficiencies were evident when undertaking this review. These include:

- the lack of published evaluation material exploring the effectiveness of services tasked with delivering sexual health promotion specifically to Pacific communities in New Zealand[21];
- the absence of ethnic-specific viewpoints in regards to sexual health promotion approaches and activities. The majority of the sexuality studies with New Zealand pacific communities were undertaken with Samoan communities. One unpublished study presented the perspectives of Niuean participants;
- literature that portrays the contemporary views held by Pacific communities in regards to gender and sexuality (including sexual identities such as fa'afafine and fakaleiti). A number of Pacific documents refer to traditional views of sexuality and roles, however, given the changing demographics of Pacific peoples (such as the increasing number of children who are of mixed ethnicities) it is important to capture what this may mean for future programme delivery. It would be interesting to explore whether Pacific peoples share the same views towards sexual rights such as those noted in the WAS Declaration and how terms such as 'safer sex' and 'responsible sexual behaviours' are defined;
- the absence of a Pacific model and/or frameworks specific to the area sexual and reproductive health promotion for Pacific peoples living in New Zealand. A number of Pacific models and frameworks have been developed to address specific health issues such as mental health and violence.

Further exploration into these issues raised will assist in the development of sexual health promotion activities that are responsive to the needs of Pacific communities living in New Zealand.

[21] This is consistent with New Zealand sexuality research that notes the lack of knowledge on how to implement effective prevention programmes or develop effective policies (Jackson, 2004).

Conclusion

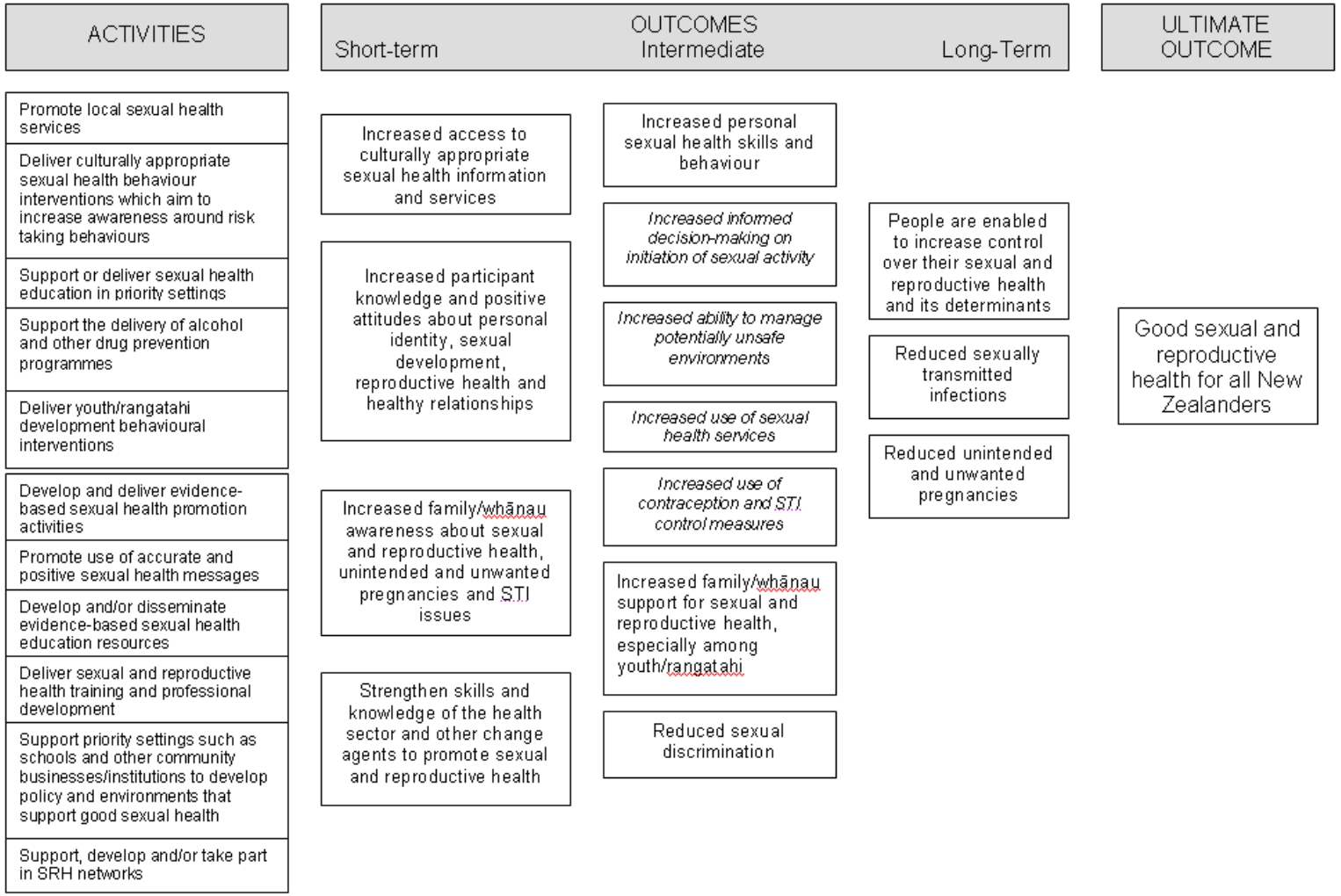
This review attempts to identify the key components of appropriate models and approaches that will enable the delivery of successful sexual and reproductive health promotion activities with Pacific peoples in New Zealand. The development of a model targeted for Pacific peoples firstly requires an understanding of how health, and in this context sexual health, is viewed within Pacific cultural groups. The review has revealed the existence of a number of Pacific health models and frameworks and general sexual health promotion theories and approaches, however none are specific to the area of sexual health promotion for Pacific communities. There are common characteristics noted within the Pacific models and frameworks, such as importance of cultural values, the holistic view of health and the importance of relationships.

