Making a Pacific Difference:
Strategic Initiatives for the Health of Pacific People in New Zealand
Foreword

Ni sa bula vinaka, faka lofa lahi atu, kia orana, talofa lava, malo e lelei, taloha ni, greetings.

Comprehensive health policies for the Pacific communities require the input of those who are most in touch with these communities. We have gone to the Pacific people themselves to define, design and lead the future planning of health services for Pacific people.

*Making a Pacific Difference: Strategic initiatives for the health of Pacific people in New Zealand* provides a package of health strategies that belong to the Pacific people and reflect their needs and their initiatives. This strategy is the first step in a commitment to work with Pacific communities to put in place a range of services and other resources to improve, promote and protect the health of Pacific people living in New Zealand. It also provides a sound starting point for the development and integration of a Pacific perspective in mainstream services.

The aims and suggested strategies set out in this document speak for themselves. I would however, like to emphasise three points:

- *Making a Pacific Difference* is unique. It represents the first national strategy to be developed by Pacific people and Pacific health workers. The consultation has revealed a common perception of what needs to be done and how. It has also confirmed the importance of ‘community involvement’ in the development, delivery and management of health services specifically for Pacific people.

- While a major focus of this document is to achieve equitable access to health services, it is important not to lose sight of the ultimate goal: to improve health status. To this end, the strategy promotes the importance of an across-government approach, with a focus on improving and strengthening intersectoral relations between government agencies.

- Pacific people will be looking for significant improvement in the design, provision and delivery of accessible and appropriate health services. *Making a Pacific Difference* provides the opportunity for the health sector to achieve a co-ordinated range of health services that respond effectively and efficiently to the diverse health needs of Pacific people throughout New Zealand.

*Making a Pacific Difference* is an excellent document. I encourage all those within the health sector (managers, policy makers, funder and providers) to adopt the proposed initiatives with the ultimate aim of establishing and maintaining accessible and appropriate health services for Pacific people.

The Public Health Group invites comment on the issues contained in this paper. Please send your comments to the address shown at the back of the book.

Karen O Poutasi (Dr)
Director-General of Health
The development of *Making a Pacific Difference: Strategic initiatives for the health of Pacific people in New Zealand* was led by Michele Vanderlann-Smith, the former Senior Advisor (Pacific People’s Health) in the Public Health Group of the Ministry of Health. The following people and organisations are acknowledged for their important contribution to this document.

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Thank you to the Ministry of Pacific Island Affairs for their valuable input to the development of the strategy.

Finally, thank you to Pacific people, the contributors, the co-ordinators of the consultation meetings, the church leaders who led those meetings, the young, the older people and the men and women who contributed their time and aspirations to *Making a Pacific Difference* for the future of Pacific people in New Zealand.

Vinaka vakalevu, fa’afetai lava, faka’aue lahi, malo aupito, meitaki maata, fakahetai.

Dr Gillian Durham  
Director of Public Health and  
General Manager, Public Health Group
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>iii</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>iv</td>
</tr>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Pacific People – An Introduction</td>
<td>3</td>
</tr>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>Pacific people in New Zealand</td>
<td>3</td>
</tr>
<tr>
<td>The Pacific concept of health</td>
<td>5</td>
</tr>
<tr>
<td>Traditional medicine and Western scientific medicine</td>
<td>5</td>
</tr>
<tr>
<td>The Pacific concept of family</td>
<td>7</td>
</tr>
<tr>
<td>How healthy are Pacific people?</td>
<td>7</td>
</tr>
<tr>
<td>The socioeconomic context</td>
<td>8</td>
</tr>
<tr>
<td>Planning for the future</td>
<td>9</td>
</tr>
<tr>
<td>Introducing the Health Strategy</td>
<td>11</td>
</tr>
<tr>
<td>Introduction</td>
<td>11</td>
</tr>
<tr>
<td>Why a health strategy is needed</td>
<td>11</td>
</tr>
<tr>
<td>Working principles for health services</td>
<td>11</td>
</tr>
<tr>
<td>Key elements of the strategy</td>
<td>12</td>
</tr>
<tr>
<td>From the strategy to specific policies</td>
<td>12</td>
</tr>
<tr>
<td>Improving the Delivery of Health Services</td>
<td>14</td>
</tr>
<tr>
<td>Introduction</td>
<td>14</td>
</tr>
<tr>
<td>The Pacific People’s Health Charter</td>
<td>14</td>
</tr>
<tr>
<td>Intersectoral collaboration</td>
<td>15</td>
</tr>
<tr>
<td>Infrastructure development</td>
<td>15</td>
</tr>
<tr>
<td>Public Health</td>
<td>15</td>
</tr>
<tr>
<td>Recruitment and training</td>
<td>16</td>
</tr>
<tr>
<td>Health promotion</td>
<td>16</td>
</tr>
<tr>
<td>Cross cultural communication</td>
<td>17</td>
</tr>
<tr>
<td>Research</td>
<td>18</td>
</tr>
<tr>
<td>Addressing Key Health Concerns</td>
<td>19</td>
</tr>
<tr>
<td>Introduction</td>
<td>19</td>
</tr>
<tr>
<td>Sexual and reproductive health</td>
<td>20</td>
</tr>
<tr>
<td>Cancer</td>
<td>21</td>
</tr>
<tr>
<td>Coronary heart disease and stroke</td>
<td>23</td>
</tr>
<tr>
<td>Injury prevention</td>
<td>24</td>
</tr>
<tr>
<td>Mental health</td>
<td>25</td>
</tr>
<tr>
<td>Nutrition</td>
<td>26</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>27</td>
</tr>
<tr>
<td>Asthma</td>
<td>28</td>
</tr>
</tbody>
</table>
### Identifying the Issues for Pacific Population Groups

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>30</td>
</tr>
<tr>
<td>Child health</td>
<td>30</td>
</tr>
<tr>
<td>Young people’s health (15–24 years)</td>
<td>33</td>
</tr>
<tr>
<td>Women’s health</td>
<td>35</td>
</tr>
<tr>
<td>Men’s health</td>
<td>36</td>
</tr>
<tr>
<td>The health of older people</td>
<td>38</td>
</tr>
<tr>
<td>Pacific people in rural communities</td>
<td>39</td>
</tr>
</tbody>
</table>

### Reviewing Health Services for Pacific People – A Quality Monitoring Model

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>40</td>
</tr>
<tr>
<td>The purpose of quality monitoring</td>
<td>40</td>
</tr>
<tr>
<td>Characteristics of quality monitoring</td>
<td>40</td>
</tr>
<tr>
<td>Characteristics of a quality health service</td>
<td>41</td>
</tr>
<tr>
<td>The Donabedian model of quality monitoring</td>
<td>41</td>
</tr>
<tr>
<td>Pacific cultural considerations</td>
<td>41</td>
</tr>
<tr>
<td>Identifying and selecting quality indicators</td>
<td>42</td>
</tr>
<tr>
<td>The client and provider relationship</td>
<td>42</td>
</tr>
</tbody>
</table>

### Conclusion

44

### Appendix – The Yanuca Declaration

45

### Contributors’ Profiles

49

### References

51

### Glossary

54

### Consultation meetings – Fono

56

### Written Submissions Received

56

### Address to Send Comments

56
Introduction

Making a Pacific Difference: Strategic initiatives for the health of Pacific people in New Zealand is a set of initiatives developed by Pacific people to enable policy makers, the funder and providers to respond appropriately, effectively and efficiently to the health needs of Pacific people over the next decade. Its purpose is to make a positive difference in the provision, delivery, monitoring and management of health services.

The strategy comprises the following sections:

- Pacific people – an introduction
- Introducing the health strategy
- Improving the delivery of health services
- Addressing key health concerns of Pacific people
- Identifying issues for Pacific population groups
- Reviewing health services for Pacific people – a quality monitoring model.

Each of these sections gives a range of practical initiatives to achieve positive health outcomes for Pacific people and to improve the management and delivery of their health care services. The aims for each issue identified were developed through the consultation process with Pacific people and the strategies suggested as a way to work towards these aims. Relevant public health objectives are also included for each identified issue (Ministry of Health 1997f).

This strategy brings together international strategic principles, the aims of the Yanuca Island Declaration of Health in the Pacific in the 21st Century (appendix), the Ottawa Charter (WHO 1986) and the initiatives of Pacific people in New Zealand.

The strategy introduces the Pacific People’s Health Charter which emphasises the need for the health sector to seek the views of Pacific people when formulating plans. It is based on the premise that the quality of health services received by Pacific people is dependent on their involvement, accurate assessment of their health needs and the ability of the funder and providers to address those needs in the services they provide.

With its focus on strategic planning, Making a Pacific Difference: Strategic initiatives for the health of Pacific people in New Zealand sets future directions for Pacific people’s health. It includes mechanisms to feed back reaction from the health sector and for ongoing evaluation.

At the core of the strategy are working principles that provide a sound starting point for the development and integration of a Pacific perspective in mainstream health and disability support services. The strategy also provides a basis for moving towards the future development of specific services for Pacific people living in New Zealand.

The working principles of the strategy have been designed to complement other key health strategies, such as Strengthening Public Health Action: The strategic direction to improve, promote and protect public health (Ministry of Health 1997f), National Plan of Action for Nutrition: The Public Health Commission’s advice to the Minister of Health 1994–1995 (PHC 1995), Advancing Health in New Zealand (Ministry of Health 1995a) and Strategies for the Prevention and Control of Diabetes in New Zealand (Ministry of Health 1997e).

In the context of providing holistic health services, Making a Pacific Difference: Strategic initiatives for the health of Pacific people in New Zealand seeks to develop a coherent and community-focused strategy to improve Pacific people’s access to health services and equity in health outcomes.

A National Advisory Group was established to guide the development of this strategy. Contributions were sought from Pacific people to prepare a consultation document for wider consultation. This consultation document Making a Difference: Strategic initiatives for the health of Pacific people formed the basis of consultation with Pacific communities. Seven consultation workshops or fonos were held with Pacific
communities throughout New Zealand during February and March 1997. Korero Pasifika: Consultation review, Making a Difference, is the collation of the issues, discussion, views, ideas, strategies and recommendations raised during consultation. It is available from the Ministry of Health. Five written submissions were also received. This document incorporates the analysis of the submissions and reflects the outcome of the national fonos. Statistical data was updated to incorporate census data of 1996 and relevant public health objectives included from the revised strategic direction for public health in New Zealand (Ministry of Health 1997f).

The term ‘Pacific people’ has been used throughout this document and refers to the population of Pacific ethnic origin (Samoan, Cook Island Māori, Tongan, Niuean, Fijian, Tokelauan) incorporating people born in New Zealand as well as overseas.
Introduction

This section looks at the place of Pacific people within New Zealand’s population. It compares the practice of traditional healing with Western scientific medicine and describes the Pacific concepts of health and of the family.

The health status of Pacific people relative to the general population is summarised. The health of Pacific people in New Zealand is influenced, not only by the quality of their health care services, but also by cultural and social factors including income, education, housing and transport. The impact of these factors on Pacific people’s health status is briefly described.

Finally, this section looks to the health status of Pacific people in the future. Under current trends, improving health standards and ensuring equitable access to appropriate health services will have enormous social and economic implications.

Pacific people in New Zealand

The Pacific population in New Zealand:

- has grown from a little over 100,000 in 1981 to over 202,000 at the 1996 Census
- forms 6 percent of the total population
- is estimated to grow to 7.2 percent of the total population by the year 2031
- is one of the fastest growing population groups in New Zealand
- is relatively young in comparison with the total population.

Figure 1 shows the percentage of Pacific ethnic groups in New Zealand. Most of New Zealand’s Pacific population comes from Samoa, followed by Cook Island Māori, then people from Tonga, Niue, Tokelau and Fiji. Other groups in New Zealand include people from Tuvalu, Papua New Guinea, Vanuatu, Solomon Islands and Kiribati.

The 1996 Census showed that Pacific people include a higher proportion of those aged under 15 than the national average.

Figure 1: Pacific ethnic groups in New Zealand
There are significant settlements of Pacific people in Auckland, Wellington, Waikato, Bay of Plenty, Manawatu-Wanganui and Canterbury. Figure 2 shows the distribution of Pacific people in each region of the Transitional Health Authority.

Pacific people living in this country represent at least 22 different cultures and speak an even greater number of languages. Therefore, the term ‘Pacific people’ does not refer to a single ‘nationality’ or ‘ethnicity’, but is a collective term for a diverse range of people from the South Pacific region.

Figure 2: Distribution of Pacific people throughout each division of the Transitional Health Authority
In the development of health policy and the purchase and delivery of health services, it is necessary to understand and acknowledge the cultural distinctions between each Pacific group. This cultural diversity means that to be effective, the design, delivery and evaluation of health services for Pacific people must involve consultation with representatives of all the major Pacific groups.

The Pacific concept of health

At different times and in different cultures, people have viewed health differently. The term ‘health’ cannot be defined absolutely, but can only be recognised and described in relation to actual situations. Disability support is an integral part of health care in Pacific cultures. The emphasis is on the total wellbeing of the individual and how that relates to the family and the community.

What is health?

The World Health Organization (WHO) suggests that health is best understood not just as the absence of disease, but as a state of complete physical, mental and social wellbeing (WHO 1947). Many of the people of the Pacific believe that spiritual wellbeing is equally essential to health. In this strategy, therefore, health is defined as a state of complete physical, mental, social and spiritual wellbeing.

The WHO definition of health is similar to the traditional medical notion of health. In both, people are regarded as complete human beings, acting in society with a purpose.

What is illness?

Like health, illness can only be defined usefully in relation to specific cultures and situations. In some cultures, a particular physical, social, mental or spiritual state will be defined as an illness, while in another culture a similar state will not be seen as abnormal.

Therefore, a person is ill if they believe, and their society generally agrees, that they are unable to perform their usual activities. In extreme cases of illness, their life may be threatened. In this strategy, illness is defined as a physical, social, mental and spiritual state that society and the individual agree will adversely affect life, relationships and the performance of duties.

What is disease?

Unlike illness, disease is defined and legitimised by the medical profession. This definition is determined by what is biologically normal for a given group of people in a given environment. The definition of disease is used to inform the patient of the presence of harmful symptoms, as a means of deciding on treatment and a basis for comparing the outcome of that treatment.

In this strategy, disease is defined as a state of physical, social, mental and spiritual abnormality as perceived by medical professionals.

As our ability to use science and technology increases, we increase our ability to create and discover defects in human biology and behaviour. However, under the holistic view of health given above, disease is important only to the extent that it affects capability and performance.

Traditional medicine and Western scientific medicine

The most important function of any health service is to serve the needs of society and promote the common good. It must serve both the client and the provider with unconditional respect for difference and without compromising individual cultures.

Pacific people recognise two distinct, but not mutually exclusive, systems which they may draw upon to restore and maintain health. For the purposes of this strategy, these are termed ‘traditional’ and ‘Western scientific’ medicine.
Traditional medicine is an integral part of the evolving culture and way of life of Pacific people. It is often a society’s response to illnesses that interfere with activities within the social, economic, political and religious systems. This response may not conform with Western scientific logic and rationality, but that does not necessarily invalidate it as an effective means of controlling and alleviating these illnesses.

Unlike traditional medicine, Western scientific medicine is a universally accepted body of knowledge and is not specific or commonly exclusive to a given community. Western scientific medicine may be defined as: the methods of treating diseases derived from the application of scientific methods and logic.

Western scientific medicine is not the only yardstick for measuring the effectiveness of all healing practices. The ultimate yardstick must be the ability of a health service to restore function and enable individuals to fulfill their obligations to themselves, each other and society, without endangering other parts of the physical and social environment.

The basic difference between traditional medicine and Western scientific medicine lies in the perception of the causes of disease. In traditional medicine, causation revolves around the disturbance of relationships with gods or supernatural beings, one another or society and the land. This disturbance leads to a state in which the person becomes incapable of, or less efficient at, meeting society’s or their own expectations. A person is healthy if they are able to meet their own or society’s expectations.

In Western scientific medicine, the cause of disease is an abnormality or organ dysfunction. This abnormality is a measurable variation from an ideal standard. Therefore, health is restored when this variation is decreased.

This fundamental difference between traditional medicine and Western scientific medicine has created an apparent dichotomy in their respective approaches to health, illness and disease.

We need to ask how much of our contemporary health care system can be provided effectively by each of these two approaches, either jointly or individually. Neither approach is likely to be entirely satisfactory in all situations. Therefore, a mutually beneficial coexistence must be the goal.

To make traditional medicine acceptable within the health system, fundamental questions must be addressed: whether traditional practices are effective at improving health; whether these practices are harmful; whether they are available, accessible, acceptable and affordable to communities; and whether they are efficient and equitable.

In the current health sector environment, the balance of power rests with the funder and providers. If traditional medicine is to be promoted as a significant part of health services, more control must be transferred to the community, so that the health care system better reflects Pacific people’s needs.

Traditional medicine and Western scientific medicine cater for different demands from consumers. The choice reflects the consumer’s perception of the best way to satisfy a health need and also the quality of response to the consumer’s demand.

In this context, the health sector should recognise the potential contribution of traditional medicine to the provision of health care and develop a clear policy framework on the integration of traditional medicine into primary health where appropriate. If traditional healing is publicly funded, it will have to conform to the usual contractual, reporting, quality and safety requirements that are agreed by the Transitional Health Authority.

While Western medicine has long replaced traditional medicine as the mainstream in the health system, there is resurgence of the acceptance and use of traditional medicine among Pacific people. With escalating health care costs, the role of traditional medicine as an integral part of the health care system cannot be over-emphasised.
The Pacific concept of family

For Pacific people, the family is the main unit in which children learn, grow and are enabled to survive the vulnerable years of early childhood. The family has also traditionally been the only support structure for older people. Regardless of actual living arrangements, ‘family’ to Pacific people usually means ‘extended family’ and includes an integration of family networks.

Although the closeness of mutual family obligations may be weakening due to socioeconomic factors or assimilation within wider New Zealand society, the implications of the extended family structure are at the centre of Pacific cultures, behaviours and beliefs. Understanding them is particularly relevant when developing health promotion programmes and implementing policy.

For example, in some communities where people are personally known to each other, it is difficult to obtain family planning information or contraceptives without the knowledge of other family members. This can undermine the basic requirements for the success of a programme: the right to privacy and a relationship of confidence between service provider and client.

Another example is in the child health area where successful programmes will meet the needs of the family and will view the child as a component of the family, not as an individual.

On the positive side, the sharing of common values and behaviour can be a catalyst for greater health promotion effectiveness.

How healthy are Pacific people?

Although the health status of Pacific people living in New Zealand has shown improvement, recent statistical data shows that:

- the hospitalisation rate for infants under one year of age was 39 percent higher than the national rate in 1995, while that for children aged 1–4 years was 28 percent higher. Among 10–14 year olds, the hospitalisation rates for Pacific children for acute rheumatic fever, pneumonia and middle ear infection were well above the national rates
- the late fetal death rate for Pacific people’s births was 48 percent higher than the national rate in 1995. Infant and neonatal death rates for Pacific babies were lower than the national average
- Pacific children continue to be admitted to hospital for pneumonia at four times the rate for all children and for acute rheumatic fever at five times the national rate
- unintentional injury (mainly motor vehicle crashes) and suicide accounted for 67 percent of deaths of Pacific people aged 15–24 in the period 1991–94
- in 1995 the major causes of hospitalisation for Pacific males were unintentional injuries (including motor vehicle crashes), respiratory diseases, perinatal conditions and disease of the digestive system
- Pacific women have consistently higher fertility rates in all ages beyond 19 years
- Pacific women continue to have the highest abortion rate
- in 1993, 19 percent of Pacific female cancer registrations were for breast cancer and one-quarter for cancer of the cervix, ovary and uterus. The rates for the latter three types of cancer exceed the national female rates, whereas the breast cancer rate is below the national rate
- pregnancy, respiratory diseases and genitourinary diseases also head the list for hospitalisations of females
- Pacific people continue to suffer the highest incidence of rheumatic fever and rheumatic heart disease, obesity and related dietary conditions
- the incidence of cancer of the liver is higher among Pacific people than among the general population
- the incidence rate of tuberculosis among Pacific people in 1996 (31 per 100 000 population) was more than 10 times higher than the rate for Europeans (3 per 100 000) (Ministry of Health 1997a)
• schizophrenic and psychotic disorders and alcohol dependence or abuse are the leading diagnoses for first admission to psychiatric institutions. Pacific people attempt to address mental illness by using traditional health remedies and consulting church ministers and often present late for formal psychiatric treatment.

The current health status of Pacific people can be attributed to a number of factors including the nature of the illnesses, lack of access to appropriate services, delay in seeking treatment and lack of follow-up and support to manage the illness or necessary treatment, the influence of cultural and religious issues and the low socioeconomic status of Pacific people.

Participation by Pacific people in the decision-making process, management and evaluation of health programmes and services is necessary to enable these programmes and services to respond effectively to the health needs of Pacific people.

The socioeconomic context

The poor health status of Pacific people in New Zealand probably can be explained broadly in terms of the low socioeconomic status of Pacific communities.

The Public Health Association of New Zealand report (Public Health Association of New Zealand 1992) for the Ministry of Health:

• acknowledged income as being a key factor influencing health status
• found substantial evidence that low education is associated with low health status
• found that the unemployed have worse physical and mental health than the employed
• found that children in sole-parent families are at greater risk of health problems than other children
• found that housing has a direct impact on health
• found that being without private transport or access to public transport affects health status both directly by reducing access to public health services and indirectly by reducing social networks beneficial to good health.

There is a lack of relevant statistical information on the impacts of socioeconomic factors on the health status of Pacific people in New Zealand. The report cited above did not explore specifically the interaction between economic and social factors and ethnicity and their effects on the health status of Pacific people.

However, Pacific people perceive that their lifestyle in the Islands is healthier than in New Zealand, especially in relation to diet, use of cigarettes and alcohol and domestic violence. The mental health of Pacific people in New Zealand is also considered to be poorer. Actual physical health was directly affected by income since health care was often not accessed because it was not affordable.

Often, cultural obligations are met at the expense of health care (PHC 1994). According to Tukuitonga (1990), these traditional obligations, on top of the need to meet everyday living expenses, have maintained an under-class economic existence in New Zealand for many Pacific families.

Some of the socioeconomic factors with a potentially significant impact on the health status of Pacific people are as follows.

Income and employment

Studies reviewing the influence of economic and social factors on health status indicate that low income is perhaps the most significant. Further, the health of a population is affected more by the distribution of wealth within that population, than by the actual level of wealth (Public Health Association of New Zealand 1992).

Pacific communities have experienced increased economic hardship since the 1980s, especially with the steep rise in unemployment.

The Pacific unemployment rate has decreased in recent years but is still high, with a rate of 16.9 percent in comparison to 16.2 percent for Māori and 5 percent for Europeans (Statistics New Zealand 1997b).
There have been no studies of the specific effects of unemployment on Pacific people. It cannot be assumed that the effects on Pacific people will be the same as on other New Zealanders. Pacific people themselves see unemployment as one of the major factors contributing to their poor health status. The resulting lack of income restricts their ability to meet health costs or access health care and has contributed to other social problems such as domestic violence.

Tukuitonga (1990) considers that Pacific children are admitted to hospitals more frequently than the children of other ethnic groups, often in a more severe state, because families cannot afford adequate primary medical care and primary care services are often not responsive to Pacific people.

**Housing**

There is a two-way relationship between housing and health. Most obviously poor housing can lead to, or worsen, physical and mental health problems. As well, those with poorer health, particularly poorer mental health, are likely to end up in the worst housing (Public Health Association of New Zealand 1992).

The main housing problems faced by Pacific people are high cost, overcrowding and unsuitable home designs. The households of most Pacific people contain relatively more people than the households of most other ethnic groups in New Zealand. Pacific people are also less likely to own their own homes.

**Education**

There is substantial evidence that a low level of education is associated with poor health status. The 1996 Census (Statistics New Zealand 1997a) revealed that:

- 46 percent of Pacific people of working age (15 years old and over) had no formal qualifications
- 2 percent of Pacific people had university qualifications
- New Zealand-born Pacific people are more likely to hold post-school qualifications than Islands-born Pacific people.

Overall, Pacific people continue to have fewer formal qualifications than those in the general population (Krishnan et al 1994a).

**Transport**

There are two main ways in which transport impacts upon health:

- death, injury and distress resulting from road traffic crashes
- the role of transport in people’s access to services and facilities.

Research indicates that the effects of being without private transport or without access to public transport are most severely felt by groups which are already disadvantaged (Public Health Association of New Zealand 1992). Only 22 percent of households in Otara (where Pacific people make up 52 percent of the population) have a registered car, compared with 88 percent of households within the total North Health division of the Transitional Health Authority (Mitchell 1995).

The lack of access to transport can impact directly on health by reducing access to publicly funded health services offering both preventive and treatment services. It has a less direct impact in restricting access to the social support networks considered to be important to good health.

**Planning for the future**

If the current population trend continues, the health status of Pacific people will have significant implications for the health sector.

Current high fertility levels mean that the Pacific population will continue to grow for many years and will have relatively high proportions of young and old people. If immigration trends continue, this will also add to the increased population of Pacific people in New Zealand.
Current gaps in health services for Pacific people (eg, the lack of appropriate and established processes for Pacific people to monitor and evolve their health services), will have a major impact on their future health status and health needs. Although cultural and economic factors undoubtedly play a role, obstacles within our health care system that restrict access to effective and efficient health services should not be ignored.

The Pacific Islands Health Research Units at Whitireia Polytechnic (Wellington) and Auckland University (sponsored by the Health Research Council) are involved in research concerning the development and monitoring of Pacific people’s health in New Zealand.

Improving the health of Pacific people requires a commitment by government agencies to develop policies to improve and maintain their health. Pacific people in New Zealand also have a role to play. The way ahead is a joint approach to ensuring equitable access to effective and appropriate health services for Pacific people.
Introducing the Health Strategy

Introduction

This section explains why this strategy is needed to co-ordinate the development of appropriate health services for Pacific people. It sets out the underlying working principles and identifies the four main areas for action: improving the delivery of health services; key areas for improving health standards; identifying the specific health needs of Pacific men, women, children, young and older people; and establishing a model for monitoring the quality of health services for Pacific people.

The roles of the Ministry of Health, the Ministry of Pacific Island Affairs and the funder are outlined, along with the key elements of the strategy.

Why a health strategy is needed

A strategy is important for the development of appropriate health services and best practice standards for the management and delivery of these services. It provides the basis for co-ordination of activities across the health sector, and also support for regional and local development and the implementation and monitoring of relevant policies and plans for Pacific people. It also provides a sound starting point for the development and integration of a Pacific perspective in mainstream initiatives.

Working principles for health services

The strategy is based on the following working principles that any organisation and individual can apply in the development and delivery of health services for Pacific people.

<table>
<thead>
<tr>
<th>Working Principles</th>
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<td>• <strong>Respect for individual dignity</strong> – the development and delivery of health services will be provided in a manner that acknowledges respect for cultural and individual differences. This includes basic service elements of appropriateness and quality of service, effectiveness and efficiency in the delivery of service, and empathy in the care and treatment of clients.</td>
</tr>
<tr>
<td>• <strong>Equity of access</strong> – a dimension of individual dignity. The principle of equity of access reflects the desirability of achieving greater equity in the allocation of health resources, as measured by health outcomes and health status.</td>
</tr>
<tr>
<td>• <strong>Acceptability</strong> – access to acceptable services is an essential element in improving health outcomes for Pacific people. There can be no fixed rules to ensure services are appropriate to specific Pacific cultures. Rather, programmes need to be designed and evaluated on a case by case basis, with clear objectives and population groups in mind.</td>
</tr>
<tr>
<td>• <strong>Community involvement</strong> – Pacific people must have the opportunity to play a major role in the design, development, implementation and evaluation of health services which affect their communities.</td>
</tr>
<tr>
<td>• <strong>Workforce development</strong> – consumers’ needs are more likely to be effectively met if the health service providers reflect the linguistic and cultural backgrounds of those consumers. To achieve this, the health sector needs to openly value the linguistic and cultural skills of its workforce and to acknowledge this during the recruitment and training of staff at all levels of the health system.</td>
</tr>
<tr>
<td>• <strong>Effective resource use</strong> – effective organisational structures and programmes for managing and monitoring resource use, through measurement of health outcomes, are essential components of every health strategy.</td>
</tr>
</tbody>
</table>
Key action areas

There are four areas of action to improve the health of Pacific people:

1. improving the delivery of health services
2. addressing key health concerns
3. identifying the issues for Pacific population groups
4. establishing a model for reviewing the quality of health service delivery to Pacific people.

These are discussed in detail later in this document. Some of these key areas may change over time, or it may become appropriate to add new key areas. Therefore, progress in each area will need to be monitored on a regular basis.

The role of the Ministry of Health

The Ministry of Health is responsible for advising the Minister of Health and the Government on Pacific people’s health issues. The Ministry has the responsibility to develop a strategic policy framework for the health sector which includes improving and sustaining health gains for Pacific people.

The role of the Ministry of Pacific Island Affairs

The Ministry of Pacific Island Affairs provides strategic advice to the Government on issues affecting Pacific people resident in New Zealand, particularly in the areas of education, employment, economic development, intersectoral issues and health. A Protocol for Policy Commentary and Information Exchange was agreed between the Ministry of Pacific Island Affairs and the Ministry of Health in June 1997 (Ministry of Health 1997d). This protocol specifies ways for the two Ministries to work together to improve the effectiveness of policy advice for improving health outcomes for Pacific people in New Zealand.