The characteristics necessary for an effective programme are well documented in a number of international studies. These studies demonstrate success in relation to the delaying of sexual onset, reducing the numbers of youth engaged in sexual activity and increasing the rates of contraceptive use amongst teenagers. Local and international literatures also identify the characteristics required of those tasked with delivering sexual health promotion programmes. These include having specific content knowledge as well as cultural knowledge. The ability to engage effectively from the outset is crucial. Literatures specific to Pacific communities in New Zealand (and largely dominated by qualitative methods of enquiry) stress the need for programmes to have Pacific involvement at all stages of development and implementation. Useful suggestions for promotion and prevention efforts are documented by Pacific researchers. These include framing sexual health messages under the umbrella of forming 'responsible family and peer relationships' and 'general health', noting the use of language specific to the audience, recognising the diverse worlds that Pacific peoples in New Zealand traverse and the use of mediums that are resonate with Pacific communities, such as Pacific radio stations, drama, music and art.

The review also identifies the challenges inherent in developing a sexual health promotion programme for Pacific communities. Without overgeneralising, this is a community that is guided by traditional customs, values and beliefs that may inhibit open and frank discussions. The views of grandparents, parents and children may differ, especially within the New Zealand context where there is exposure to different value systems. The needs of youth, rural and urban Pacific populations and groups such as fa'afafine and fakalaiti also need to be acknowledged and addressed.

The future is promising for Pacific peoples. This review builds on the existing knowledge base and presents some insights that may enable progression towards further activities in the field of Pacific sexual health promotion.