The role of the funder

The funder is charged with the responsibility for ensuring high quality health care and is therefore uniquely placed to improve health outcomes for Pacific populations. The onus is upon the funder of health services to be proactive in its development of regional services for Pacific people. Collectively these may have significant impacts on the health status of Pacific people throughout New Zealand.

Key elements of the strategy

The strategic approach

The implementation of the strategy involves three phases:

1. identifying aims and strategies for future development
2. integrating the strategy into the health sector
3. establishing ongoing monitoring and evaluation of key areas for action.

The strategy aims to ensure consistency and better accountability of health services for Pacific people. The need for monitoring and research is especially important in addressing the variations in health between regions and different groups within the Pacific population. It will be necessary to identify the variations that occur in particular health problems in order to concentrate efforts on people at risk and to adopt different strategies for different population groups.

From the strategy to specific policies

The strategy provides a framework for working towards better health outcomes for Pacific people. The development of specific policies should support a programme for action which builds upon the strategic initiatives and takes into account the broader implications of other government policies that impact upon Pacific people’s health.
Specific policies should focus on the following areas for development and action:

- improving access to appropriate health care services for Pacific people, in particular, access to primary health care
- involvement of Pacific people throughout the development, implementation and monitoring of health services for Pacific people
- workforce planning and development.
Improving the Delivery of Health Services

Introduction

This section introduces the Pacific People’s Health Charter with its three key elements: consumer participation; culturally appropriate health service provision; and service provision and resource allocation. The public health goal to improve, promote and protect the health of Pacific people is outlined.

Changes are needed to make services more responsive and user-friendly for Pacific people. These changes are outlined in the areas of infrastructure development, recruitment and training, health promotion and intersectoral collaboration. Approaches to cross-cultural collaboration are identified.

PACIFIC PEOPLE’S HEALTH CHARTER

Consumer participation
That Pacific people are consulted about and involved in the design, development, implementation and evaluation of health care services which affect their communities.

Culturally appropriate health service provision
That the health sector provides culturally appropriate and relevant services to Pacific people in structures, settings and languages that Pacific communities can identify with and use.

That the health sector provides culturally appropriate and relevant health services to Pacific people with special consideration to be given to the diverse individual communities (Samoan, Tongan, Cook Island Māori, Fijian, Tokelauan, Niuean and Tuvalu communities).

That the health and education sectors actively recruit Pacific people to train as health professionals.

That health services for Pacific people are delivered by health professionals who have the knowledge and skills to respond to the needs of Pacific people.

Service provision and resource allocation
That expenditure by the funder on Pacific health services is in proportion to the burden of ill health.

That the Ministry of Health, policy makers, the funder and providers should recognise and respond to the need for co-ordination in the management and delivery of health services and consistency in monitoring the effectiveness and efficiency of health promotion and other health services.

That appropriate communication strategies and Pacific media are used to promote the range of health services that are available to Pacific people and how to access these services.
Intersectoral collaboration

Addressing the health needs of Pacific people cannot be achieved by the health sector alone. Responding to economic, environmental and social influences on health effectively requires an intersectoral approach at the national policy level, involving those organisations whose actions impinge on Pacific people’s health.

The aim of this process is to ensure that the health of Pacific people is taken into consideration throughout the planning, implementation and evaluation process. At the very least, this implies that when health aims are in conflict with aims in other sectors, effort will be made to find a solution which does not have an adverse effect on Pacific people’s health and that possible adverse effects are made clear. At best, this approach leads to the acceptance of health as a major goal of development in its own right and to its inclusion in planning for national social and economic development.

Closer links at the national policy level are needed. The protocol between the Ministry of Health and the Ministry of Pacific Island Affairs is an important step in this direction.

Collaboration and co-ordination on such a scale does not happen of its own accord. Sometimes policy makers are not aware of the health implications of their plans or perceive health as being mainly concerned with medical services and therefore of little relevance to their responsibilities.

To overcome such obstacles requires the health sector to understand the effect of diverse policies on health in relation to Pacific people. Also to facilitate the development of effective policy, the Government needs to establish administrative arrangements at national, regional and local levels to encourage intersectoral action.

Infrastructure development

The health of Pacific people is influenced by structural and administrative systems, as well as the quality of health service design and delivery. Many fonos have identified poor communication between individuals and organisations whose activities influence the health status of Pacific people as a major health issue itself.

Better management of health services for Pacific people is fundamental to greater equity: more efficient administration; more accountability to the people; and improved quality and performance of services. Structural change is not simply to make health services and institutions more responsive to Pacific people, but is necessary if services are to become more user-friendly.

Roles and responsibilities within the health sector should be defined clearly to avoid unnecessary duplication and to create the best opportunities to improve efficiency and health gains. Improving infrastructure requires co-ordinated planning with specific statements of intended action relating to quality monitoring systems, recruitment and retention of Pacific people, workforce development, consumer consultation and community development.

Public health

The principles in the Pacific People’s Health Charter are reflected in the objectives for Pacific people in Strengthening Public Health Action: The strategic direction to improve, promote and protect public health (Ministry of Health 1997f). This strategy has been developed to co-ordinate public health action across the Government. The inclusion of a goal for Pacific people is a significant step towards improving, promoting and protecting the health of Pacific people.
Public Health Goal

To improve, protect and promote the health of Pacific people.

Relevant Public Health Objectives

- To provide Pacific people with the opportunity to play a major role in the design, development, implementation and evaluation of public health services which affect communities.

- To ensure that all services are culturally appropriate and relevant to Pacific people in structures, settings and languages that Pacific communities can identify with and utilise.

- To ensure education and cross-cultural training opportunities in public health are funded which reflect the health and cultural needs of Pacific people to reflect their representation in the local population.

- To recognise and respond to the needs for co-ordination in the delivery of public health services, consistency in monitoring the effectiveness and efficiency of health promotion and the management of these services.

Recruitment and training

Improving recruitment strategies and increasing education and training opportunities for Pacific people in the health sector is an important component of the strategy. The skills, knowledge, experience and understanding that Pacific health workers bring to the health system needs to be acknowledged. Opportunities should be developed for these workers to play a role in the design, development, implementation and evaluation of health services affecting Pacific people. Implementation of this strategy requires development of an appropriately skilled health workforce and a recruitment and training strategy for Pacific people.

Real improvement to Pacific people’s health requires a planned approach to recruitment so Pacific people are equitably represented throughout the health sector – as health professionals, managers and administrators. Mutual respect and understanding between Pacific and other health workers is essential for a high standard of service provision. To support this, all health personnel should receive appropriate cross-cultural education and training. This could be through educational institutions in health professional education programmes, or as in-service education programmes in the health sector.

Health promotion

When Pacific people migrate to New Zealand, they usually arrive with little or no knowledge of the New Zealand health system, including what services are available or how to access them. It is important that in the planning of health promotion, special attention is given to developing health information resources appropriate for both new and established Pacific communities.

Health promotion strategies should provide for maximum community participation. Pacific people should be increasingly involved as full partners in health services, from the identification of needs, selection of priorities, planning and implementation, to the evaluation of activities to improve their own health.

Whatever method is used to communicate information, it is important to consider very carefully the language and literacy needs of those receiving the information. Language difficulties are one of the major barriers to service uptake and are, therefore, a health issue themselves.

The health service providers must not only know about the users of their services, but also who the non-users are and why they do not use health services. In order to provide health services that are sensitive to cultural, religious and linguistic needs, health professionals need education on cultural health issues.

Health promotion programmes need to target specific populations, taking into consideration the varying circumstances of Pacific people, including their diversity and geographical location and differing needs according to gender and age. The principles of the Ottawa Charter (WHO 1986) – to build healthy public policy, create supportive environments, strengthen community action, develop personal skills and reorient...
health services – provide a practical framework for designing and evaluating programmes with clear objectives and population groups in mind.

To bring about change in behaviour, all health promotion programmes directed at Pacific people must be presented and delivered in a way that is culturally relevant and can be appreciated by various communities of Pacific people. Development of realistic alternatives that incorporate Pacific values should be encouraged.

Without adequate co-ordination of the content and timing of health promotion programmes, there is a danger of inconsistent messages across topics. This is at best wasteful, at worst damaging. Focusing on separate initiatives in isolation from other relevant issues decreases the effectiveness and efficiency of resource use.

Cross-cultural communication

In some Pacific cultures it is considered the norm to speak up, to reveal one’s thoughts and opinions and to interrupt people when they are speaking. However, other Pacific cultures value a reserved temperament, allowing others to speak on one’s behalf and to speak softly or just listen without comment.

What is appropriate for one culture might not fit another. Traditions are continually changing and are interwoven with experiences that may not be understood by the dominant culture. It is hard to create explicit, lasting written guidelines on respectfully dealing with each of the Pacific cultures. Therefore, the following approaches are designed to help the provider develop an awareness of their own perception of culture and to identify the perspectives of others.

Approaches to cross-cultural communication

Ethno-specific

This approach focuses on culture as a set of collective attitudes, values, beliefs and behaviours shared by its members. It is about differences between cultures. The focus needs to be on the current context to avoid the dangers of stereotyping whole cultures. Therefore, the following could be key questions for gaining information.

- Does the provider have adequate factual understanding of the different cultural practices involved? If so, what practices are they?
- Is the provider from the Pacific or a descendant? If not, how was their experience gained for their cultural understanding?
- Where can cultural understanding be gained, in order to integrate it into programmes?

Psychological/interpersonal

Where there is evidence of poor communication arising from ethnic/cultural differences, a selection of activities from the psychological/interpersonal approach would be appropriate to integrate into mainstream provider training. This training approach focuses on culture as personal feelings, beliefs and attitudes. It raises awareness of cultural differences and relates cross-cultural issues directly to a participant’s own attitudes, feelings and experiences. It also provides interpersonal strategies for gaining and giving more in cross-cultural interactions and, most importantly, it tackles the psychology of prejudice and racism.

However, if not handled sensitively, participants can feel that the breakdown of social interactions are matters of individual failure and that cultural attitudes come from outside the agency, rather than being largely generated within the agency itself.

Linguistic

This approach is useful when members of an agency are required to use oral and written language effectively in cross-cultural interactions. It requires providers to analyse various spoken interactions – did the listener understand the words used, or has the interpretation of the words been given a different perspective? It also involves analysing and discussing different communication styles and their impact on the listener.
This approach needs to be presented in the broader organisational, cultural and social contexts which give language its shape and form. It provides information on identifying possible causes of breakdowns in communication in cross-cultural contexts, as well as developing appropriate strategies for dealing with communication difficulties.

**Socio-historical**

The organisation should have an understanding of the social and demographic facts which produce the composition of its clientele. The socio-historical approach focuses on culture as facts which are historical as well as descriptive. This approach relates the concept of culture to New Zealand’s historical experience and, in turn, to the practical needs of the client. It also relates the Māori, colonial and migrant history of New Zealand to client demographics. This will help the organisation to understand the composition of its members (and potential members) and determine the nature of the organisation’s clientele (and potential clientele).

**Research**

Gaps in information cause difficulties for consumers as well as providers, the funder and policy makers. More focused research is necessary to evaluate the success of health interventions and provide comparative information on priority groups, regional areas and programme strategies.

Particular attention should be given to the monitoring of population and health trends of Pacific people and the impact of health promotion initiatives.

Research should take into account cultural and ethical standards and be carried out in consultation and partnership with local Pacific communities. The findings must be made accessible to Pacific people, policy makers, the funder and providers.

**Aims**

- To integrate the needs of Pacific people into health policy development.
- To implement the Pacific People’s Health Charter at all levels of the health sector, with specific emphasis on the area of health promotion and policy development.
- To establish quality monitoring systems for the evaluation of health promotion programmes and services for Pacific people.
- To develop employment, recruitment and retention strategies for Pacific health workers at all levels of service delivery. These strategies should reflect regional Pacific demographic profiles.
- To strengthen collaborative working relations with Pacific communities in the development of health services and policies.
- To provide a co-ordinated programme of health promotion for Pacific people, with extensive use of multimedia initiatives.

**Suggested Strategies**

- Establish projects to build a knowledge base for the development of effective and appropriate Pacific people’s health promotion programmes.
- Develop agreed guidelines for use of Pacific people’s health data.
- Formulate and implement human resource development programmes and policies in a manner that recruits and retains Pacific people in the health workforce.
- Employ the linguistic and cultural resources in the workforce to full effect. Develop more flexible arrangements for using these resources within and across the health sector.
- Establish a formal culturally appropriate complaints mechanism which is accessible, identifies service gaps and improves consumer satisfaction.
Addressing Key Health Concerns

Introduction

This section identifies eight key areas of priority health concerns and provides a range of specific strategies to address them. These key areas were selected because:

- each area is a major cause of premature death or avoidable ill health for Pacific people
- effective interventions are possible, offering significant scope for improvement in health outcomes, and the design and management of health services.

In this strategy, health is defined as a state of complete physical, mental, social and spiritual wellbeing. Within this context and the context of family health, all the key areas are relevant to the health of families. This is consistent with the holistic approach to Pacific people’s health.

This symbol reflects the inter-relatedness of each major health strand to each other. Each dimension is interwoven into a concept of continuity promoting the elements of holistic health.
It should be stressed that because the health problems which affect Pacific people vary from region to region according to their different circumstances, the key issues have not been listed in order of importance.

Responsibility for identifying priority areas for action at the regional level will rest with the funder of health services in consultation with Pacific people.

Addressing key health issues will have consequential benefits for infants and young people. For example, establishing healthy lifestyles at a young age will itself be crucial to the long-term wellbeing of Pacific people. Similarly, all the key areas are relevant to older people. Preventive measures can often be just as successful in older people, men and women as in younger people.

**Sexual and reproductive health**

Sexual and reproductive health problems have a major influence on Pacific communities in health, social and economic terms. Although there has been some improvement in the provision of sexual and reproductive health services for Pacific people in New Zealand, Pacific women:

- have the highest rate of unplanned pregnancies and abortions
- remain the most infrequent users of contraception
- are more likely to have complications at the time of childbirth
- had a late fetal death rate 48 percent higher than the national rate in 1995.

Many of the risk factors for unplanned pregnancies and adolescent pregnancies – educational, occupational, interpersonal and emotional problems – are also risk factors for other health problems. Many pregnant Pacific women have limited access to financial resources and other support.

A focus on addressing sexual and reproductive health needs of Pacific people should significantly improve the overall health status of Pacific men, women and children.

**Understanding the problem**

Pacific people have identified the following reasons for these problems.

- Cultural and religious issues – these issues shape attitudes toward sexuality, sex before marriage, abortion and approach to family planning.

- Administration and service delivery – many existing services are not directly relevant to the way Pacific people see their problems being solved and simply do not meet their needs. The main criticisms of services include: fragmentation, duplication and overlap due to lack of national and regional coordination; lack of consistency in design, delivery and monitoring; inefficiency; and inadequacy of resources.

- Barriers to access reproductive and sexual services. These barriers include: not knowing where the services are; how culturally acceptable and appropriate they are; how much information is available; the cost of services; and concerns about confidentiality.

A more lateral and innovative approach to service delivery, workforce development and quality monitoring is needed. Services can be improved through further training of providers in the principles of community consultation, cultural safety and improved quality monitoring of relevant health care services.

Ownership of programmes and some degree of staffing or management of health services by appropriately trained Pacific people will contribute greatly to the acceptability and success of sexual and reproductive programmes.

The Education Review Office report, *Reproductive and Sexual Health Education* (1996), which was commissioned by the Ministry of Health, showed that few schools were providing effective sexuality education programmes, many were not meeting their obligations in relation to consulting parents and guardians and most teaching staff delivering these programmes were not trained to teach them. This is a particular issue for Pacific people because of the high proportion of Pacific people who are school age and because of the need to ensure sexuality education is both comprehensive and appropriate in terms of cultural and religious issues.
Pilot programmes

Pilot programmes are being funded by the Transitional Health Authority to promote sexual and reproductive health for Pacific people. Evaluating these programmes will allow the funder to identify the most appropriate programmes with the best health outcomes for Pacific people. The guidelines for this initiative are based on the recommendations from the National Pacific Islands Sexual and Reproductive Health Conference, sponsored by the Ministry of Health in 1995.

Sexually transmitted diseases and HIV/AIDS

Pacific people are at particular risk of sexually transmitted diseases due to the low use of condoms. Chlamydia and gonorrhoea are the most common sexually transmitted diseases seen among Pacific people.

In women, cancer of the cervix is associated with HPV (human papillomavirus which can cause genital warts). HPV is relatively common in all women, but its progression to cancer is a rare event. Although Pacific women appear to have a higher incidence of cervical cancer than non-Māori non-Pacific women, the number developing the disease each year is quite small – seven in 1994 (NZHIS provisional figures).

Aims

- To ensure that a comprehensive range of sexual and reproductive health services for Pacific people is readily accessible, culturally appropriate, effective and efficient.
- To ensure that information, education and counselling for responsible sexual behaviour and effective prevention of sexually transmitted diseases (including HIV) are integral components of all reproductive and sexual health services.
- To ensure co-ordination and consistency in sexual and reproductive health services and programmes.
- To improve monitoring of sexual and reproductive health problems.
- To involve Pacific men and women in the design and delivery of sexual and reproductive health services.
- To increase Pacific men’s and women’s acceptance of and involvement in their reproductive rights and responsibilities.

Relevant Public Health Objectives

- To promote responsible sexual behaviour to minimise unplanned pregnancy and the incidence of sexually transmitted diseases and HIV/AIDS.
- To reduce illness, disability and death rates from cancer, particularly cervical cancer.

Suggested Strategies

- Encourage the use of community development programmes to raise awareness of sexual and reproductive health problems and solutions.
- Promote research to determine the impact of sexually transmitted diseases and sexual and reproductive health issues within the Pacific population.
- Include a cultural safety component in workforce development for existing sexual and reproductive health services.
- Promote the development of appropriate guidelines for sexuality education in schools.

Cancer

Cancer is a major cause of death among Pacific people living in New Zealand and is a major cause of hospitalisation.

The quality of data collected on the incidence of cancer of any site in Pacific people living in New Zealand is highly variable. People from the South Pacific with cancer are often referred to New Zealand for diagnosis and/or treatment, so the incidence of some cancers is likely to be affected by imported cases.
Cancer of the liver and stomach are more prevalent among Pacific people than other New Zealanders, but cancers of the large bowel are relatively infrequent (Tukuitonga et al 1992). The magnitude of the difference in rates for these cancers means this difference is unlikely to be due to imported cases.

New cancer registrations for 1993 show that the incidence of cancer of other sites for Pacific people is similar to the incidence nationally. Lung cancer, followed by cancer of the prostate is the leading site among Pacific males and cancer of the breast is the leading site among Pacific women, followed by cancer of the cervix. This is similar to the pattern of cancer seen in other New Zealanders except that prostate cancer is more common than lung cancer in New Zealand non-Pacific males (Ministry of Health 1997b).

The pattern of cancer in Pacific people reflects the prevalence of risk factors for cancer. Hepatitis B carriage, a risk factor for primary liver cancer, is much more prevalent among Pacific people. Smoking rates among Pacific people are lower than for Māori but higher than for other ethnic groups and cervical screening uptake is lower among Pacific women than other New Zealand women.

Pacific people generally present for cancer treatment with advanced disease. In a study of breast cancer in Auckland, Newsman noted a relatively high proportion of Pacific women with advanced disease on initial presentation (Newsman et al 1988). Late presentation reduces the probability of cure and long-term survival.

While male incidence of cancer is expected to increase, deaths from cancer are expected to decline slightly among men. Similar trends are predicted for females (Cox 1995). Major changes in ethnic composition are likely to significantly alter the burden of cancer in the New Zealand population in the future.

Many cancers are preventable. Screening programmes, together with education about risk factors and early treatment, can reduce the incidence of some cancers and prolong life. There are two national cancer screening programmes for women: the National Cervical Screening Programme; and the National Breast Cancer Screening Programme (Breast Screen Aotearoa NZ). Unique cultural and behavioural characteristics which could increase the risk of cancer among Pacific people need to be accommodated within any cancer control programme if cancer incidence is to be reduced. Providers of treatment services for cancer should also develop more culturally responsive care to ensure that Pacific people comply with therapies and complete their treatment successfully.

Early detection and treatment of cancer will lead to a reduction in the incidence of cancer in the Pacific population.

**Aims**

- To raise awareness of the common types of cancer and associated risk factors within the Pacific population.
- To develop appropriate treatment and therapies that encourage early and ongoing treatment for Pacific people.
- To improve the quality of data on new cancer registrations among Pacific people.

**Relevant Public Health Objective**

- To reduce illness, disability and death rates from cancer.

**Suggested Strategies**

- Develop and promote suitable health promotion programmes to reduce the cancer risk factors in the Pacific population, thereby reducing the incidence of common cancers.
- Promote effective primary prevention of common cancers, for example, a reduction in smoking uptake and promotion of smoking cessation programmes and vaccination for hepatitis B.
- Identify high risk groups and provide services which support programmes for the primary prevention of common cancers.
- Encourage Pacific women to enrol in the national cervical and breast cancer screening programmes.
- Encourage and promote early presentation for treatment through development of appropriate networks which provide support for Pacific people with cancer.
Coronary heart disease and stroke

Coronary heart disease (CHD) is one of the major causes of death among the Pacific population. It is generally accepted that the main risk factors for CHD and stroke are:

- cigarette smoking
- raised plasma cholesterol
- raised blood pressure
- lack of physical activity
- diet and lifestyle
- family history of CHD.

The effects of socioeconomic issues such as poor standard of housing, unemployment and low income levels can also seriously compromise health and nutritional wellbeing, to an extent that increases the risk of CHD and stroke.

Much of the premature death and ill health associated with heart disease and stroke is potentially preventable.

Smoking

Tobacco smoking shortens life through increasing the risk of coronary heart disease and cerebrovascular disease as well as lung cancer and other conditions such as chronic obstructive airways disease. For those who smoke, stopping smoking is the single most effective means of reducing risk for CHD and stroke. Of the Pacific population in New Zealand over 15 years, 34 percent were regular cigarette smokers in 1995 (Cancer Society and Ministry of Health 1996). Prevalence of smoking among the Pacific population needs to be reduced to help reduce rates of heart disease and stroke.

Nutrition

Food and nutrition are key factors contributing to the poorer health status of Pacific people. Obesity, hypertension, diabetes and heart diseases are more common among Pacific people than other New Zealanders. Dietary changes due to limited resources and the different types of food available in New Zealand have resulted in increased intake of saturated fat, refined sugar, energy and salt and reduced fibre intake. Excessive dietary intake of saturated fatty acids results in raised plasma cholesterol levels. Development of community programmes, booklets and videos, such as those promoted by the Pacific heartbeat programme, can contribute to reducing the risks of heart disease and stroke.

Obesity

A recent study found that 66 percent of Samoan males and 78 percent of Samoan females are obese (Bell et al 1997). Obesity results from a dietary energy intake chronically in excess of energy expenditure and is thus related to both diet and physical activity. Obesity contributes to both raised plasma cholesterol levels and raised blood pressure.

Significant adult obesity appears earlier in those people who grow up in New Zealand. Early intervention aimed at younger people needs to be implemented in places such as schools or church communities. Health promotion programmes are needed in relevant languages to assist people to see the relationship between obesity and important health problems such as heart disease, stroke, high blood lipid levels, diabetes and hypertension.

Physical activity

Regular physical activity is associated with multiple health benefits. Data from the 1992/3 New Zealand Health Survey suggest that in all age groups, Pacific people were less likely to engage in vigorous exercise than the rest of the population (Statistics New Zealand and the Ministry of Health 1993).
Elevated blood pressure

Hypertension is a risk factor for many conditions including heart disease and stroke. One study (Scragg et al 1993) showed that compared with Europeans, Pacific people had a higher mean blood pressure level, were less likely to be receiving treatment for hypertension and were therefore more likely to be at risk of its effects. Excessive consumption of alcohol and sodium (mainly as sodium chloride – common salt) contribute to raised blood pressure. Other factors such as diet, obesity, low levels of physical activity, high blood lipid levels and stress are also important contributors. Interventions aimed at the family unit level can be implemented to try and address all of these factors.

Aims

• To promote healthy lifestyle behaviours among Pacific people to reduce the incidence of coronary heart disease and stroke.
• To promote the development and delivery of appropriate health promotion programmes and improve the access to treatment services for Pacific people with coronary heart disease and stroke.

Relevant Public Health Objective

• To reduce illness, disability and death rates from heart disease and stroke.

Suggested Strategies

• Promote research to determine the impact of coronary heart disease and stroke within the Pacific population.
• Develop educational programmes to improve nutrition and encourage physical activity.
• Encourage effective networking and sharing between community-based programmes to facilitate better resource utilisation.

Injury prevention

Injury represents a significant proportion of the emergency, hospital and rehabilitation costs borne by the health sector (Phillips et al 1993). The cost of injury is even more substantial when the impact of injury on social, educational and economic systems is considered. The immediate and long-term impact of injury on the individual, family and friends in terms of pain, grief, suffering and permanent disability must be considered as a major cost to society.

Injury is one of the major causes of death and hospitalisation among Pacific people. The leading types of hospitalised injury cases in 1995 were falls, medical or surgical complications, cutting and piercing injuries and motor vehicle crashes.

Those most vulnerable to injury include children, older people and people with disabilities, who may all rely to varying degrees on others for their safety. For people reliant on others, good quality care and supervision may be the best protection from harm.

Burns, poisonings and injury in motor vehicles and on the road are the main causes of hospital admissions among toddlers (PHC 1994). Unintentional injury (two-thirds of these were motor vehicle crashes) and suicide accounted for 67 percent of the deaths of Pacific people aged 15–24 years in the period 1991–94.

Among Pacific males aged 25–44, unintentional injuries accounted for 21 percent of all deaths in 1991–94. Most of these resulted from motor vehicle traffic crashes. The overriding principle of injury prevention is that injuries are preventable.

Increased awareness of injury prevention strategies by Pacific communities will lead to a reduction in disability and deaths from unintentional injuries. Injuries contribute to a very significant amount of ill health and disability, which in some cases may be lifelong. As more information becomes available about the consequences, it will be possible to make better estimates of the level of chronic illness and disability that could be avoided by Pacific communities.
Aims

• To reduce the cost of medical treatment, rehabilitation and compensation arising from injuries among the Pacific population.
• To use information collected on the results of injuries, and relevant research, to develop preventive strategies appropriate to Pacific people.
• To improve measures to reduce poisonings from drugs and medications, especially by toddlers.

Relevant Public Health Objectives

• To reduce death rates, injury and disability from road traffic crashes.
• To reduce death rates and disability from unintentional injuries.

Suggested Strategies

• Promote injury prevention as a health issue.
• Develop specific promotion programmes related to types of injuries.
• Develop and implement health programmes related to vulnerable groups of people. For example, in regard to children, promote the use of child restraints in cars and safety measures at home and in the child’s play environment.

Mental health

Much of the evidence about Pacific people’s mental health is drawn from institutional statistics. One of the major concerns of Pacific communities is that because of the type of data collected, and the process of collection, these published statistics do not adequately represent the levels of stress and trauma faced by Pacific people. The limitations of the data need to be acknowledged.

While there are similarities among Pacific nations, there is no one Pacific approach to mental health issues. In addition, there is a major shortage of Pacific professionals who are comfortable with both Western and traditional approaches.

Issues of cost, training and control of Pacific knowledge still need to be fully addressed.

There is concern about over-reliance on hard data. There is considerable community knowledge about mental health issues which needs to be incorporated into strategic thinking, including:

• the incorrect classification of Pacific ethnicity of people within the mental health system
• the delivery of inappropriate Western counselling models to Pacific clients, for example, giving a budgeting package to a person under stress because of church and family commitments arising from fa’alavelave (gifts of money for ceremonial purposes)
• the need to emphasise traditional healing processes and their use in conjunction with Western models
• the importance of spirituality that is understood in both Christian and pre-Christian terms.

Some predictions about the future of mental health can be made with reasonable confidence. There will be a growing division between New Zealand-born and Pacific-born people about the needs of Pacific people and the best methods for meeting those needs. The position of the church in New Zealand’s Pacific cultures is likely to be weakened. The extended family structure will be weakened by economic forces and the second generation of New Zealand-born Pacific people are likely to grow up in relative poverty, with a weakened cultural base. All these factors represent a risk to the mental health of Pacific people.

Promoting and maintaining the mental health of Pacific people has considerable cultural, social and economic benefits. The maintenance and development of Pacific cultures within New Zealand provides the basis for mental wellbeing and educational and employment success for Pacific people.

Positive Pacific cultures will keep the rates of admissions to mainstream mental health and justice systems low. They will see the enhancement and development of Pacific people’s health and support services which include Western models and will enable mainstream mental health and welfare services to respond more effectively to Pacific people’s needs.
The following strategies for the maintenance and improvement of Pacific people’s mental health are based on two assumptions. The first is that an individual’s mental health is a function of biological, psychological and cultural/sociological factors. While all three functions are equally important, it is very difficult and possibly culturally damaging to address the first two functions before the third. This means that measures that are culturally empowering and that work from a Pacific perspective are necessary before issues at the level of the individual can be addressed.

The second assumption is that migrant communities that fail by the second generation to make rapid progress up the economic ladder will be at risk of major increases in rates of mental illness, particularly as their own culture comes increasingly under siege in their new country. Improved economic circumstances will be an important condition for the maintenance of Pacific cultures and therefore of Pacific people’s mental health.