Appendix 1: Draft Sexual Health Promotion - Programme Logic Model (Ministry of Health)



Appendix 2: Objectives of "The Roles and Responsibilities of Some Samoan Men in Reproduction' research study

The specific objectives of the research, as set out in the original proposal, were

1. To investigate the value of parenthood and children to these men and their 'partners'*.
2. To discover men's and women's ideas about their roles and responsibilities in reproduction.
3. To describe any differences in desired family size between the men and their 'partners' and how differences or agreement affect contraceptive and contraceptive practices.
4. To understand the process of fertility decision-making in the context of negotiation between partners and within the context of wider family.
5. To elicit knowledge and attitudes about reproductive physiology and conception, and about contraception, contraceptives and how they work
6. To gather information on access to contraception and contraceptive service delivery.
7. To gather information on contraceptive practices.
8. To assess the cultural values relating to contraception from analysis of secondary materials, life story, and, especially, key person interviews.
9. To evaluate the research methods and design of this project.
10. To work with sexual health practitioners, policy makers and educators with a view to implementation of the findings (Anae, et al., 2000a, p. 1).

*Partners' refers to actual and potential partners, including, for unpartnered men, women of roughly the same age and background.

Appendix 3: Nga Matauranga – Knowledge Base

A competent health promoter will know the following areas:

Te Tiriti o Waitangi	• The pre-eminent place of Te Tiriti o Waitangi in guiding health promotion action in Aotearoa New Zealand. • The attainment of health, with an emphasis on the retention and strengthening of Māori identity, as a foundation for the achievement of individual and collective Māori potential.
Aotearoa context	• Māori concepts, principles and practices of health and their impact on and implication for health promotion action. • Pacific concepts, principles and practices of health and their impact on and implication for health promotion action. • Understanding of cultural and social diversity.
Ottawa Charter	• The concepts, principles and values of health promotion as defined by the Ottawa Charter for Health Promotion and subsequent charters and declarations, see Appendix 2.
Health equity	• The concepts of health equity, social justice and health as a human right as the basis for health promotion action.
Ethics	• The ethical values and code of ethics/practice for health promotion in Aotearoa New Zealand.
Determinants	• The range of social, economic, political, and environmental determinants of health. • The determinants of health, impacts on and implications for health promotion action.
Prevention	• Prevention of avoidable morbidity and mortality, including prevention of communicable and non-communicable diseases.
Models	• Health promotion models, including associated integrated ways of working, and approaches which support empowerment, participation, partnership building.
Evaluation and Research	• The key ethical issues in health promotion research and their implications for practice. • The evidence-informed and research methods, including qualitative and quantitative methods, required to inform and evaluate health promotion action.
Key related areas	• Concepts and theories of change management and the implications for health promotion action. • The systems, including health systems and structures, policies and legislation that impact on health and their relevance for health promotion action. • The evidence-informed models and approaches of effective project and action management (including needs assessment, planning, implementation and evaluation) and their application to health promotion action. • The health promotion contribution to civil defence and public health emergencies. • The communication processes and current information technology required for health promotion action.

Source: (Health Promotion Forum of New Zealand, 2012, p. 12)

REFERENCES

Adolescent Health Research Group. (2003). A health profile of New Zealand youth who attend secondary school. *The New Zealand Medical Journal, 116*(1171), 1-9.

Agnew F, Pulotu-Endemann F.K, Robinson G, Suaalii-Sauni T, Warren H, Wheeler A, et al. (2004). *Pacific Models of Mental Health Service Delivery in New Zealand ("PMMHSD") Project*. Auckland: Clinical Research and Resource Centre. Waitemata District Health Board, Health Research Council of New Zealand.

Aitaoto, N., Braun, K. L., Dang, K. L., & So'a, T. (2007). Cultural considerations in developing church-based programs to reduce cancer health disparities among Samoans. *Ethnicity & Health, 12*(4), 381-400.

Anae, M., Fuamatu, N., Lima, I., Mariner, K., Park, J., & Suaalii-Sauni, T. (2000a). *Tiute ma Matafaiaoi a nisi Tane Samoa i le Faiga o Aiga. The Roles and Responsibilities of Some Samoan Men in Reproduction* (No. 0958206716). Auckland: Pacific Health Research Centre, University of Auckland.

Anae, M., Fuamatu, N., Lima, I., Mariner, K., Park, J., & Suaalii-Sauni, T. (2000b). *Tiute ma Matafaiaoi a nisi Tane Samoa i le Faiga o Aiga. The Roles and Responsibilities of Some Samoan Men in Reproduction.* Auckland: Pacific Health Research Centre.

Auckland District Health Board - Pacific Family Support Unit. (2012). Culture and Care Connecting. Pacific Best Practice Guidelines. Auckland: Auckland District Health Board.

Bogle, B. (2006). Sexual health promotion in midwifery practice In J. B. V. Manning (Ed.), *Health Promotion in Midwifery. Principles and Practice* (2 ed ed., pp. 111-126). London: Edward Arnold.

Bowden, J., & Manning, V. (2006). Health promotion in midwifery : principles and practice: London : Hodder Arnold, 2006

2nd ed. / edited by Jan Bowden, Vicky Manning.

Channing, M., Ualika, C., & Ha'unga, V. (2012). *Parish Community Nursing Service and innovative ways to increase health screening.* Paper presented at the 2012 Pacific Edge. Transforming Knowledge into Innovative Practice. HRC Pacific Health Research Fono, Waipuna Conference Centre.

Counties Manukau District Health Board. (2008). LotuMoui. 2012, from http://www.sah.co.nz/Funded-Services/Pacific-Health/LotuMoui.htm

Craig, E. (2008). *The health of Pacific children and young people in New Zealand / prepared for the Ministry of Health by Elizabeth Craig ... [et al.] on behalf of the New Zealand Child and Youth Epidemiology Service*. Dunedin, N.Z.: New Zealand Child and Youth Epidemiology Service,.

Department of Health. (2003). Effective Sexual Health Promotion Toolkit: a Toolkit for Primary Care Trusts and Others Working in the Field of Promoting Good Sexual Health and HIV Prevention. London: Department of Health.

Education Review Office - The Ministry of Education NZ. (2007a). *The Teaching of Sexuality Education in Years 7 to 13. June 2007.* Wellington: The Ministry of Education.

Education Review Office - The Ministry of Education NZ. (2007b). *The Teaching of Sexuality in Education in Years 7 to 13: Good Practice*. Wellington: The Ministry of Education.

Farran, S. (2010). Pacific Perspectives: Fa'afafine and Fakaleiti in Samoa and Tonga: People Between Worlds. *Liverpool Law Review, 31*(1), 13.

Finau, È., & Percival, T. (2010). *Halafononga faka Tonga ki he faka'ehi'ehi'o e hia fakamālohi' = Tongan pathways to the prevention of sexual violence*. Auckland: Pacific Health, School of Population Health, University of Auckland.

Fogel, C. I., Forker, J., & Welch, M. B. (1990). Sexual Health Care. In C. I. Fogel & D. Lauver (Eds.), *Sexual Health Promotion* (pp. 19-38). Philadelphia, PA: W.B Saunders Company.

Fogel, C. L. (1990). Sexual Health Promotion. In C. I. F. D. Lauver (Ed.), *Sexual Health Promotion* (pp. 1-18). Philadelphia, PA: W.B Suanders Company.

Fotu, M., & Tafa, T. (2009). The Popao model: a Pacific recovery and strength concept in mental health. *Pacific Health Dialog, 15*(1), 164-170.

Glover, M., Nosa, V., Watson, D., & Paynter, J. (2010). *WhyKwit : a qualitative study of what motivates Māori, Pacific Island and low socio-economic peoples in Aotearoa/New Zealand to stop smoking*. Auckland, N.Z: University of Auckland, School of Population Health, Centre for Tobacco Control Research.

Gluckman, P., & Hayne, H. (2011). *Improving the Transition. Reducing Social and Psychological Morbidity During Adolescence. A report from the Prime Minister's Chief Science Advisor. May 2011.* . Auckland: Office of the Prime Minister's Science Advisory Committee.