**Aims**

- To develop and increase the role of Pacific agencies (such as churches and trusts) as deliverers of community and health services to Pacific communities.
- To provide Pacific communities with culturally appropriate mental health promotion, health education, prevention and early identification and intervention services.
- To identify traditional Pacific terminology and support and healing systems relating to mental illness.
- To develop specific programmes for early identification of and early intervention in mental illness, in particular depression and drug and alcohol abuse.
- To research the nature of mental illness from the perspective of Pacific cultures.
- To research the prevalence of mental illness in Pacific people and the effectiveness of promotion, prevention, support and treatment services, under traditional and Western frameworks.
- To research the utilisation of community mental health services by Pacific people.
- To research the reliability and validity of ethnicity recording with respect to Pacific people in mental health services.

**Relevant Public Health Objective**

- To promote mental health and wellbeing.

**Suggested Strategies**

- Use traditional structures (churches, fono, extended family networks) and New Zealand structures (trusts, resource centres, schools, sports clubs, radio, TV) for mental health promotion work.
- Develop NZQA-approved mental health promotion training programmes for Pacific health promoters, which are cost-effective and which maintain Pacific control over their cultural processes and knowledge.
- Translate descriptions of key Western mental illnesses and support and treatment systems into Pacific languages.
- Train Pacific interpreters in a detailed understanding of mental health concepts and processes.
- Promote increased responsiveness to Pacific people within mainstream mental health services and increase the number of Pacific people in the mental health workforce.

**Nutrition**

Food and nutrition are key factors in the poor health of Pacific people. Obesity, hypertension (high blood pressure), diabetes (non-insulin dependent) and heart disease are more common among Pacific people than Europeans and in some cases more common than among Māori (Tuikuitonga 1990; Scragg et al 1991).

High blood pressure is itself a risk factor for many chronic diseases. Pacific people have some of the highest rates of high blood pressure and diabetes in the world.

Pacific men, especially, are genetically more prone to high uric acid levels which can cause gout. These high levels lead to gout at a higher rate than normal when the men migrate to a new environment such as New Zealand. These diet-related diseases can be countered by controlling factors such as weight, fat and salt intake, and increasing physical activity.
Adequate nutrition is needed for normal growth and resistance to infection. Poor nutrition early in life can reduce both quality of life and life expectancy. Attention to childhood nutrition must be included in food and nutrition programmes involving Pacific people. Poor nutrition is not just a medical problem but is closely related to social and economic disadvantage. Both are major problems for Pacific people. Preliminary data suggest that Pacific people are worse off than other ethnic groups in terms of their range of food, ability to buy basic food items and the choice between buying food and paying other bills (PHC 1994).

Comprehensive nutrition services need to include support for people with diet-related conditions as well as promoting healthy eating. For this to be effective, Pacific people must be involved in the design, running and monitoring of these services.

Pacific people tend to see food as something to enjoy rather than as a source of nutrients needed to keep them healthy (Fitzgerald 1980). The cultural meaning of food for Pacific people must be respected. For example, while some traditional foods may lack nutritional value, their cultural value remains very powerful. The development of culturally appropriate food and nutrition programmes must include careful attention to these qualitative dimensions.

All nutritional programmes involving Pacific people need to address food and health in the context of Pacific society rather than just focusing on scientific principles. Attempting to change value systems outright, especially in the social context of eating, may have severe consequences that outweigh any nutritional benefits (Leach 1989).

### Aims

- To reduce diet-related health problems while maintaining cultural aspects of nutrition for Pacific people.
- To empower Pacific people to develop, implement and monitor culturally appropriate nutrition education programmes and resources.
- To promote ongoing research into diet-related health problems in the Pacific population.

### Relevant Public Health Objective

- To reduce the incidence of food-related health disorders by improved nutrition.

### Suggested Strategies

- Develop nutrition resources and programmes that respect cultures and preferred ways of learning of Pacific people, implemented at the community level and based on community needs.
- Strengthen and maintain links between the communities, health service providers and other organisations with a role in providing nutrition information.
- Differentiate between health service provision which targets the prevention of diet-related diseases and that which ensures respect for the care of people with diet-related diseases.
- Develop and support food and nutrition programmes which foster the development of healthy diet and lifestyle in Pacific children.

### Diabetes mellitus

There are two main types of diabetes, insulin dependent diabetes mellitus (IDDM) (type I) and non-insulin dependent diabetes mellitus (NIDDM) (type II). This section refers to type II diabetes which accounts for over 95 percent of cases in New Zealand and is most common among Pacific, Māori and Asian communities.

Available studies suggest diabetes affects 4–8 percent of Pacific people, compared to 2–5 percent of all New Zealanders. Pacific people are at a higher risk of developing NIDDM and complications than the general population (Ministry of Health 1997e).

Compounding any predisposition to diabetes is the high prevalence of obesity amongst Pacific people. The onset of diabetes occurs about 10 years earlier in Pacific people than Europeans (Lunt et al 1990). Complications involving the eyes, nervous system, kidneys and blood pressure also occur earlier and are more severe among Pacific people (Simmons et al 1994; Lunt et al 1990). Diabetes is among the leading
Aims

• To reduce the impact of diabetes in the Pacific population.
• To increase understanding and self-management of diabetes.
• To improve early detection of diabetes among high risk groups.
• To provide ongoing follow-up and support for Pacific people with diabetes.
• To improve diet and exercise among Pacific people.

Relevant Public Health Objective

• To reduce disability and death rates from diabetes mellitus.

Suggested Strategies

• Develop culturally appropriate diabetes health promotion programmes and education resources.
• Improve co-ordination between primary and secondary care for diabetes.
• Improve co-ordination between various diabetes health promotion initiatives.
• Develop a Pacific diabetes health promotion syllabus for Pacific community health workers and refresher training courses for health professionals.
• Develop appropriate monitoring and evaluation methods for services provided for Pacific people with diabetes.

Asthma

The prevalence of asthma in Pacific people is the same as in other ethnic groups. However, Pacific people have a higher death rate, three times that of the European population. Increased awareness, knowledge and skills combined with improved access to health services will help to close this gap. Pacific children have the highest hospital admission rates for asthma and when admitted are more likely to have not received any asthma medication in the preceding 24 hours (Mitchell and Quested 1988). Asthma is an important cause of illness in Pacific women, with high rates of hospitalisation and death.

Probable reasons for these disparities include the following.

Cost of services

Many Pacific asthmatics attending hospital accident and emergency departments are of lower socio-economic class. Visiting their normal doctor may be difficult due to embarrassment over debts. The lower socioeconomic status of Pacific people is a factor inhibiting their access to primary health care.

Lack of knowledge

Pacific patients are less likely to recall their asthma medications. The self-reported prevalence of asthma symptoms among teenage Pacific children was lower because they do not understand terms such as wheezing and because there may be difficulty translating such terms into languages in which there is no
equivalent word. There is little translated asthma resource material available in New Zealand. Asthmatics need to know about the dangers of untreated asthma and about the improved quality of life that is possible with regular follow-up and treatment. With this knowledge, self-management skills can be improved.

**Self-management**

Europeans are more likely to own a Peak Flow Meter than Pacific people and are more likely to have an asthma management plan. The unpredictable nature of asthma means that adequate skills and knowledge are vital to survival. Death rates can be minimised by appropriate action and treatment.

**Lack of medications**

Pacific people are less likely to take asthma preventers. Mitchell and Quested (1988) suggested that the ethnic differences in asthma death rates were due to different prescribing habits by general practitioners. It is also possible that Pacific people discontinue their preventive medication after they have been started because of lack of understanding of this treatment, or do not request new medications when they run out.

**Less access to medical care**

Hospital accident and emergency departments are seen by many Pacific people as the most appropriate places to go for asthma management. A study of people aged 15–49 years presenting to the accident and emergency department of an Auckland hospital suggested that Pacific people with asthma were less likely than European New Zealanders to have a regular general practitioner (Garrett et al 1989). Frequently cited reasons for non-attendance at asthma outpatient clinics were forgetfulness and travel costs. More culturally appropriate and sustained medical care is needed.

**Lack of research**

There is a need for more information about the reasons for poor access to health services. There is currently no information on health promotion programmes that impact directly on Pacific asthma sufferers. The impact of smoking in Pacific households as a factor in acute asthma is also unknown.

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**Aims**

- To increase awareness of the symptoms of asthma and encourage early intervention and treatment in the Pacific population.
- To increase the informed use of appropriate medications for Pacific people with asthma.
- To improve knowledge about the dangers of untreated asthma and the quality of life advantages of regular treatment of Pacific people with asthma.
- To improve the self-management skills of Pacific people with asthma, including access to a regular primary health care provider.

**Relevant Public Health Objective**

- To reduce disability and death rates from asthma.

**Suggested Strategies**

- Implement and maintain culturally appropriate asthma health promotion programmes in Pacific communities.
- Undertake further research into the effects of asthma on the Pacific population.
Identifying the Issues for Pacific Population Groups

Introduction

This section identifies specific health issues for six groups within the Pacific population and suggests strategies for delivering better health services for each of them.

For children, equitable access to both well child care and treatment services is essential for the promotion and maintenance of child and family health. The strategy identifies key health issues for Pacific children and suggested strategies to address the wide disparities in health outcomes for Pacific children.

For young people, who make up a high proportion of the Pacific population, socioeconomic factors such as overcrowding and low income are significant contributors to health problems.

Health needs specific to Pacific women include family planning resources and health promotion programmes in their own languages. Access to culturally appropriate health services is a key issue in improving the health and quality of life of Pacific women.

There has been a growing recognition that Pacific men’s health experiences are different to those of women, as is their interaction with health services. The rates of cancer and mental illness, among others, are higher than national rates. Primary health education programmes for Pacific men need to be pitched at a variety of levels and settings.

The proportion of older people in the Pacific population is relatively small but is projected to increase sharply in the coming decades, creating a demand for culturally appropriate community and residential health services. These may include traditional remedies and traditional healing practices, although more research is needed to determine the effectiveness of these.

The delivery of health services in rural and remote communities requires new approaches for improving Pacific people’s access to health services. Rural and isolated populations have particular needs because of the distance at which health services are located.

Child health

Improving health outcomes for children in New Zealand is a Government priority. The Ministry of Health is working on the development of a national child health strategy that includes strategies to improve the health of Pacific children.

Pacific women have a higher birth rate than any other ethnic group in New Zealand and Pacific children are over-represented among all children in the under-five age group. By the year 2031, Pacific children are expected to be 11.8 percent of New Zealand’s children, up from 7.3 percent in 1991 (Statistics New Zealand 1995).

Acute respiratory infections are the leading cause of hospitalisation for infants, with pneumonia, asthma, infectious and parasitic diseases, burns and unintentional injuries being the dominant causes of admissions among toddlers (PHC 1994 a).

Pacific children aged 5–9 years were hospitalised for pneumonia at twice the rate of all children in this age group from 1992–95. Pacific children in this age group also had higher rates of acute rheumatic fever and glomerular nephritis than all other children had.

The hospitalisation rates of Pacific children aged 10–14 years for acute rheumatic fever, pneumonia and otitis media were well above the national rates between 1992 and 1995.
Pacific children had a higher failure rate during hearing testing among new school entrants in 1995–96 (National Audiology Centre 1996). The majority of all failures that result from conductive hearing loss are due to chronic otitis media with effusion (glue ear) (National Audiology Centre 1996).

Also important is that a high proportion of Pacific children are being brought up in a situation of socioeconomic disadvantage. Approximately 31 percent of Pacific children under four years of age lived in sole-parent families in 1991 and these families have lower incomes than those of two-parent families. Large families, overcrowding, smoking and alcohol abuse within the home are also important risk factors for the health of Pacific children.

Key health concerns for Pacific children are as follows.

**Acute respiratory infections**

Respiratory illnesses are the leading cause of hospitalisation of Pacific children aged under 15 years in 1995. Hospital admission rates for respiratory illness are significantly higher among Pacific children under five years old compared with the national rates. The rates were most discrepant for infants under one year of age, where Pacific infants had twice the risk of being hospitalised with a respiratory illness.

**Other infections**

The rates of invasive pneumococcal disease, *Haemophilus influenzae type b* (Hib) and staphylococcal disease were found to be very high among Pacific children under five years in a 1994 study (Voss et al 1994). However, the introduction of the Hib vaccine to the National Immunisation Schedule in 1994 has dramatically reduced the incidence of the disease overall (Ministry of Health 1996d).

The situation with meningococcal disease is serious. An analysis of meningococcal disease by ethnicity for 1993–1996 indicates that the rate for Pacific people (79.6 per 100 000) was nearly eleven times the rate in the European population (7.4 per 100 000). Rates of disease are particularly high among those under five years of age with the highest rate being amongst Pacific children under one year of age (570.7 per 100 000) (ESR 1997).

**Fetal, perinatal (stillbirth) and infant mortality**

The late fetal death rate among births to Pacific mothers in 1995 was 48 percent higher than the rate in the total population. Lack of antenatal care and intrauterine anoxia are two important factors in this higher rate. For perinatal mortality, the Pacific rate was 36 percent higher than the national average in 1993. Among infants under one year of age, the hospitalisation rate was 39 percent higher than the national rate in 1995 and for children aged 1–4 years, 28 percent higher.

The risk factors for sudden infant death syndrome (SIDS) include: babies being placed to sleep on their fronts; not breast feeding; maternal smoking; and bed sharing with mothers who smoke (Mitchell et al 1992; Mitchell et al 1993; Scragg et al 1993). To reduce rates of SIDS, the access of Pacific people to information and education about SIDS risk factors needs to be improved, together with encouragement to breast feed (full or partial) to six months, to avoid prone sleeping of infants and to avoid exposure to tobacco smoke.

**Hearing loss in children**

Hearing loss in early childhood has a significant effect on emotional, social and educational development. Its early detection is essential to ensure optimum development of speech and language and to minimise the longer term effects on educational performance. In the majority of cases, hearing loss in children is due to chronic otitis media with effusion (glue ear).

Amongst new school entrants, Pacific children are more than twice as likely to fail hearing tests as are other children (National Audiology Centre 1996). Improving the accessibility of primary and secondary health care services, including screening, referral, health promotion and primary prevention has the potential to significantly reduce the rate of child hearing loss within the overall population.
Rheumatic fever and rheumatic heart disease

New Zealand continues to have a high rate of rheumatic fever and rheumatic heart disease. The rate for Pacific people is about 70–75 per 100 000. In contrast, the rate for European New Zealanders is two per 100 000 (Ministry of Health 1997c).

Notification data indicate that there are marked regional variations in acute rheumatic fever (ARF) rates (Baker and Chakraborty 1996). In the period 1990–94, the annual age-standardised rate of ARF for all people under age 30 years was 8.3 per 100 000. For Pacific people, it was nearly six times the national rate of 48.6 per 100 000.

Immunisation

Immunisation is a key element in ensuring the reduction and elimination of vaccine-preventable diseases in Pacific communities. Vaccine-preventable diseases are now notifiable in New Zealand (from 1 June 1996) and the ethnicity of the child is recorded.

The current national immunisation schedule protects children against nine serious diseases: measles, mumps, rubella (German measles), diphtheria, tetanus, pertussis (whooping cough), *Haemophilus influenzae type b*, polio and hepatitis B. Although some of these diseases are under control (polio and diphtheria), New Zealand continues to experience regular epidemics of mumps, measles and whooping cough.

During the 1991 measles epidemic, a specific national surveillance system was established to monitor the outbreak. For the reported cases, there was a marked ethnic difference with Māori and Pacific children significantly over-represented among hospitalised cases and experiencing higher rates of measles complications. This trend is being repeated in the 1997 measles epidemic. A major contributing factor to these ethnic differences is likely to be the lower levels of immunisation coverage in Māori and Pacific populations (Baker 1996).

Increasing the immunisation coverage rate among Pacific children and addressing the wider socioeconomic risk factors will decrease the incidence of disease and reduce treatment costs, long-term morbidity and mortality associated with these diseases. Contributing factors to the low immunisation coverage for Pacific people include:

- culturally inappropriate services
- socioeconomic disadvantage affecting access
- unfamiliarity with services
- language barriers.

Failure to present for immunisation, rather than opposition to immunisation, is the most common explanation for the low coverage for Pacific people. Improving immunisation coverage will depend on the funder and providers identifying and developing appropriate strategies for Pacific people, such as information delivered in Pacific languages, involvement of ethnic providers, mobility of services, suitable hours for services and the ability of services to be flexible.

Programmes and services to increase coverage need to be designed in consultation with Pacific people. Health promotion services need to make more use of Pacific media. Strengthening partnerships between Pacific communities and health professionals is critical to achieving health outcomes.

Immunisation programmes and services need to be continually reviewed and updated to ensure their quality and relevance. Ongoing training to maintain levels of awareness and interest, particularly of community educators, is essential.

Co-ordination of immunisation promotion programmes and activities needs to occur at the local, regional and national levels to ensure all Pacific children are accessing the necessary services. Key documents are the *National Immunisation Strategy* (Ministry of Health 1995b) and the *Well Child–Tamariki Ora National Schedule* (Ministry of Health 1996b).

The establishment of effective information systems would enable a more accurate measure of coverage for Pacific children, measure the effectiveness of immunisation promotion and programmes and ensure a more accurate analysis of the incidence of vaccine-preventable diseases among Pacific people, particularly children.
Research needs to continue into risk factors and their impact on the immunisation rates for Pacific people. This research should involve Pacific parents, caregivers and communities at every stage of the planning, implementation and evaluation processes. Research outcomes must benefit Pacific communities.

The Well Child–Tamariki Ora Health Book (Ministry of Health 1996c) needs to be valued equally by all stakeholders as the parents’ officially held records. These records must be kept up to date by vaccinators, parents and caregivers.

### Aims

- To strengthen the family unit and improve parenting skills.
- To improve access to primary health care services.
- To deliver effective co-ordinated child health promotion strategies that include monitoring and ongoing research into the health of Pacific children.

### Relevant Public Health Objectives

- To protect children from preventable infectious diseases by improving immunisation.
- To continue the reduction in rates of sudden infant death syndrome.
- To reduce disability and death rates from asthma.
- To reduce hearing loss in children in the under-five age group.
- To reduce death rates and disability from unintentional injuries.
- To reduce morbidity and mortality from rheumatic fever.

### Suggested Strategies

- Investigate the use of mobile vaccinators to immunise children to extend the role of current providers.
- Promote breast feeding, reduced smoking by parents and better access to preventive and treatment services.
- Reduce disability and mortality from acute respiratory infections and asthma by encouraging earlier presentation of children for medical attention and the use of asthma action plans.
- Reduce unintentional injury by improving water safety.
- Reduce burns from hot or corrosive substances.
- Improve measures to reduce poisonings from drugs and medications, especially by toddlers.
- Increase the use of seatbelts/child restraints in cars.
- Promote road safety measures at home and in the child’s play environment.
- Fund appropriate parenting programmes that will strengthen the family unit.
- Promote research for the prevention and reduction of the increased vulnerability of Pacific children to infectious diseases.
- Provide community-based support services (especially in areas with a significant Pacific people’s population) for pregnant Pacific women in difficult circumstances or ‘high risk’ families, from early pregnancy until the child is five years old.

### Young people’s health (15–24 years)

The Pacific population in New Zealand has a very youthful age structure due to recent migration history and high fertility rates. These young people constitute an important national resource. A major challenge for the Government is to build and foster favourable environments for the wellbeing and growth of youth.

The main causes of death of Pacific people aged 15–24 are unintentional injuries and suicide (Statistics New Zealand 1991; PHC 1994). The main causes of hospitalisation for young Pacific men in 1995 were unintentional injuries (mainly falls and motor vehicle crashes), followed by respiratory diseases, skin diseases, digestive diseases and intentional injuries. Unintentional injury rates in this age group were higher for Pacific males than the general male population. For young Pacific women the main causes of hospital admission are pregnancy-related. Again, these rates are greater than in the general young New Zealand female population.
The younger the mother, the greater the likelihood of a poor pregnancy outcome, incomplete schooling, sole parenting, reliance on low income jobs, welfare dependency, child abuse and neglect (Department of Health 1992).

Other health problems for young Pacific people are poor mental health status, substance abuse and sexually transmitted diseases. Associated with these problems are concerns about insufficient life skills, high unemployment and increased crime offending rates among Pacific young people. Pacific people have identified smoking, unemployment, low income, drug and alcohol abuse, domestic violence and suicide as growing concerns (PHC 1994).

There is evidence that young people are aware of their health problems but too often are unable to access the resources they need. This may be due to barriers to use, gaps in services and lack of dedicated services/resources for young people (Disley et al 1995).

Gaps in health services for Pacific young people identified by North Health include:

- few services promoting sexual health, including planned parenthood
- a shortage of services that focus on the needs of youth
- a lack of written, visual and telephone health information for young people, parents and caregivers
- a shortage of services that promote mental health and help prevent suicide
- a lack of joint programmes between health services and other sectors including education
- a need to help families provide caring stable support.

Pacific young people should be actively involved in the planning, implementation and evaluation of development activities that have a direct impact on their daily lives. This is especially important with respect to information, education and communication activities and sexual reproductive services, including the prevention of early pregnancies, sex education and the prevention of HIV/AIDS and other sexually transmitted diseases.

Innovative programmes must be developed to make information, counselling and services for sexual and reproductive health accessible to young people. Such programmes must both educate and enable men to share more equally in family planning, domestic and parenting responsibilities and to accept responsibility for the prevention of sexually transmitted diseases.

### Aims

- To ensure that Pacific people (especially young people) are involved in planning and developing appropriate resources and programmes.
- To promote mental health programmes to improve Pacific young people’s coping and life skills.
- To ensure better access to primary health care and specialist health services.

### Relevant Public Health Objectives

- To reduce death rates, injury and disability from road traffic crashes in young people.
- To reduce tobacco use, exposure to environmental tobacco smoke, and their adverse health consequences.
- To promote responsible sexual behaviour to minimise unplanned pregnancy and the incidence of sexually transmitted diseases and HIV/AIDS.
- To improve health by reducing drug- and alcohol-related harm amongst young people.
- To improve health by minimising harm related to substance abuse.
- To reduce death rates from suicide.

### Suggested Strategies

- Consult with Pacific young people about their health concerns.
- Consult with Pacific health workers about the barriers to accessing health services in this age group.
- Use Pacific media to reach the wider communities.
- Promote research into the risk factors and causes of suicide among Pacific young people.
Women's health

There are health issues that are specific to Pacific women.

- Fewer Pacific women than non-Pacific women use formal contraception.
- Pacific women have a very high rate of medically-supervised abortions.
- Three-quarters of Pacific female hospitalisations are for pregnancy, childbirth and health services related to reproduction.
- The Pacific population has a much younger age structure than the total population and this will lead to significant population growth over the next three decades.
- Asthma is a major cause of hospitalisation for Pacific women.

Hospitalisation rates for stroke, pneumonia, diabetes, infectious and parasitic disease, asthma, bronchiectasis and bronchitis are also above the national rates for Pacific women 65 years and over.

Particular problems for women living in isolated areas include:

- lack of contact with Pacific communities
- lack of involvement in health issues
- lack of resources to enable people who have appropriate information to distribute it widely
- the excessive workload of Pacific health workers, who must often provide information to Pacific women on a voluntary basis, to the detriment of their personal health and wellbeing.

Cancer

In 1993, 19 percent of Pacific female cancer registrations were for breast cancer and one-quarter for cancer of the cervix, ovary and uterus. The rates for the latter three types of cancer exceed the national female rates, however, the breast cancer rate is below the national rate.

Mortality

The mortality rates for Pacific women aged 25–44 and 45–64 years are below the national mortality rates for these groups. In the 25–44 age group, cancer and stroke were the leading cause of death from 1991–94, while cancer, ischaemic heart disease and diabetes were the leading cause in the 45–64 years age group. The registration rates for breast cancer and cancer of the colon/rectum are lower than the rates for all New Zealand women.

Access to health services

Access to health services is a key issue to improving the health and quality of life for Pacific women. They need to know how and why to access health services, including details of where and when specific services are available. Services need to be culturally appropriate for Pacific women in order for the services to be used with any frequency. Information provided through radio and television, in the user’s first language, is of vital importance.

Existing initiatives

Cervical screening

The National Cervical Screening Programme (NCSP) which commenced in New Zealand in 1990, was the first nationally co-ordinated screening programme for all women, including Pacific women. The benefits for Pacific women included the first attempts to co-ordinate health education resources, training and translations. Regional co-ordinators were set up in areas of New Zealand where there were high concentrations of Pacific people, such as Auckland and Wellington.

To ensure that the incidence of cervical cancer and deaths of Pacific women are significantly reduced and the policy objectives are achieved, Pacific women must be involved in all levels of the decision-making process of the cervical screening programme.

The NCSP policy has identified Pacific women as a priority group and special efforts and initiatives are directed at increasing screening rates (Ministry of Health 1996a).
Among Pacific women, the registration rate for cancer of the cervix is higher than the rates for all New Zealand women (PHC 1994). Cervical smear tests can detect abnormal cells which may, if left untreated, eventually develop into cancer. Treatment at this stage is very effective. The success rate for adequate treatment of pre-cancers is 98–100 percent (Sharp and Cordiner 1985). It is estimated that there would be an increase in both incidence and mortality from cervical cancer in the absence of an organised cervical screening programme and that approximately 340 new cases per year could occur (Cox 1995).

**Breast cancer screening**

A national breast cancer screening programme is being implemented over the next three years by the Transitional Health Authority. The programme will offer free mammography screening to women aged 50–64 years who do not have symptoms of breast cancer. The Transitional Health Authority has identified strategies for increasing participation by Pacific women in the breast cancer screening programme.

### Aims

- To improve the health status of Pacific women in New Zealand.
- To provide health services that are culturally appropriate and responsive to the health needs of Pacific women.

### Relevant Public Health Objectives

- To promote responsible sexual behaviour to minimise unplanned pregnancy and the incidence of sexually transmitted diseases and HIV/AIDS.
- To reduce illness, disability and death rates from cancer, particularly cancer of the cervix.

### Suggested Strategies

- Ensure family planning information and advice is available in languages Pacific women understand.
- Develop innovative health promotion programmes aimed at encouraging contraceptive use among Pacific women.
- Provide nutrition services appropriate for Pacific families.
- Provide cheaper or free clinics for Pacific women.
- Standardise training for educators, according to the NZQA accreditation system.

**Men’s health**

Pacific men’s health, as a specific issue, has been gaining more attention in both the community and the health care field. There has been a growing recognition that men’s health experiences are different to those of women’s, as is their interaction with health services.

The Pacific Islands Men’s Health fono (Christchurch, August 1995), North Health (Auckland, March 1996) and the Pacific Islands Men’s Strategic Planning Group (Wellington, March 1996) provided opportunities for Pacific men to discuss the broader social and environmental issues that impact negatively on men’s health and comment on areas of priority.

### Problem areas

The Public Health Commission (PHC 1994) identified that Pacific men’s health status was poor compared with that of Pacific women. Some issues pertaining to Pacific men’s health include (PHC 1994):

- high unemployment for Pacific people (16.9 percent compared with 5 percent for Europeans) (Statistics New Zealand 1997b) contributes to the poor health status of Pacific men. There is a cycle of poverty, where high unemployment and increased alcohol and drug use led to poor diet, poor housing and increased violence (Crawley et al 1995). The threat of unemployment and the location of employment, especially in the manufacturing sector, combined with the demands of shift work and inability to take time off to attend health fono, were seen as further disadvantaging men in obtaining health information.
there were differences in the experience of Pacific men in rural and urban settings. For example, unemployment tends to be more devastating for those living in rural areas, due to the lack of choices. Also, when factories close in rural areas, people tend to shift to the larger urban areas to be closer to the markets.

in the years 1991–94, cancer and ischaemic heart disease each caused 19 percent of deaths of Pacific men. Cerebrovascular disease, unintentional injury and respiratory diseases each caused 8 percent of deaths.

hospitalisation rates are higher than average for both Pacific males and females. Pacific men also had a higher chance of being readmitted into a psychiatric hospital than a non-Pacific male.

a high percentage of Pacific men aged between 18–35 years were admitted to psychiatric hospitals under compulsory detention, with psychotic disorders such as schizophrenia and alcohol dependence the leading diagnoses for first admission. Anecdotal information from clinicians in forensic psychiatric services such as Purehurehu Unit in Porirua, the Mason Clinic in Auckland and Wai o Hine national secure unit in Marton show over-representation of Pacific men in this age group at these units.

There appears to be an over-representation in the ‘dual diagnosis’ category of psychosis with alcohol/drug dependence and correlation of Pacific-born men being admitted with a manic depressive illness due to alcohol dependence.

Health education programmes

Much of the illness and injury suffered by men is preventable. Education programmes need to be pitched at various levels and settings, for example, at the personal self-discovery level, through friends and peers at schools or hotels, through resources such as books and videos, at tertiary educational levels and community levels. Specifically, cultural communication workshops are required for health professionals, patients, their families and the community.

Primary health is the preferred area for focusing programmes for Pacific men, to promote healthy living and reduce rates of cancer, high blood pressure and nutritional problems. Mainstream health services need to ensure that their services are available, acceptable, accessible and affordable to Pacific men. Cultural safety of existing mainstream services is a major concern to Pacific men, especially as one bad experience will discourage many more men from using that service, due to word-of-mouth reports or the ‘Pacific grapevine’.

Developing a consumer-focused approach will better enable future planning and deployment of resources specific to the needs of Pacific men. A strategy aimed at addressing Pacific men’s health should achieve improvements in health outcomes and ensure better access to health services which are appropriate and sensitive to their needs.