Gorin, S. S. (2006). Models of Health Promotion. In S. S. Gorin & J. H. Arnold (Eds.), *Health Promotion in Practice* (pp. 21-66). California: Jossey-Bass.

Gorin, S. S., & Arnold, J. H. (2006). Health promotion in practice / Sherri Sheinfeld Gorin, Joan Arnold, editors ; foreword by Lawrence W. Green: San Francisco : Jossey-Bass, c2006

1st ed.

Gorinski, R., & Fraser. (2006). *Literature review on the effetive engagement of Pasifika parents and communities in education*. Wellington: Ministry of Education.

Health Promotion Forum of New Zealand. (2012). *Nga Kaiakatanga Hauora mo Aotearoa. Health Promotion Competencies for Aotearoa New Zealand.* Auckland: Health Promotion Forum of New Zealand.

Health Research Council of New Zealand. (2003). *Guidelines on Pacific Health Research*. Auckland: Health Research Council of New Zealand.

Helu, S. L., Robinson, E., Grant, S., Herd, R., & Denny, S. (2009). *Youth '07 : the health and wellbeing of secondary school students in New Zealand. Results for Pacific young people*. Auckland: The University of Auckland.

Hope, L.-T., Rankine, J., & Percival, T. (2010). *Ko na auala faka-Tokelau ke puipui ai na amio faifakaulugaliki fakamalohi = Tokelau pathways to the prevention of sexual violence*. Auckland: Pacific Health, School of Population Health, University of Auckland.

Jackson, S. (2004). Identifying future research needs for the promotion of young people's sexual health in New Zealand. *Social Policy Journal of New Zealand* (21), 123.

Jameson, A., Sligo, F., & Comrie, M. (1999). Barriers to Pacific women's use of cervical screening services. *Australian and New Zealand Journal of Public Health, 23*(1), 89-92.

Kekus, M., Proud, P., Bell, S., Clark, T. C., Newman, J., Taylor, A., et al. (2009). *Te Remu Tohu: A Framework for Youth Health Workforce Development.* Auckland: Youth Health Workforce Alliance.

Kingi, P., Rankine, J., & Percival, T. (2010). *Tau puipuiaga Faka-Niue ke taofi e mahani kolokolovao = Niue pathways to the prevention of sexual violence* Auckland: Pacific Health, School of Population Health, University of Auckland.

Kirby, D. B. (2003). Risk and Protective Factors Affecting Teen Pregnancy and the Effectiveness of Programs Designed to Address Them. In D. Romer (Ed.), *Reducing Adolescent Risk. Toward An Integrated Approach.* (pp. 265-283). California: Sage Publications.

Kirby, D. B. (2007). *Emerging Answers 2007. Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*. National Campaign to Prevent Teen and Unplanned Pregnancy.

Kirby, D. B., Laris, B. A., & Rolleri, L. A. (2007). Sex and HIV Education Programs: Their Impact on Sexual Behaviors of Young People Throughout the World. *Journal of Adolescent Health 40*(3), 206-217.

Kupa, K. (2009). Te Vaka Atafaga: a Tokelau assessment model for supporting holistic mental health practice with Tokelau people in Aotearoa, New Zealand. *Pacific Health Dialog, 15*(1), 156-163.

Le Va. (2009). *Let's get real. Real skills plus seitapu. Working with pacific peoples*. Auckland: Te Pou o Te Whakaaro Nui. The National Centre of Mental Health Research, Information and Workforce Development.

Lui, D. (2007). Soifua Malolooina. In P. Culbertson, M. N. Agee & C. O. Makasiale (Eds.), *Penina Uliuli: Contemporary Challenges in Mental Health for Pacific Peoples.* Honolulu: University of Hawaii Press.