Aims

• To improve the health and wellbeing of Pacific men, with a focus on those most at risk and develop health services that are more responsive to their needs.
• To ensure that Pacific men are involved in the planning, implementation and monitoring of health services for Pacific men.
• To target education and training strategies which increase sensitivity to Pacific men’s health issues across the full range of health professionals and health service providers.
• To link future funding for Pacific men’s health to evidence-based practice and health outcomes.

Suggested Strategies

• Review existing health promotion strategies to address the needs of Pacific men and emphasise new education programmes to improve men’s use of health services and promote innovative approaches to encourage men to adopt healthy lifestyles.
• Develop training and educational packages/programmes that involve Pacific men in determining the content, delivery and monitoring of health programmes for Pacific men.
• Establish a national Pacific men’s network.
The health of older people

The older population (aged 65+) represents 3 percent of the total Pacific population. However by 2031, it is projected to increase by 150 percent.

The most common causes of hospital admissions and deaths among older Pacific people are degenerative diseases, many of which are related to diet and lifestyle. The projected population increase implies that degenerative diseases associated with older people will continue to be a major health concern for Pacific people, creating a demand for culturally appropriate community and residential services. The role of the extended family in the long-term care of elders should not be taken for granted, particularly as 80 percent of Pacific income earners have an income less than $20,000 per annum, compared with 64 percent of income earners in the total population.

The following are the major issues identified for Pacific older people, based on consultations undertaken in Auckland.

- **Accessibility** – problems include lack of transport, language difficulties, lack of knowledge of health services and lack of money to pay for specific services, for example, general practitioners.
- **Acceptability** – some current health services are culturally inappropriate for Pacific people, mainly due to different concepts of health and the service delivery of health professionals and health promotion.

### Traditional remedies

It is unclear to what extent older Pacific people use traditional remedies and traditional healers instead of, or in addition to, Western health care. However, health professionals should understand and respect the personal use and value of traditional remedies to people of different cultures. There is also a need for educational programmes among the various ethnic groups to explain what publicly funded health and disability support services are available. Such programmes would be best undertaken by people trained from the Pacific groups concerned.

<table>
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<tr>
<th>Aims</th>
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<tr>
<td>To promote policy development relating to the health of older people that recognises different ethnic needs and is the basis for planning comprehensive health services provided by public, religious, welfare and private sector organisations.</td>
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<tr>
<td>That health education programmes are delivered in a manner that is culturally appropriate.</td>
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<tr>
<td>To ensure that there is readily available information about wellness strategies, different types of support and how to access that support.</td>
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### Relevant Public Health Objectives

- To maintain and improve mobility amongst older people/kaumātua.  
- To protect older people/kaumātua from preventable infectious diseases, such as influenza.  
- To improve and maintain social support for older people/kaumātua.

### Suggested Strategies

- Develop policy advice on health needs of older Pacific people, including mobility, infectious diseases, social support among older people, access to health services, acceptability of current health services and cultural safety of current health services.  
- Actively promote multidisciplinary health promotion and education programmes for older people, supported by a national programme developing appropriate resources.  
- Train health care workers in cross-cultural skills so that they can care for older people of other cultures in a sensitive manner.
Pacific people in rural communities

In rural areas there are generally fewer health services and less choice; the further people live from a major urban centre, the further they have to travel to get specialist treatment. Transport difficulties for rural Pacific communities are highlighted in times of emergency and when consumers require specialist services. In many urban areas there is lack of affordable, reliable public transport to carry consumers to health services.

Those living in rural areas tend to suffer poorer health status and also have poorer access to health services.

The low health status of these populations can be explained by the underutilisation and appropriateness of primary care services, limited funding, insufficient access to information and inadequate resources to develop and implement Pacific health initiatives.

Gaps in rural health services for Pacific people include:

- financial barriers such as unemployment/low income
- transport barriers
- acceptability barriers: Pacific people may not be comfortable with the service provider or manner in which the service is given
- scarcity of Pacific service providers
- inadequate training of health care workers, working with Pacific people
- fragmented local and national intersectoral co-ordination
- limited community knowledge of preventive resources.

A different pattern of health care resource is necessary in rural and remote communities to compensate for isolation and distance.

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**Aims**

- To improve the health and holistic wellbeing of Pacific people living in rural communities with a focus on those most at risk, by developing and establishing services that are culturally appropriate, accessible and responsive to the needs of Pacific people.
- To ensure that funds and resources are directed to the planning, delivery and monitoring of health services for Pacific people.

**Suggested Strategies**

- Involve Pacific people in the planning, delivery and monitoring of health services for Pacific people.
- Set up a mobile health clinic to provide access to services for those Pacific people living in remote areas.
- Establish a ‘one-stop-shop’ of health services, delivered from community facilities, which integrates and provides health services for the whole family and other social services.
- Promote health education in relevant Pacific languages.
- Establish training and workforce development to ensure health care is provided in a manner which is culturally appropriate for Pacific people.
- Establish quality monitoring systems to ensure appropriate and accountable delivery of health services to Pacific people.
Introduction

Continuous monitoring and review of health services for Pacific people is necessary to check that objectives are being met, outcomes achieved and that the provision of health care to the Pacific community is continually improved. Quality monitoring provides a model for progress.

This section outlines the characteristics common to quality monitoring systems, and to a quality health service. It describes an appropriate model for evaluating health services – the Donabedian model – and lists the Pacific cultural influences which must be taken into account during this process.

Other key factors in quality monitoring are the selection of specific indicators of quality services and the relationship between the client and the provider.

Finally, this section sets out a process for collecting and disseminating information at each stage of the quality monitoring process, to enable continuous improvement of services.

The purpose of quality monitoring

Quality monitoring of health services for Pacific people is to enable continuous improvement in the provision of health care services to Pacific communities. This is achieved by:

• setting quality requirements and expectations on the part of both the provider and the community
• assisting providers to improve their service, through appropriate delivery of education, information and advisory services
• establishing a set of relevant and dynamic indicators to allow measurement of, and therefore feedback on, the services offered
• creating good communication both within the provider organisation and between the provider and the relevant community.

Characteristics of quality monitoring

• A clear vision that incorporates quality needs to be developed in consultation between the provider and the user. It will form the basis for decision making and be the inspiration for customer service.

• Commitment from the highest level of the service organisation. However, quality cannot be imposed from above and in order for a quality culture to take hold, it is very helpful to develop ‘champions’ in key areas.

• Everyone involved, both givers and receivers of health care services, have a valid contribution in terms of requirements, ideas and feedback. Participation should be encouraged, especially: between the health practitioner and the client and family; within the different disciplines and roles inside an organisation, for example, between management or administrative functions and health professionals; between individual and related service providers, for example, between general practitioners and child health services; and between the health service organisation and the target group or community.

Not only is communication inside these areas important, but communication between them is also paramount. This helps to promote awareness and support and to enable the feedback and assessment processes to function.

• Recognition – people will actively participate in quality when they know their contributions are valued and their ideas acted on. This recognition need not be financial. Often public recognition is sufficient and also has the effect of motivating other providers.
Characteristics of a quality health service

The desirable elements of a quality service are:

• availability – health services are population or community based and as such need to provide appropriate coverage. These services combine health promotion and health protection strategies

• accessibility – providing the right service to the right people in the right manner. Services must be flexible and participative (by consulting with the community concerned) to ensure that providers use the correct language and deliver the service appropriately. This includes consideration of what is culturally appropriate

• effectiveness – an effective service maximises health gains for available resources. This relies on a good understanding of the community health profile and researching similar programmes in the literature. Programmes can often link in and synergise with other sectors to provide enhanced effectiveness. Ongoing evaluation is necessary to ensure that a programme is doing what it is supposed to

• acceptability – if there is a public mandate for a service (through Government, or consultation with a provider), then it is deemed to be acceptable. Customer satisfaction relates to health gain effects in the community rather than for the individual

• continuity – health programmes are not usually ‘overnight successes’. They take time to be effective and improvements are often only visible after years. This means that continuity of the service is important, as is maintaining a constant standard

• organisational competence – organisations delivering quality health services require a diverse, multi-disciplinary approach in order to provide a comprehensive and integrated service.

Health services require skills in epidemiology and the social, medical and physical sciences. They must also be able to deliver community-based programmes with sufficient resources to deal with unexpected occurrences.

Some statutory public health functions require Medical Officers of Health and health protection officers to administer health legislation.

The Donabedian model of quality monitoring

The outcomes of health care are coming more into focus. Practitioners are increasingly being asked to define what the expected outcomes of intervention are and to measure how often they are achieved. The central theme of quality monitoring is one of improvement in the delivery of health promotion and health care services to customers.

In considering the quality monitoring plan, the Donabedian Model of Structure, Process and Outcome provides a format in which to develop the plan. The Donabedian model can offer useful insights into the quality of services being offered. There are three components to the model.

• Structure – addressing the organisational setting in which the service is provided. Measures in this area are concerned with the nature of the organisational environment, the types of technology available and the number, type and qualifications of the professionals providing the service.

• Process – focuses on the activities of the service and asks whether the right actions were taken. It includes an evaluation of the intervention, such as laboratory tests and health promotion campaigns. It also addresses the cultural guidelines and protocols which govern these activities.

• Outcome – considers the impact of the service. It refers to the effectiveness of the service in terms of health gains and quality of life. It also focuses on the responsiveness of the service to the needs of the user. It asks the fundamental question of whether or not the service delivered the required benefits.

Pacific cultural considerations

The consideration of cultural factors is critical to the provision of quality health care services. There are factors to consider.

• Language – feedback from current programmes indicates that (for women especially) promotion and awareness campaigns are/can be more effective when conducted in the appropriate Pacific language.
• Communication methods – a variety of communication methods should be considered, such as charts, brochures and videos, especially if a commentary is available in a Pacific language. Overhead projector transparencies must be used appropriately and not to keep distance from the speaker to the audience, it may be perceived as less intimate for small groups. These resources need to be introduced by a speaker who preferably has knowledge of at least one Pacific language or can understand the audience needs if the information is not clear.

• Family structure and relationships – the Pacific family is a stronger, more influential unit than most non-Pacific families. It can also be restrictive for this very reason. Any health service or promotion needs to recognise this and encourage full family participation and communication when necessary and if appropriate. Otherwise, alternative strategies would need to be aware of this influence.

• Church – the influence of Church leaders in providing a forum for discussion and education is considerable in the Pacific community. The national conference on Pacific Islands Sexual and Reproductive Health (Auckland, July 1995) highlighted the past reluctance of Church leaders to co-operate in this area. Service providers need to be sensitive to the influence of the Church and encourage full information provision to the Church through women’s groups and community leaders.

Identifying and selecting quality indicators

What measures should be used in the provision of a quality service? Indicators need to be co-operatively established between provider and consumer and must be relevant to the programme’s objectives. Some will evolve over time as requirements become clearer or change. Examples of suggested indicators follow.

• Occurrence – establish a statistical ‘norm’ of the occurrence concerned, for example, the number of reported cases of asthma in a particular community or location. If figures are not available, consider setting up a monitoring and measuring programme to obtain this information.

• Price of non-conformance – the consequences of not providing the service, or providing it inappropriately, may include: recurrence of the same health problems; exceeding requirements; extenuating the health problems; or complaints from consumers. It may be desirable to measure these consequences financially – perhaps in terms of the cost to the provider, the community or the country.

• Evolving other indicators – suitable indicators could be established between the provider and the community by reviewing the components of the Donabedian model in terms of structure, process and outcome and exploring the relevance of each of the questions to the service being offered.

The client and provider relationship

The following diagram illustrates the relationship between client community and service provider. Note the interactions between these two groups, demonstrating the participative nature of the venture.

Figure 4: The client and provider relationship
Monitoring – the data collection phase of the process. Once indicators have been established and measures decided, data is collected regarding the service/programme provided.

Assessment – the assessment phase analyses the data collected and establishes trends and other meaningful information. This enables an appropriate course of action to be decided upon.

Action – the service or programme delivery takes place.

Evaluation/feedback – initial requirements and expectations are established and continually reviewed. This phase asks: Did we do what we said we would? How well did we do it? Is the customer satisfied? The answers are communicated to the client community provider’s staff in the form of feedback.

The continuous improvement process

Systems need to be established to collect and disseminate information for each of the stages in the quality model described above. The outcomes of the service, seen in terms of the established indicators, describe the information to be collected. These outcomes need to be periodically reviewed at the review and feedback stage.

The questions that will empower the process are:
• is this the best way of doing it?
• is it culturally appropriate?
• are we doing the right things?

Wherever possible, measures should be established as quantifiable. This allows:
• improvement to be easily perceived and reported
• areas of improvement to be set in priority
• efficient allocation of resources.
**Conclusion**

*Making a Pacific Difference: Strategic initiatives for the health of Pacific people in New Zealand* identifies issues and suggests strategies for the health sector to respond appropriately, effectively and efficiently to the health needs of Pacific people.

Responding to economic, environmental and social influences on health in an effective manner requires an intersectoral approach between government agencies and organisations. This strategy calls for closer links at a national level to improve policy development that contributes to improving the health of Pacific communities.

The Pacific People’s Health Charter promotes the need to involve Pacific people in the development of policies, the planning, delivery and monitoring of health services. Participation by Pacific people must be ensured if service provision is to be truly responsive to their needs.

The quality of health services received by Pacific people depends on the accuracy of the needs assessment process and the ability of the funder to translate those needs into contract specifications for providers. Concerted efforts are needed at all levels of the health sector to ensure they recognise, and are responsive to, the particular health and cultural needs of this population group.

Acceptability is an important component of the design and delivery of health care services. It may be that some services are inequitable in the way they are organised, making them unacceptable to some of the Pacific people that they are intended to serve. Monitoring the responsiveness of health services to the needs of Pacific people is important to improve acceptability.

Gaining access to acceptable services is an essential element in improving health outcomes for Pacific people. Improving access will require the funder and providers to know not only about the users of the services, but also who the non-users are, and why they do not use particular health services.

*Making a Pacific Difference* can be achieved with improved management, more efficient administration, more accountability to the people and improved quality and performance of health services to Pacific people in New Zealand.
Responding to the economic changes which are affecting quality of life in Pacific island countries, and taking into account the approaches articulated in the document *New Horizons in Health* endorsed by the Regional Committee of the World Health Organization’s Western Pacific Region at its forty-fifth session in 1994, a Ministerial Conference on Health for Pacific Islands was convened in Fiji from 6 to 10 March 1995. The priority issues for the conference were human resources development; health promotion and protection; and supply and management of pharmaceutical and essential drugs. Participants reviewed the level of human resources development in the Pacific island countries; examined the various trends and changes affecting the health situation; and identified possible strategies and options which could be adopted in the light of each country’s unique situation.

During the first two and half days (6–8 March), Permanent Secretaries/Directors met as a working group to formulate and discuss recommendations for the Ministers to consider during their two-day conference on Yanuca Island (9–10 March). The Permanent Secretaries/Directors’ meeting was held in Suva, close to the Fiji School of Medicine, its teaching hospital, the Colonial War Memorial Hospital and the Fiji School of Nursing.

Health Ministers and Permanent Secretaries/Directors from the Cook Islands, Fiji, Kiribati, Marshall Islands, Federated States of Micronesia, Nauru, Niue, Palau, Papua New Guinea, Solomon Islands, Tonga, Tuvalu, Vanuatu, and Samoa, together with observers from Australia, France, Japan, New Zealand, United States of America, regional organisations and United Nations agencies attended the Ministerial level sessions on Yanuca Island.

Over the two days on Yanuca Island, the working papers prepared by the working group were discussed, and the priority issues were defined in the context of Pacific island needs. It was confirmed that sustainable development relating to the three priority issues discussed is consistent with the political commitment for people-centred development which already exists in all Pacific island countries. It was also emphasised that the development approaches will have to be consistent with the values which make up the unique Pacific way of life.

Consensus was reached on a course of action to place the health and wellbeing of Pacific people at the centre of national development plans. This consensus is reflected in the Yanuca Island Declaration on Health in the Pacific in the 21st Century. The Declaration embodies the collective concern and commitment of all the participating Pacific island countries. It commits countries to act to enhance the quality of life and the continuing wellbeing of people. It also calls on concerned donor-countries and funding agencies, United Nations bodies and specialised agencies, regional and subregional organisations and institutions and non-governmental organisations, some of whom participated in the Conference to provide technical and financial support. Pacific island countries are challenged to formulate and implement strategies to meet their commitments.

THE YANUCA ISLAND DECLARATION OF HEALTH IN THE PACIFIC IN THE 21st CENTURY

The Conference of Ministers of Health of the Pacific islands, meeting on Yanuca Island, Fiji, on this 10th day of March 1995, responding to the challenge of changing global conditions and the priority issues raised during the forty-fifth session of the WHO Regional Committee for the Western Pacific;

Believing that:

- new challenges in health in the twenty-first century call for clarity of purpose and broad-based participation to achieve health islands;

continued/...
healthy islands should be places where:
- children are nurtured in body and mind;
- environments invite learning and leisure;
- people work and age with dignity;
- ecological balance is a source of pride;

Endorses:
the concepts reflected in the Western Pacific Region document *New Horizons in Health*;

Adopts:
the concept of ‘healthy islands’ as the unifying theme for health promotion and health protection in the island nations of the Pacific for the twenty-first century;

Recognising that:
- Pacific island countries share many common features in terms of geography, population size, socio-economic status, history, culture, and particularly fragile ecosystems;
- a wide range of health-related challenges needs to be addressed in addition to those highlighted at this Conference, particularly the special needs of those in remote and rural areas;
- limited resources in relation to health personnel, facilities, supplies and materials, require Pacific island countries to work closely together and share resources in achieving health goals;
- many training institutions and programmes for the health professions in countries of the Pacific already exist, including medical, nursing and allied health science schools in American Samoa, Cook Islands, Fiji, Guam, Kiribati, Northern Mariana Islands, Marshall Islands, Federated States of Micronesia, Palau, Papua New Guinea, Samoa, Solomon Islands, Tonga, and Vanuatu;
- the WHO Regional Committee for the Western Pacific, at its forty-first session, endorsed the concept of a network of existing health training and education institutions in the Pacific;
- there is an urgent need for co-ordinated action among these institutions in training human resources for health to address the special health care needs of the Pacific islands;
- health care processes need to change, becoming more holistic and better integrated and linked through networks to meet the complex challenges of the future;
- health promotion and health protection are essential components of this change process;
- environmental health must be integrated with other health programmes, and linked to the activities of other sectors;
- in implementing environmental health programmes, new status needs to be granted to environmental health professionals in government services;
- the 1989 WHO Plan of Action for the Development of the Fiji School of Medicine and the 1994 draft report on the Fiji School of Medicine Development Plan have set the direction for the School;
- improvements in quality, safety, efficacy, availability of drugs and cost effectiveness could be made by Pacific island countries through bulk purchasing schemes for pharmaceuticals, essential drugs, vaccines, medical supplies and equipment;

Being mindful that:
- joint approaches must allow for discretion within countries to accommodate individual differences;
- intercountry approaches must be implemented with flexibility that is responsive to changing circumstances;
- resource implications must be clearly defined and understood in developing and implementing these new approaches;
• training programme development initiatives should consider the full spectrum of health workforce categories as appropriate in the respective countries, including medical, nursing, oral health, pharmacy and the broad range of other allied health professionals;

• academic policies relating to the range and design of educational programmes and student intake should be closely linked to the current and projected health workforce needs of Pacific island countries;

• improvement of collaborative activities and partnership strategies between service providers and training institutions is needed;

• while there are potential benefits in embarking on properly co-ordinated bulk purchasing initiatives, such initiatives should not undermine national sovereignty, nor incur extra cost or cause delay in delivery of vaccines and essential drugs

• collaboration in bulk purchasing schemes should not merely reduce costs but should contribute to higher standards of health care through the rational use of drugs

AGREES, in relation to the development of the health workforce:

• to intensify efforts to further strengthen collaborative relationships through networking, and involve all existing training institutions in the development of human resources for health in the Pacific;

• to reaffirm the role of the Fiji School of Medicine as a major training institution for health workforce development in the Pacific, and to encourage the Government of Fiji to finalise and implement the 1994 Development Plan;

• to endorse the intention of the Government of Fiji to make the Fiji School of Medicine an autonomous institute within the Ministry of Health with provisions for policy input by other Pacific island countries, and to support appropriate financial arrangements for sustainability;

• to further review the appropriateness of the first tier Primary Care Practitioners programme in meeting the health workforce needs of Pacific island countries;

• to introduce postgraduate training at the Fiji School of Medicine to complement the existing postgraduate training programmes at the University of Papua New Guinea;

AGREES also, in relation to environmental health:

• to encourage governments to designate a focal point with an appropriate mandate and sufficient authority to design and implement the activities which follow from this agreement;

• to participate in designing a common protocol for developing national action plans delineating these activities;

• to develop national action plans which align with the unique health and environmental needs of each country;

• to jointly identify factors which adversely influence environmental health;

• to share information concerning effective policies, legislation, intersectoral actions and other enabling strategies to promote health and protect the environment;

• to identify innovative approaches, such as the healthy islands concept, and promote their application;

• to collaborate in building capacity at all levels to develop and manage environmental health programmes and activities;

• to grant new status to environmental health professionals in government services;

• to formulate performance indicators to measure outcomes, and monitor and evaluate environmental health initiatives, including training;
AGREES further, in relation to the supplying management of pharmaceuticals, medical equipment and essential drugs in the Pacific;

- to initiate collaborative programmes to promote rational drug use and the development of national drug policies;
- to establish a multidisciplinary committee to further analyse the benefits of establishing a bulk purchasing scheme;
- to design a model framework for drug legislation and regulatory controls which could be customised to the requirements of the respective countries;
- to develop core, essential drugs lists using generic names that are currently available in all countries, to be updated every two years;
- to establish or identify a reference laboratory for quality testing of pharmaceutical supplies in the Pacific;
- to standardise quality assurance procedures by requiring from manufacturers, among other things:
  - certification of analysis;
  - evidence of compliance with good manufacturing practice;
  - evidence of participation in the WHO certification scheme;
  - expiring dates when purchasing drugs;
- to urge Pacific island countries which have not yet participated in the WHO certification scheme to initiate action to do so;
- to encourage standardisation of essential equipment, such as X-ray machines to enhance better servicing and maintenance arrangements;
- to support the development of appropriate training in pharmaceuticals and operation and maintenance of biomedical equipment to facilitate the development of simple inventory procedures and utilisation surveillance mechanisms, including exchange of information on accredited suppliers of drugs and equipment;
- to establish and maintain an inventory of health technology and expertise available in Pacific island countries and promote access to, and utilisation of, these resources and expertise;
- to investigate, analyse and document traditional and herbal medicines that can be used in Pacific island countries;

CONCLUDES that:

- all countries in the Pacific must strive to work together towards a healthy island state through sharing of information, technology and expertise for the betterment of the environment and health status of the people of these island nations. To this end, the Conference urges the Ministers of Health to gain endorsement of this Declaration from their respective governments;
- all concerned donor countries and funding agencies, United Nations bodies and specialised agencies, regional and subregional organisations and institutions and nongovernmental organisations, some of whom participated in the Conference as observers are invited to continue to provide technical and financial support to Pacific island nations in formulating and implementing their proposed strategies and options for human resource development, health protection and health promotion, supply and management of pharmaceutical essential drugs.

10 March 1995
Michele Vanderlanh-Smith is Fijian-German and was the senior policy advisor on Pacific people’s health for the Ministry of Health until June 1997. She has an extensive background in prison health education programmes. Michele is a graduate of the Master’s in Business Administration (Executive) from Massey University. She is currently employed with the Ministry of Foreign Affairs and Trade. Michele was the project manager who led the development of *Making a Pacific Difference*.

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Anna Bailey is a Samoan-born registered psychiatric, general and obstetric nurse. She is the co-ordinator of the Pacific Islands Immunisation Promotion programme, Auckland, and is involved with the Pacific Heartbeat Committee, Pasifika, the Samoan Nurses Association of New Zealand and Pacific Islands Health and Welfare, Auckland.

Geoff Bridgman, a Pākehā, holds a PhD in psychology and is the research director of the Mental Health Foundation. He has worked as a consultant for World Vision in Romania, and developed development assessment schedules which have been used in Australia, Tonga, Canada and Britain. His interests include research and analysis on disability and mental health, Māori and Pacific Island mental health and television violence.

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Ale Logo was born in Samoa and lives in Auckland. He works with the Regional Public Health promotion team and is responsible for developing health resources for Pacific communities.

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Maria Samoa is Samoan and a voluntary community health worker in Gisborne. Her work has focused on women and children through Women’s Refuge and Rape Crisis, and she has also been involved with drug and alcohol counselling. Maria is currently a student studying social work.

Dr Ellis Situ, a New Zealand Samoan, is a general practitioner in Auckland.

Marion Smith is of English, Irish, Jewish and Caribbean ancestry and was the inaugural director of the Pacific Islands Chamber of Commerce. She is completing her Master in Public Policy, specialising in immigration policy issues, and is contracted to the Australian Government as its head of migration in New Zealand.

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Michael Tuialii is Samoan-born. He holds a BA in Social Policy and is currently studying towards a Bachelor of Law at Victoria University. Michael is a member of the Church of Jesus Christ of Latter Day Saints and is actively involved with young people.

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References


**Acquired immunodeficiency syndrome (AIDS):** A serious disease of the immune system, caused by infection with the human immunodeficiency virus (HIV), allowing the establishment of particular diseases which may cause the death of the affected person.

**Cerebrovascular disease:** A chronic disease affecting the blood vessels in the brain. Also known as stroke.

**Cervical cancer:** Cancer of the cervix or neck of the womb.

**Cervical smear:** A technique used to detect precursors of cervical cancer. The test is based on the examination of cells which are removed from the cervix and examined under a microscope.

**CHE:** Crown health enterprise.

**Communicable diseases:** Diseases capable of being passed from one person to another.

**Goal:** A general aim to which to strive.

**Health status:** A set of measurements which reflect the health of populations. The measurements may include physical function, emotional wellbeing, activities of daily living, and so on.

**Herpes simplex (HSV):** A group of herpes viruses, some of which may be transmitted sexually to cause inflammation of the genital skin.

**Human papillomavirus (HPV):** A group of wart viruses, some of which are sexually transmitted.

**Incidence:** The number of new cases or deaths that occur in a given period in a specified population.

**Information:** Information on health matters is an important precondition to ensure that people are able or willing to make healthy choices. The way in which people access and use information varies according to their general literacy, their personal and social skills and the social and physical environment in which they live and work.

**Intersectoral:** Involving various sectors of the community.

**Intervention:** A specific prevention measure or activity designed to meet a programme objective.

**Ischaemic heart disease:** Also known as coronary heart disease.

**Monitoring:** The performance and analysis of routine measurements, aimed at detecting changes in the environment of health status of populations.

**Morbidity:** Illness.

**Mortality:** Death.

**Notifiable disease:** A disease that is notifiable under section 74 of the Health Act 1956 and specified in the First Schedule, or under section 3 of the Tuberculosis Act 1948.

**Objective:** The end result a programme seeks to achieve.

**Ottawa Charter:** The Charter developed and adopted by the first International Conference on Health Promotion held in Ottawa, Canada, in November 1986. This Charter defines health promotion as the process of enabling people to increase control over and to improve, their health. Health promotion action means: building health public policy; creating supportive environments; strengthening community action; developing personal skills and reorienting health services.

**Pacific people:** The population of Pacific ethnic origin (Samoan, Cook Island Māori, Tongan, Niuean, Fijian and Tokelauan) incorporating people born in New Zealand as well as overseas.

**PHC:** Public Health Commission.

**Population screening:** Screening is the process of testing a whole population of healthy people (those with no symptoms) in order to pick up early signs of disease, or precursors of disease.

**Prevalence:** The number of instances of given disease or other condition in a population at a designated time. Prevalence includes both new (incidence) and existing instances of a disease.
**Primary health care:** Essential health care made universally attainable to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part of the country’s health system of which it is the nucleus and of the overall social and economic development of the community.

**Public health services:** Goods, services, or facilities provided for the purpose of improving or protecting public health.

**Rate:** In epidemiology a rate is the frequency with which a health event occurs in a defined population.

**THA:** Transitional Health Authority.

**Risk factor:** An aspect of personal behaviour or lifestyle, an environmental exposure, or an inborn or inherited characteristic that is associated with an increased risk of a person developing the disease.

**Screening mammogram:** A breast X-ray used as a wellness check for women who have no symptoms.

**Sexually transmitted diseases:** Infections spread by the transfer of organisms from person to person during sexual contact.

**SIDS:** Sudden infant death syndrome.

**Well child care/Tamariki ora:** Term used to describe all health promoting and disease prevention activities undertaken in the primary health care setting for children and their families.

**WHO:** World Health Organization of the United Nations.
Consultation Meetings / Fono

Wellington Consultation Meeting  10 February 1997
Christchurch Consultation Meeting  12 February 1997
Dunedin Consultation Meeting  13 February 1997
Auckland Consultation Meeting  18 February 1997
Tokoroa Consultation Meeting  19 February 1997
Gisborne Consultation Meeting  22–23 February 1997
Rotorua Consultation Meeting  5 March 1997

Note: The outcome of these seven consultation meetings is reported separately in Korero Pasifika: Consultation review, Making a Pacific Difference (available from the Ministry of Health). The information gathered from these meetings was considered as submissions from the Pacific community.

Written Submissions Received From

The Ministry of Pacific Island Affairs
Central Health division of the Transitional Health Authority
Family Planning Association of New Zealand
The Royal New Zealand Plunket Society
Hutt Valley Health Corporation Ltd

Address to Send Comments

The Public Health Group of the Ministry of Health would like your comments on the issues raised in this document. These should be addressed to:

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