Macpherson, C. (1996). Pacific Islands identity and community. In P. Spoonley, D. Pearson & C. Macpherson (Eds.), *Nga Patai: Racism and ethnic relation in Aotearoa/New Zealand* (pp. 124-143). Palmerston North: Dunmore Press.

Macpherson, C. (2001). One Trunk Sends Out Many Branches: Pacific Cultures and Cultural Identities. In C. Macpherson, P. Spoonley & M. Anae (Eds.), *Tangata O Te Moana Nui. The Evolving Identities of Pacific Peoples in Aotearoa/New Zealand* (pp. 66-80). Palmerston North: Dunmore Printing Press.

Macpherson, C., Spoonley, P., & Anae, M. (2001). Pacific Peoples in Aotearoa: an Introduction. In C. Macpherson, P. Spoonley & M. Anae (Eds.), *Tangata O Te Moana Nui. The Evolving Identities of Pacific Peoples in Aotearoa/New Zealand*. Palmerston North: Dunmore Press.

Matenga-Ikihele, A. (2012). *Let's talk about sex: Knowledge, attitudes and perceptions towards sexual health and sources of sexual health information among New Zealand born Niuean adolescent females living in Auckland.* Paper presented at the Pacific Edge. Transforming Knowledge into Innovative Practice. HRC Pacific Health Research Fono., Waipuna Conference Centre, Auckland.

Mauri Ora Associates, & Medical Council of New Zealand. (2010). *Best Health Outcomes for Pacific Peoples. Practice Implications*. Wellington: Medical Council of New Zealand.

McClellan, V., & Guttenbeil, Y. (2000). *Final Report for the Comparative Evaluation of the Pacific People's Regional Sexual and Reproductive Health Programmes*. Auckland: Research and Evaluation Services Limited.

McGrath, B. B., & O.Ka'ili, T. (2010). Creating Project Talanoa: A culturally Based Community Health Program for U.S. Pacific Islander Adolescents. *Public Health Nursing 27*(1), 17–24.

McLaren, K. (2000). *Youth Development. Literature Review. Building Strength. A review of research on how to achieve good outcomes for young people in their families, peer groups, school, careers and communities.* Wellington: Ministry of Youth Affairs.

Minister of Health and Minister of Pacific Island Affairs. (2010). *Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2010-2014*. Wellington: Ministry of Health.

Ministry of Education. (2007). *The New Zealand Curriculum. For English-medium teaching and learning in years 1-13*.

Ministry of Health. (2000). *The New Zealand Health Strategy*. Wellington: Ministry of Health.

Ministry of Health. (2001). *Sexual and reproductive health strategy : Phase One*: Wellington, N.Z. : Ministry of Health, 2001.

Ministry of Health. (2002a). *He Korowai Oranga: Māori Health Strategy*. Wellington: Ministry of Health

Ministry of Health. (2002b). *The Pacific Health and Disability Action Plan*: Wellington, New Zealand : Ministry of Health=Manatū Hauora, 2002.

Ministry of Health. (2002c). *Youth Health: A Guide to Action*. Wellington: Ministry of Health.

Ministry of Health. (2002a). *New Zealand Youth Health Status Report*. Wellington: Ministry of Health.

Ministry of Health. (2003). *HIV/AIDS Action Plan: Sexual and Reproductive Health Strategy*. Wellington: Ministry of Health.

Ministry of Health. (2008). *Pacific Youth Health: A paper for the Pacific Health and Disability Action Plan Review*. Wellington: Ministry of Health.

Ministry of Health. (2010). *Statement of Intent 2010-2013*. Wellington: Ministry of Health.

Ministry of Health. (2012). *Tupu ola moui : Pacific health chart book, 2012*. Wellington, N.Z.: Ministry of Health.

Ministry of Pacific Island Affairs. (1999). *The Contributions of Pacific Peoples in New Zealand* Wellington: Ministry of Pacific Island Affairs.
Ministry of Social Development. (2012a). *Falevitu. A literature review on culture and family violence in seven Pacific communities in New Zealand.* Wellington: Ministry of Social Development.
Ministry of Social Development. (2012b). *Nga vaka o kāiga tapu. A Pacific Conceptual Framework to address family violence in New Zealand*. Wellington: Ministry of Social Development.
Ministry of Youth Affairs. (2002). *Youth development strategy Aotearoa : action for child and youth development*: Wellington, N.Z. : Ministry of Youth Affairs, 2002.
Moore, M. R., & Brooks-Gunn, J. (2003). Healthy Sexual Development. Notes on Programs That Reduce the Risk of Early Sexual Initiation and Adolescent Pregnancy. In D. Romer (Ed.), *Reducing Adolescent Risk. Towards an Integrated Approach.* . California: Sage Publications.
Naea, M. M. N. (2008). *Navigating many worlds : Samoan mothers' views on sexuality education* Unpublished Masters thesis, University of Auckland, Auckland.
National Advisory Committee on Health and Disability. (1998). *The social, cultural and economic determinants of health in New Zealand : action to improve health : a report / from the National Advisory Committee on Health and Disability (National Health Committee)*. Wellington, N.Z: National Advisory Committee on Health and Disability.
National Health Board. (2010). *Faiva Ora National Pasifika Disability Plan 2010-2013.* . Wellington: Ministry of Health.
National Screening Unit. (2012). National Cervical Screening Programme TV Commercials. from http://www.nsu.govt.nz/current-nsu-programmes/3021.aspx
North, N., Mahony, F., & Schwalger-Teura, T. (2012). *Increasing the effectiveness of Pacific physical activity leaders in church-based programmes.* Paper presented at the 2012 Pacific Edge. Transforming Knowledge into Innovative Practice. HRC Pacific Health Research Fono., Waipuna Conference Centre.
Northern DHB Support Agency Ltd. (2010). *The Regional Pacific Model of Care and Mental Health and Addictions Service Framework, 2010*. Auckland, New Zealand: Northern District Support Agency Ltd.
Pacific Health Branch - Ministry of Health. (2007). Lotu Moui. Pathway to the People. *Voyages. New Directions in Pacific Health,* 6-11.
Paterson J, Cowley E, & Percival T. (2003). Contraceptive practices among Pacific women in New Zealand. *New Zealand Medical Journal, 117*(1188).
Percival, T., Robati-Mani, R., Powell, E., Kingi, P., Peteru, M. C., Hope, L.-T., et al. (2010a). *Pacific pathways to the prevention of sexual violence : Full report* Auckland: Pacific Health, School of Population Health, University of Auckland.
Percival, T., Robati-Mani, R., Powell, E., Kingi, P., Peteru, M. C., Hope, L.-T., et al. (2010b). *Pacific pathways to the prevention of sexual violence: Overview report*. Auckland: Pacific Health, School of Population Health, University of Auckland.
Peteru, M. C., & Percival, T. (2010). *O Aiga o le anofale o afioaga ma le fatu o le aganuu Samoan pathways to the prevention of sexual violence = Samoan pathways to the prevention of sexual violence*. Auckland: Pacific Health, School of Population Health, University of Auckland.
Powell, E., Rankine, J., & Percival, T. (2010). *Na noda sala Vaka Viti ni tarova na vei kucumi = Fijian pathways to the prevention of sexual violence* Auckland Pacific Health, School of Population Health, University of Auckland.
Pulotu-Endemann, F. K. (2001). *Fonofale Model of Health*. Paper presented at the Pacific Models for Health Promotion. Massey University 07 September 2009.
Pulotu-Endermann F.K, & Peteru, M. C. (2001). Beyond the Paradise Myth: Sexuality and Identity. In C. Macpherson, P. Spoonley & M. Anae (Eds.), *Tangata O Te Moana Nui. The Evolving Identities of Pacific Peoples in Aotearoa/New Zealand.* Palmerston North: Dunmore Press.

Robati-Mani, R., & Percival, T. (2010). *Te ara Kuki Airani no te paruruanga i te kino tatomo tangata = Cook Islands pathways to the prevention of sexual violence* Auckland: Pacific Health, School of Population Health, University of Auckland.

Robson, B., Purdie, G., & Cormack, D. (2010). *Unequal Impact II: Maori and Non-Maori Cancer Statistics by deprivation and Rural—Urban Status, 2002–2006*. Wellington Ministry of Health.

Sandfort, T. (2006). Sexual Health. In S. S. Gorin & J. H. Arnold (Eds.), *Health Promotion in Practice*. California: Jossey-Bass.

Selu, E., & Percival, T. (2010). *Auala faka-Tuvalu e puipui ei a uiga puke malo = Tuvalu pathways to the prevention of sexual violence*. Auckland: Pacific Health, School of Population Health, University of Auckland.

Smith, L. S. (1990). Human Sexuality from a Cultural Perspective. In C. I. Fogel & D. Lauver (Eds.), *Sexual Health Promotion* (pp. 87-96). Philadelphia, PA: W.B.Saunders Company.

Statistics New Zealand. (2006). QuickStats About Pacific Peoples. Retrieved 30 March 2012, 2012

Statistics New Zealand and Ministry of Pacific Island Affairs. (2010). *Demographics of New Zealand's Pacific population*. Wellington: Statistics New Zealand and Ministry of Pacific Island Affairs,.

Sua'alii, T. M. (2001). Samoans and Gender: Some Reflections on Male, Female and Fa'afine Gender Identities. In C. Macpherson, P. Spoonley & M. Anae (Eds.), *Tangata O Te Moana Nui. The Evolving Identities of Pacific Peoples in Aotearoa/New Zealand*. 2001: Dunmore Press.

Suaalii-Sauni, T., Wheeler, A., Saafi, E., Robinson, G., Agnew, F., & Warren, H. (2009). Exploration of Pacific perspectives of Pacific models of mental health service delivery in New Zealand. *Pacific Health Dialog, 15*(1), 18-27.

Suaalii-Sauni, T., Wheeler, A., Saafi, E., Robinson, G., Agnew, F., Warren, H., et al. (2009). Exploration of Pacific perspectives of Pacific models of mental health service delivery in New Zealand. *Pacific Health Dialog, 15*(1), 18-27.

Taskforce on Whānau Centred initiatives, & Ministry of Social Development. (2010). *Whanau Ora. Taskforce Report*. Wellington: Ministry of Social Development.

Te Pou o Te Whakaaro Nui, Kingi-Uluave, D., & Olo-Whanga, E. (2010). *Talking therapies for Pasifika peoples : best and promising practice guide for mental health and addiction services*. Auckland, N.Z: Te Pou o Te Whakaaro Nui.

Tiatia, J. (2008). *Pacific cultural competencies : a literature review*. Wellington: Ministry of Health.

Tuitahi, S. (2009). *Fonua: A Pasifika Model for Health Promotion.* Paper presented at the Pacific Health Promotion Models Workshop, Massey University.

Tupuola, A. M. (2000). Learning Sexuality: Young Samoan Women. In A. Jones, P. Herda & T. Suaalii (Eds.), *Bitter Sweet - Indigenous Women in the Pacific* (pp. 61-72). Dunedin: University of Otago Press.

Tupuola, A. M. (2004). Talking Sexuality Through an Insider's Lens: The Samoan Experience. In A. Harris (Ed.), *All About The Girl* (pp. 115-125). New York: Routledge.

Work and Education Research & Development Services. (2011). *Evaluation of the Theatre in Health Educaiton Trust (THETA) sexual and reproductive health programme. August 2011*. Auckland: Work and Education Research & Development Services.

World Association for Sexual Health. (2008). *Sexual Health for the Millennium. A Declaration and Technical Document*. Minneapolis, MN, USA: World Association for Sexual Health.